Health and Social Care Scrutiny Sub-Committee Agenda

To: Councillor Carole Bonner (Chair)
Councillor Margaret Mead (Vice Chairman)
Councillors: Kathy Bee, Sean Fitzsimons, Andrew Pelling and Andy Stranack

Reserve Members: Councillors: Sue Bennett, Pat Clouder, Bernadette Khan, Manju Shahul-Hameed, James Thompson and David Wood

Non Voting Co-opted HealthWatch Croydon Member (Elect) Mr Jai Jayaraman.

A meeting of the **HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE** which you are hereby summoned to attend, will be held on **Tuesday 17th January 2017** at **6:30pm** in **Council Chamber, Town Hall, Katharine Street, Croydon, CR0 1NX**

JACQUELINE HARRIS-BAKER
Acting Council Solicitor and Action Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

June Haynes
Members Services Manager (Scrutiny)
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www.croydon.gov.uk/agenda
13 January 2017

PRE MEETING FOR COMMITTEE MEMBERS ONLY:
Committee Room F5 at 6.00pm
Committee Members are expected to attend

If on the day you are delayed or unable to attend please contact x 62317 or the Town Hall Reception Desk direct on 0208 760 5525.

Members of the Public are welcome to attend this meeting. If you require any assistance, please contact the Scrutiny Team as detailed above.

AGENDA - PART A

1. Apologies for absence

2. HealthWatch Co-option (Page 1)

HealthWatch Co-option

3. Minutes of the meeting held on 8 November 2016 (Page 5)

Minutes of the meeting held on 8 November 2016

4. Disclosure of Interest

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality in excess of £50. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Business Manager at the start of the meeting. The Chairman will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

5. Urgent Business (if any)

To receive notice from the Chair of any business not on the Agenda which should, in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

6. Exempt Items

To confirm the allocation of business between Part A and Part B of the Agenda.

7. Cabinet Member Question Time:
Councillor Louisa Woodley, Cabinet Member for Families, Health and Social Care (Page 13)

Cabinet member Question Time:
Councillor Louisa Woodley, Cabinet Member for Families, Health and Social Care

8. **Transforming Services for People with Learning Disabilities** (Page 27)

   Transforming Services for People with Learning Disabilities

9. **Outcome Based Commissioning for Over 65s - The Croydon Alliance** (Page 39)

   Outcome Based Commissioning for Over 65s - The Croydon Alliance

10. **CCG Progress Report on the Primary Care Variation Reduction Strategy** (Page 71)

    CCG Progress Report on the Primary Care Variation Reduction Strategy

11. **Annual Report of the Director of Public Health 2016** (Page 95)

    Annual Report of the Director of Public Health 2016

12. **South West London Joint Health and Overview Scrutiny Committee**

    South West London Joint Health and Overview Scrutiny Committee

13. **South East London Joint Health and Overview Scrutiny Committee**

    South East London Joint Health and Overview Scrutiny Committee

14. **Work Programme** (Page 137)

    Work Programme

15. **[The following motion is to be moved and seconded as the "camera resolution" where it is proposed to move into part B of a meeting]**

    That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended.

AGENDA - PART B

None

REPORT TO:	**Health and Social Care Scrutiny Sub Committee 17 January 2017**
AGENDA ITEM:	**2**
SUBJECT:	**Co-option to the Health and Social Care Scrutiny Sub Committee**
LEAD OFFICER:	**Jacqueline Harris-Baker Acting Borough Solicitor and Acting Monitoring Officer**
CABINET MEMBER:	**Not applicable**

ORIGIN OF ITEM:	At its meeting on 28 September 2010, Health, Social Care and Housing Scrutiny Sub Committee Members agreed to invite an annual nomination from HealthWatch Croydon to sit on the Committee as a non-voting co-optee. Nominations are required for the municipal year 2016/17.
BRIEF FOR THE COMMITTEE:	To consider nominations received from Healthwatch Croydon for an in year amendment to the nomination previously received.

1. EXECUTIVE SUMMARY

1.1 At its meeting on 28 September 2010, Health, Social Care and Housing Scrutiny Sub Committee Members agreed to invite HealthWatch Croydon (formally Croydon LINk) to nominate a potential co-optee.

1.2 At its meeting on 19 October 2010, Scrutiny and Overview Committee agreed a framework for co-option to the Committee and its Sub Committees, which is attached at **appendix 1**.

1.3 HealthWatch Croydon has nominated Darren Morgan for the 2016/17 municipal year. Mr Jai Jayaraman, Interim Chief Executive would like to be considered as a replacement for the remainder of the municipal year 2016/17

2 RECOMMENDATION

2.1 The Sub Committee is recommended to:

Appoint Jai Jayarama as a non-voting co-opted member as nominated by the HealthWatch Croydon for the remainder of the municipal year 2016/17.

CONTACT OFFICER: June Haynes,
Members Services Manager (Scrutiny).

BACKGROUND DOCUMENTS: None

Appendix 1

FRAMEWORK FOR THE NOMINATION, APPOINTMENT AND RETENTION OF NON-VOTING CO-OPTEES TO CROYDON SCRUTINY COMMITTEES

The Council's constitution permits Scrutiny Committees to appoint non-voting co-optees. The purpose of this 'Framework' is to lay some ground-rules as to how Scrutiny Committees might use this opportunity.

Non-voting co-optees appointed by Scrutiny Committees should*:*

- be nominees of relevant broad-based voluntary or private sector networks or forums
- be willing to draw knowledge from, and feed information back to, their nominating network or forum as one means of promoting wider public understanding of, and involvement in, Scrutiny
- not be individuals who are strongly identified with partnership working with Croydon Council (in order to avoid potential conflicts of interest that might result from contributing to both partnership and scrutiny work on the same or similar issues)
- provide a short written statement on how they believe they can make an effective contribution to the Scrutiny Committee to inform the Committee's decision on whether or not to appoint nominees put forward
- be prepared to attend an induction session with the Scrutiny Unit or with Committee members
- be appointed for the remainder of the municipal year, or for a shorter period if the Committee so decides
- have their membership withdrawn if they fail to attend two successive meetings without good cause
- on appointment, sign an undertaking to observe the Council's Code of Conduct for Councillors and complete an entry in the Register of Interests
- not be a member of more than one Croydon Scrutiny Committee
- confirm their willingness to accept and seek to fulfil the above expectations prior to their appointment

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HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE

Minutes of the meeting held on Tuesday 8 November 2016 at 6.35pm, Council Chamber, Town Hall, Katharine Street, Croydon.

WRITTEN MINUTES – PART A

Present: Councillor Carole Bonner (Chair)
Councillor Margaret Mead (Vice Chairman)
Councillors: Kathy Bee, Sean Fitzsimons, Bernadette Khan and Andy Stranack.

Darren Morgan, HealthWatch Croydon Co-optee

Also in attendance for part or all of the meeting
Councillor Louisa Woodley, Cabinet Member for Families Health and Social Care

Also in Attendance Paula Swann, Chief Officer, Croydon CCG, Stephen Warren, Director of Commissioning, Croydon CCG, Pratima Solanki, Director, Adult Social Care & Disabilities, Sean Olivier, Safeguarding Adult Co-ordinator, James Burgess, Head of Disability Commissioning and Brokerage and Rachel Flowers, Director of Public Health.

A58/16 Apologies for absences

Apologies for absences were received from Councillor Andrew Pelling, Councillor Bernadette Khan deputised.

A59/16 Minutes of the Last Meeting held on Tuesday 27 September 2016 and Tuesday 18 October 2016.

Minutes of the meetings held on Tuesday 27 September 2016 and Tuesday 18 October 2016 were agreed.

A60/16 Disclosure of Interest

At 6:41pm Councillor Andy Stranack disclosed that he is a Member of the Clinical Commissioning Group Outcome Based Commissioning specialist working for over 65s.

A61/16 Urgent Business

None

A62/16 Exempt Items

Part B minutes of the meeting held on Tuesday 27 September 2016.

A63/16 Adult Social Care: Overview of the Care Home Market in Croydon
(agenda item 6)

Pratima Solanki, Director of Commissioning made the presentation of the report, other officers in attendance to contribute to the debate were Sean Olivier, James Burgess, Head of Disability Commissioning and Brokerage, Barbara Peacock, Executive Director, Councillor Louisa Woodley and the Director of Public Health, Rachel Flowers.

Members having reviewed the report welcomed an introduction to the report. Officers agreed that the department continues to achieve more for less however the low prices that Croydon offers care homes are causing a crisis in relation to placements.

Officers reported that the Care Quality Commission (CQC) recognise that Croydon continues to have the largest provider marketing in London, 228 locations, the general outlook and ratings are good or adequate. No homes have rated inadequate, the authorities shared lives programme had been rated outstanding, the CQC giving Croydon a "pat on the back" for good examples of interaction with care homes resulting in the residents of Croydon having a good experience. Regular CQC inspection outcomes are reported to each Adult Social Services Review Panel which officers offered to forward to the Committee in future.

The second part of the CQC work in Croydon is to monitor and investigate safeguarding enquiries. Which represents a great burden due to the scale of care settings in Croydon. The department has a good reputation of managing safeguarding queries. Using robust processes if a home is placed in suspension the authority will inform all other London boroughs of a change in status.

The national picture describes the care home economy as being at a "tipping point". The major concern is related to recruitment and retention, as Croydon had a large provider base other boroughs look to Croydon when looking for placements.

Officers reported that the need for older people beds will continue to increase and that the OBC should help to sustain the market as older people will stay in their homes longer before requiring full time care in a labour intensive setting. The sustainable and transformation plan across south west London will also support this.

Officers, provider forums, commissioners and network care homes report that the outcome of analysis is that dementia nursing beds are at a premium, and ask how will this shortage be managed? Some beds use could be redirected from learning disability beds, as independent living is being encouraged, the departmental approach is reactive trying to keep people in their home longer.

Officers reported that Care UK have already converted 6 new beds into the system and that work continues to redefine the community strategy and review how commissioning will address future demand as Croydon, as a regeneration borough needs build its housing strategy across all homes.

The Committee asked what the impact was and what the consequences were to Croydon slipping from 3rd best performers to 6th. Officers responded that NHS Improvement seek to develop a recovery and investment plan. Croydon are in discussions to increase its rates to pay the same rate as neighbouring boroughs. The STP should regulate prices across London.

The Committee are concerned that the OBC is viewed as the driving force to deliver change across all disciplines, with no alternative.

Historically, Heavers farm, was the Councils new for old programme, officers were asked to explain, if the new for old was to solve nursing and dementia, what has happened that the strategy has not delivered, and are the new homes being used effectively? Officers reported that extra care units and homes PFi scheme are being used currently 85% occupancy. People living longer and when they eventually require nursing care it is at a higher level of nursing need. There is recognition that not all nursing homes are right for the dementia conversation, however the OBC should resolve and redefine specialties.

Officers confirmed that 6 beds located at Addington heights continued to be used as dementia beds. Members asked if Croydon should be seeking to build or convert more beds to address the dementia bed shortage. Officers confirmed that this is an area of potential development, as more beds are required across South West London.

Members discussed the transformation plan and asked how things were working. Officers reported that the alliance are working together and that the OBC is all about contracting and that officers are looking to sign this off this year move towards formal implementation next year, however some specialties in the model of care can start to be implemented now, as multidisciplinary teams can delivery this working with local GPs

The Committee recorded their continuing concern regarding the pressure on the OBC to succeed, this included the documented shortage of nursing and pressures on other parts of the system.

The Chair stated and the Committee were expected to review the OBC at the pre decision stage and hope that this can be achieved within the committee and alliance work programmes. In additional the Committee agreed that they would want to be involved in the development of older people staying in their homes.

A64/16 Progress Update on the Better Care Fund (agenda item 7)

Paula Swann, Chief Officer, CCG and Stephen Warren were in attendance to present this item to the Committee, who requested in-depth detail about the relationship between the Better Care fund (BCF) and the Outcome Based Commissioning for Over 65s; and asked again what the consequences would be if either the BCF or the OBC initiatives failed.

Officers confirmed that the report was an overall summary of the BCF with the inclusion of a detailed plan for the financial year. Members debated the current situation in that the BCF was being held at the minimum statutory requirement for 2016/17 and that it was unclear if the OBC had commenced. Officers confirmed that the £212m was made up of savings from the CCG and that the final decision around reassurance rating had been fully approved for the remainder of the financial year.

The electronic clinical recording system EMIS went live in July 2016, the Members asked if there had been any early indication of trends or initial feedback that officers could provide. Currently the system is used to co-ordinate the "my care" functionality of the patient record, the system is currently being rolled out to local GPs. Initial feedback from healthcare professionals is that the system is working well and is helpful. The Committee recognised that the take up of the system had not been high across Croydon GPs and wanted clarity around the attraction and promotion amongst GPs. The Committee requested fuller details of how the systems benefits had been promoted, this information would be provided at a future date.

The Committee commented that instances of dementia where on the increase and wanted some assurances about staffing levels. Officers reported that staffing level are currently sufficient and that additional staff would be available to meet the growing demand. Keeping the dementia advisor and early detection as the main focus would keep this service going and fully supported.

Hospital services were discussed and the success of the rapid response team debated. The services has achieved the 2hrs response target time despite the continued increase in activity over the past 2 years. Non elective admissions are on target which means system is working and the GP networks can support this as they rate the service as helpful.

Outcome Based Commissioning (OBC) was the focus of debate, officers confirmed that this initiative was regarded as the council's vehicle for the integration between social care and health, the OBC is viewed as being significant to achieving aspirations Officers from the People Department confirmed that Croydon's OBC journey is comparable to other authorities across the country as Croydon continues to move towards health and social care integration however the parameters of this are still to be determined. The commissioner and provider alliance are further along than other areas.

The Committee recognised that the guidance to officers seemed to be constantly delayed, prompt notification would assist delivery and thanked officers for the report and the subsequent presentation.

A65/16 Mental Health Services – Croydon CCG (agenda item 8)

Paula Swann, Chief Officer CCG and Stephen Warren, Director of Commissioning CCG presented the report to the Committee. The debate included the following key issues.

The Committee highlighted that the performance rating contained a high percentage of amber ratings, officers confirmed that this was as a result of the existing funding challenge. It was reported that currently CAMHs funding levels are protected and extra resources are being diverted into reprioritising the service.

Officers confirmed that the exiting mental health strategy and based on the JSNA to address some of the contributors to the significant increase in occupied bed days.

The importance of supported housing was discussed in relation to how successful independent living is to improved outcomes, officers reported that housing in combination with all physical health aspects would form a complete pathway for service users.

Members were concerned that Croydon figures were similar to those published in the national press in relation to service users being evicted from their homes due to an extended hospital stay. The Committee asked officers if there had been any intelligent networking regarding flows of information from health providers to landlords/benefits agencies. There had also been instances of service users also being unable to maintain their mortgage payments, Members asked how this was being addressed. Officers agreed that this was a major issue resulting in 127 services users in Croydon over the past 18 months having their benefits stopped whilst in hospital. The gateway team would be the best areas to work through some of these issues.

The Committee asked if the local substance misuse service performance is comparable to services available nationally. Officers confirmed that Croydon is performing well and that the complexity of working with this group is compounded as there would generally be a duel diagnosis.

Members were encouraged to note that CAMHs waiting times are on the decline but recognise that there is still some work to be done to record acceptable waiting time for this group of young people.

The Committee requested more detail regarding the 127 instances of services users ended in financial difficulty due to a hospital stay and requiring

the use of the gateway team to re-establish their benefits or arrange rehousing.

Members discussed how the best scrutinise this concern, a more detailed report was debated as was the setting up of a sub group. Ultimately it was agreed that a recommendation be made by the Committee to request that the Streets, Environment and Housing Scrutiny Sub Committee review the rates of evictions and housing benefits of service users within their work programme.

The Committee **RESOLVED** refer an item on the eviction and housing benefits concerns arising from a hospital inpatient stay to the Street, Environment and Housing Scrutiny Sub Committee.

A66/16 HealthWatch Update (agenda item 9)

Darren Morgan reported that the national survey of 2000 GP services reported that services were rated overall good however some concerns raised in relation to receptionists triage results.

A67/16 South West London Joint Health and Overview Scrutiny Committee (agenda item 10)

The SWL JHOSC are currently canvassing Members for a date to receive an update from the South West London Sector CCG regarding the future sustainability and transformation plan following submission to NHS England.

North West London had agreed to host a PAN London JHOSC Forum on 24 November 2016 to discuss the sustainability and transformation plans on a pan London basis.

A68/16 South East London Joint Health and Overview Scrutiny Committee (agenda item 11)

The SEL JHOSC had not met since the last meeting of the Sub Committee.

No agreement had been signed yet between the boroughs in regard to shared services and the costs would be allocated equitability.

A69/16 Work Programme (agenda item 12)

The Committee were due to receive an item on the outcome based commissioning initiative awaiting a reporting date from officers.

Summary of the discussion in part B.

Minutes of the last meeting held on 27 September 2016 were agreed.

Meeting ended 8:51pm

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Councillor Louisa Woodley

Cabinet Member for Families, Health & Social Care (FHSC)

Deputy, Councillor Callton Young

Responsibilities

- Adult Safeguarding Board
- Adult Social Care
- Better Care Fund / Care Act
- Disability Service
- Domestic & Sexual Violence – FHSC & FSJ*
- Gateway Services – Adults & Housing Need
- Housing Needs & Assessment
- Adult Mental Health
- NHS Commissioning Advice
- NRPF
- Public Health
- Social Work
- Adult Commissioning

Policy Developments

- Care Act 2014: Modernisation and consolidation of adult care law with new national eligibility criteria, carers' right to assessment, a wellbeing principle, statutory Adult Safeguarding Boards and a right to independent advocacy
- Children & Families Act 2014 Links with Care Act – opportunities for integration of services: reforms for children and young people with Special Educational Needs and Disabilities (SEND)
- Better Care Fund (BCF) aims to promote better integration between health and social care to provide a whole system approach to improving patient outcomes through investing in community based services. In 2016-17 BCF will be increased to a mandated min of £3.9bn to be deployed locally on health & social care through pooled budget arrangements between LA's & CCG's

Projects and Programmes

Live Well (person centred integrated lifestyle service)

- Launch of 'Just Be...' online behaviour change platform in July 2016 supported by development of MI change; in-house lifestyle services to be launched in October 2016, encouraging people to make healthier lifestyle choices including smoking and weight management

Transforming Adult Social Care (TRASC) Programme

- 'A life not a care plan' - TRASC will deliver personalised services and a financially sustainable adult social care system which can meet increasing demand arising from an aging population and an increase in clients with increasingly complex needs

Outcome Based Commissioning (OBC) for over 65's

- Ontegrated commissioning of all health and social care services for our over 65 population. Improving outcomes set by our residents through a new model of care and long term outcomes based, capitation contract delivered by a local Alliance of providers across the statutory, voluntary and community sector

All Age Disability Service 0-65

- Development and delivery of our All Age Disability Framework focusing on our understanding of needs and developing clear pathways from birth to 64 for children with Special Educational Needs and Disabilities and adults with disabilities and support for their families

Commissioning for Personalisation (TRASC workstream)

- Achieve outcomes and a sustainable model of ASC, market facilitation for direct payments, commissioning of effective payroll and support planning and brokerage services, domiciliary care and care home market management, supported living accommodation and accreditation of personal assistants

Social Isolation JSNA and action plan

- To be developed following Croydon Congress event on Social Isolation & Loneliness

Improving Mental Health

- Continue to implement strategy to strengthen community provision for adult mental health; and develop our work in increasing dementia

Welfare reform

- Implementation of Phase 2 of the "Gateway" approach to reach more families

Housing Needs

- Continue to reduce families in emergency and temporary accommodation

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Councillor Louisa Woodley

Cabinet Member for Families, Health & Social Care

January 2017

Successes

- Transforming Adult Social Care
- Gateway
- Public Health
- Go-On Croydon
- Delivery of equipment service
- Outcomes Based Commissioning for over 65s

Transforming adult social care (TRASC)

Essential to reducing cost pressures through better demand management, effective commissioning and promoting independence at every opportunity.

Benefits

better access to advice, information

support through re-ablement

more choice and control

more support to live independently

Gateway

Getting recognised

- Second place at Andy Ludlow 2016 / shortlisted for LGC Awards 2017

Temporary accommodation / emergency accommodation

- Loss of private sector accommodation
- Multi-assessment prevention response
- 25% of clients prevented from statutory homelessness
- Home from Home scheme prevented 50 people going to temporary accommodation

Expanding the service

- Community Connect
- Croydon Enablement and Support Triage Service (CREST)

Public Health

Smoking cessation

- Second year of substantial increase for people who have stopped smoking

Just Be

- Digital behaviour change platform, provides lifestyle information, interventions and advice
- Interactive central hub, with support on issues such as weight management, alcohol-harm reduction, physical activity, mental health and well-being, smoking and sexual health

Obesity

- Food Flagship Programme – transforming the food environment; working with schools, food businesses and community organisations

Go On Croydon

Year-long council led project to make sure everyone in our borough has Basic Digital Skills

- Recycled computer equipment now in community centres
- Developing local digital champions / computer clubs

Go On has supported the development of digital skills amongst older people including:

- Age UK's Digital Zone offers
- Sheltered housing workshops
- Go Back to College IT workshops

Assistive technology:

- Sentab and Vizbuzz

Delivery of equipment service

A vital service to vulnerable residents of Croydon and surrounding areas.

- Supplying 30,000 pieces of equipment each year
- meeting all our customer performance and assurance indicators
- Five-year business plan
- Strong partnerships with other local authorities
- Economies of scale through procurement purchasing power
- 30% saving from suppliers on equipment
- Significant potential to grow, be profitable and bring benefit to Croydon, whilst providing an excellent service to Croydon

Outcomes Based Commissioning 65+ (OBC)

Croydon Alliance for Over 65s

- Transformational arrangement, integrating health and social care for over 65s from Apr 17
- £223m per year, £44m for social care (2017/18)

New Models of Care

1. Multidisciplinary Community Hub
2. My Life Plan
3. Personal Independence Co-ordinators
4. Point of Access and Information
5. Living Independent For Everyone

CROYDON www.croydon.gov.uk | Delivering for Croydon

NHS Croydon Clinical Commissioning Group

Croydon Health Services NHS Trust

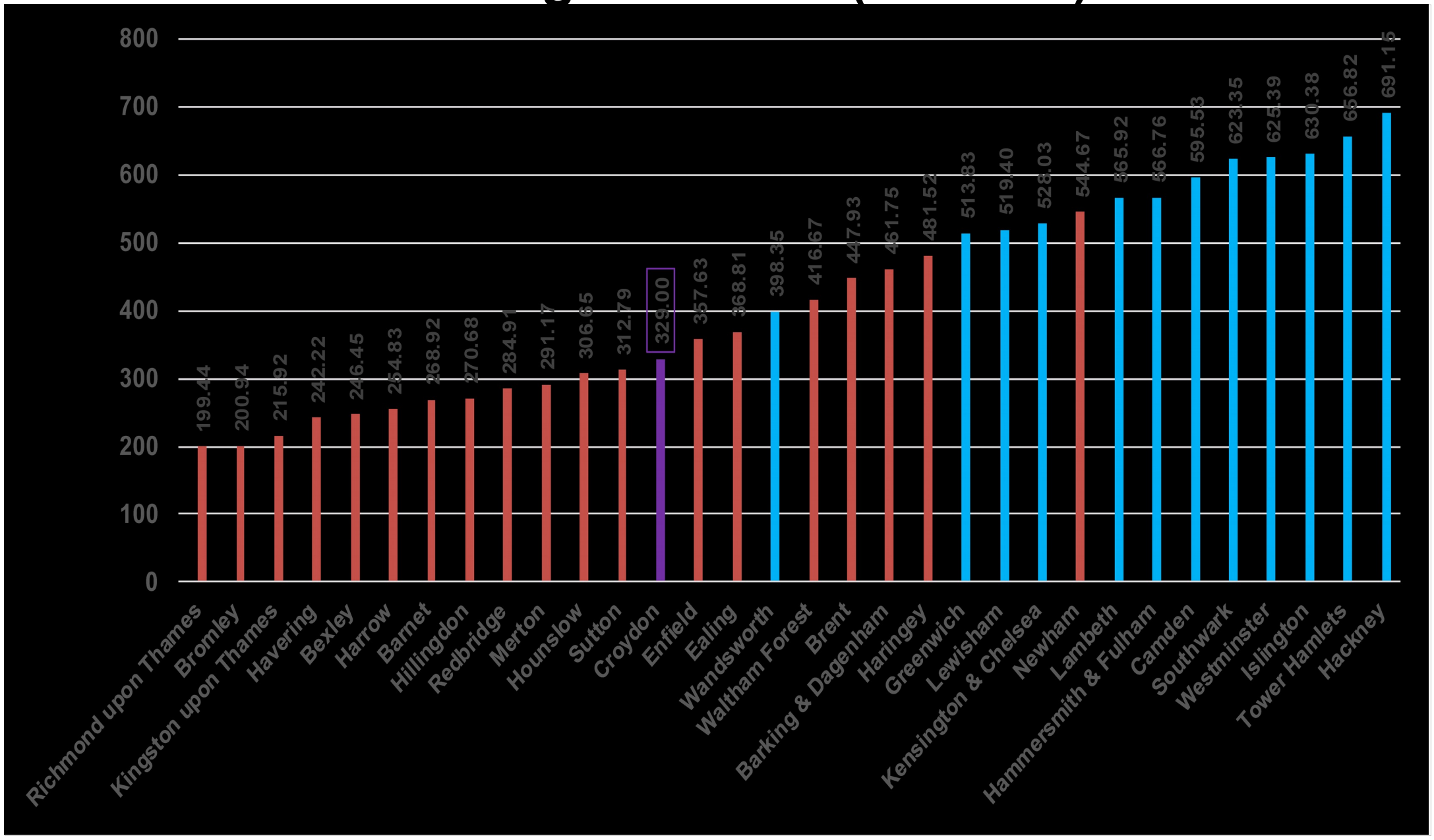
South London and Maudsley NHS Foundation Trust

Croydon ageUK

Challenges

Budget and demand

Funding Per Head (London)



Based on Authorities core spending power/population

Croydon Funding Per head £329.00

Budget and demand

Expected demand pressures impact £8.3m from 2017 - 21

General Fund	12/13	13/14	14/15	15/16	16/17
Budget	£117.304	£112.909	£104.875	£102.420	£105.751
Outturn	£118.987	£117.003	£109.379	£105.751	£108.542
Overspend	**£1.683**	**£4.094**	**£4.504**	**£3.331**	**£2.791** *forecast*

Key demand indicators for the service, December 2016 Six month percentage change shown in brackets		
Care packages – planned hours, OP,PD, LD	83,379	(+9%)
Placements – residential & nursing, OP,PD, LD	674	(-4%)
No. of contacts / referrals	941	(-0.2%)
No. of new social care assessments	642	(+79%)

Population change	2016	2030	Increase
0-24	122,698	133,992	9.20%
25-64	210,930	223,134	5.79%
65+	49,780	71,488	43.61%

People aged 65 and over predicted to have dementia	2014	2015	2020	2025	2030
Croydon	3,341	3,463	3,914	4,536	5,417

Mental health review

Significant local and national challenges in adult mental health services

- growing demand
- over-reliance on inpatient provision
- challenging financial environment; and
- need for greater integration

Review of Croydon's five-year Mental Health Strategy - 2014/19

- particular focus on the experience of, and outcomes for, BAME communities.
- reference group with multi agency membership
- Report due Spring 2017

General Release

REPORT TO:	**Health and Social Care Scrutiny Sub Committee 17th January 2017**
AGENDA ITEM:	**8**
SUBJECT:	**Transformation of services for people with Learning Disabilities**
LEAD OFFICER:	**Barbara Peacock, Executive Director People,** **Paula Swann, Chief Officer, Croydon CCG**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Families, Health and Social Care**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Stephen Warren, Director of Commissioning, Croydon CCG** **Caroline Baxter, Assistant Director of Disability 0-65.**

ORIGIN OF ITEM:	**This item forms part of the Committee's work programme**
BRIEF FOR THE COMMITTEE:	To review and consider the progress of the transformation programme in place for people with learning disabilities

1. EXECUTIVE SUMMARY

This report looks at the developments, plans and actions that have or are transforming the way the London Borough of Croydon is supporting people presenting with Learning Disabilities. Much of the work is encompassed in the broader Transformation of Adult Social Care Programme (TRASC) that is currently underway.

This report details the current actions and the plans for the future of Learning Disability Services including information on The TRASC Programme, an Asset Based Approach to Social Care, Support Planning and Brokerage, In-borough provision, Safeguarding, Co-Production and moving forward.

2. TRANSFORMATION OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

2.1 Introduction

The Transformation of Adult Social Care (TRASC) Programme is key to enabling the Council to deliver personalised services, "a life not a care plan", as well as a financially sustainable adult social care system. It is a response to reducing budgets and increasing demand arising from an aging population and an increase in clients with increasingly complex needs.

The Programme will also reduce underlying cost pressures through better demand management, effective commissioning and promoting independence at every opportunity to release further cost efficiencies. The intended benefits of the Programme are:

- People will have better access to advice, information and targeted prevention that will help them to live their lives without support from the Council;
- People will be supported through re-ablement to be as independent as possible;
- People will have more choice and control, leading to higher satisfaction levels; and
- More people will be supported to live independently.
- In line with the Care Act we are moving toward delivering services through an Asset Based Approach.

The focus of the Care Act is about meeting need not simply providing services. Promoting wellbeing is not always about local authorities meeting needs directly. It is about ensuring that a system is also in place for people to access the information they need to take control of their care and support and choose the options that are right for them. The system has not always offered enough choices about the range of ways that the needs of the individual could be met.

- The asset based approach in part, is about financial sustainability within adult social care. It is about increasing peoples' independence, reducing dependency on services and to ensure those requiring long term support receive this for those needs which cannot be met in any other way.

- The emphasis is to find solutions with the person to address their needs utilising their own assets during all interactions with adult social care.

This is a cultural shift for staff as well as service users.

2.2 What is the Asset Based Approach?

To protect and maximise the individual's independence, resilience, ability to make choices and to promote well-being by focussing on:

Resilience, ability to make choices and to promote wellbeing by focusing:

- A person's strengths, capabilities, skills, knowledge and potential.
- The person's existing network – including family, friends and neighbours and community resources.

Thinking differently - moving away from a services orientated approach and focussing more on promoting independence:

- Asking different questions
- Finding out what a person wants to achieve
- What is important to the service user?
- What is already working well for them?

- In revising the customer journey from the front door onwards, whichever route a person comes into the council, similar conversations should be occurring.

Case Study – a resident with high learning disability needs

The TRASC High Needs Review Team, led by Dan Fisher and Caroline Peters, focuses on finding alternative more proportionate forms of support for people with high learning disability needs. An example of the work they have conducted with one of our residents is captured in the case study below:

> "*Mr. A is an intelligent gentleman who had a successful career in education. Mr. A was married with one child but sadly divorced and lost contact with his family. Following a period of alcohol misuse, it was reported that he was living on the streets and then admitted to hospital after collapsing. Mr. A was later admitted to a specialist nursing home out of borough and was treated for a number of years for a chronic memory disorder resulting from alcohol misuse.*
> *Following a review by a Social Worker from the TRASC High Needs Team, it was found that his placement was no longer suitable because he was more physically and cognitively able than some of the other residents. Mr. A agreed to move back to Croydon where he received a period of Reablement in Extra Sheltered Accommodation. He has now moved into another flat where he continues to be mostly self-reliant which has a positive impact on his health and wellbeing.*
> *Mr. A informed the High Needs Team of new outcomes he would like to achieve including volunteering in education again. According to Mr. A, it will give him 'great joy' if he can use his knowledge in education to assist the next generation and he can give back to the community*".

2.3 Developments to in-borough provision for people with learning disabilities:

Building work is being carried out to partition the current Cherry Orchard Day Centre site to enable us to share the building with the White Horse Youth Centre. For health and safety reasons the council decided to move the Cherry Orchard Day service into Addington Heights Day Centre (which was empty) and Peter Sylvester Centre (PSC) during the building work which commenced on 1 October 2016. Annette McPartland (Head of Service Day Operations) and her management team, Kaye Carter, Caz Clark and Paul Wallingford are leading on the move.

One half will be used for White Horse Youth Centre – no decisions have yet been made regarding the other half of the building as the council will wait until the end of the process of co-production.

The council are aiming to co-produce a modern and personalised service offer for people with learning disabilities in Croydon and therefore will soon be extending an open invitation to attend a variety of events to help shape and produce this plan for the future.

The initial feedback from clients using the new sites is positive and we are continuing to work with service users and their families to develop the most appropriate model of care.

There have been some small issues regarding transport due to clients having extended journeys. This is currently being addressed. There was a specific and unforeseen transport problem, lengthening some of the journey times, due to the additional traffic pressures and diversions as a result of the recent tram incident. This of course was a temporary issue.

Current actions:

- Attendees of Cherry Orchard Day Centre have successfully moved to alternative venues in order to vacate the site for building work that enables the Youth Zone development. The managers and staff at Cherry Orchard played a huge role in supporting and reassuring attendees and their families.

- We have procured more advocacy providers to increase the capacity available to support vulnerable adults to access our pathway and support people during reviews and any changes to services and so on.

- The co-production partner (The PublicOffice) will jointly develop a vision and blueprint for the future of services and opportunities for people with a learning disability, carers and key stakeholders by the end of January 2017.

2.4 Other innovations and generic benefits arising from the TRASC programme are:

- Safeguarding – we have liaised with the Police Service on improving our joint efforts in safeguarding adults. The phased rollout of integrating safeguarding into wider social work practice has begun with the Learning Disability (LD) Team.

- Adult Social Care Pathway – reduced staff time in processing Contact Centre referrals into AIS (our case management system).

  Referrals are received through the Contact Centre. Referrals that cannot be resolved at this first point of contact will be forwarded to the Central Duty Team or Gateway. They will be allocated after initial assessment to either the appropriate Social Care Team or Crest.

- Support Planning and Brokerage – we have worked with a partner organisation to run a pilot testing a peer support planning and brokerage model. We are currently reviewing the feedback and exploring our next steps.

- CREST – We are in regular liaison with the Gateway Phase 2 Programme who are developing CREST – a team of staff who will triage Adult Social Care queries and provide a holistic and responsive service at the front door. Adult Social Care -specific training will be provided to CREST staff.

- Carers – we have developed a carers Resource Allocation System (RAS), supported by a Carers Assessment form in order to increase our offering to this resident group. The Carers Forum have welcomed the RAS. Carers were directly involved in the development of the RAS specifically the Carers Forum and Carers Partnership.

- The 0-25 service went live in April. Subsequently, we have worked together on safeguarding, the development of standard operating procedures, direct payments and the inclusion of some transitions within the high needs review team.

- Direct payments are cash payments made to an individual directly, giving a person the choice to buy and arrange their own social care services. The level of your direct payment is reviewed regularly in line with care needs and there is also the option to split the service needs to be covered partly by direct payments and partly still receive other services in the usual way via the Council.

- People taking up direct payments are given help to manage their direct payments - both in securing the services and the support they want the direct payments to provide, and in dealing with the finances. Our Direct Payments Support Service can provide support, advice and guidance and support planning. For example, they provide assistance with employing and paying people to provide care and with managing the paperwork and the cash payments.

- There is also a direct payments user group for advice and information for all current and prospective users of the direct payments scheme. Group members can provide mutual support and advice from a user's point of view

- 0-25 service joined the All Age Disability Service on the 1st of November.

- Carers RAS launches in January 2017

The Council wishes to establish the foundations for co-production by starting to learn together with the community, what it takes to co-produce not just plans, but outcomes that are important to people too. This will therefore be much more than a consultation exercise.

"Co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them." ***(Think Local Act Personal (2011) Making it real: Marking progress towards personalised, community based support, London: TLAP)***

A co-production partner (The PublicOffice Ltd) was procured in October 2016 to support the council and its stakeholders in the wider transformation of adult social care services for people with a learning disability in Croydon. There is a wide scope for this work, including day, respite, housing, employment, well-being and quality of life opportunities for people with a learning disability in Croydon.

The PublicOffice.org.uk are an organisation committed to see better life outcomes for citizens. They work with organisations that want to review what they do and how they do it, and who understand that citizens themselves have a critical role to play. Their ambition is our ambition is to create systemic change. They work to embed expertise within the system, to help organisations learn how to do things differently

themselves. Learning is the key driver: making explicit what is going on, helping people reflect on their own data, beliefs, processes and practice, and building the capability to operate in new and more effective ways.

http://www.wearethepublicoffice.com/about-us/

As part of Croydon Council's commitment to coproduction, The PublicOffice are meeting people using day services, people in supported employment, young people aged 14-25, people participating in social opportunities, people using residential centres, in supported living, people using Shared Lives, people using personal budgets/Direct Payments, and people using Heatherway and other short break services.

They will also be talking to Mencap, Croydon People First, Parents in Partnership, CASSUP, the Head of the LD Partnership Board, Croydon Employment Services, Parent/Carers, the SEN Improvement Advisors, and colleges, Council members and staff.

The PublicOffice began this exercise of listening and engagement with groups at the heart of the change, in November. They will present their indicative findings and a 'blue print' for the way forward to stakeholders at the end of January based on what they have gathered during the co-production exercise.

Given the timescales above, the Council will be able to consider the 'blue print' from the co-production and the future of Heatherway respite service in February 2017.

If our decision in February, is to close Heather Way and provide alternative opportunities for short breaks, a period of consultation would be required from the beginning of February to March 2017. The co-production exercise would not replace the requirement for formal consultation.

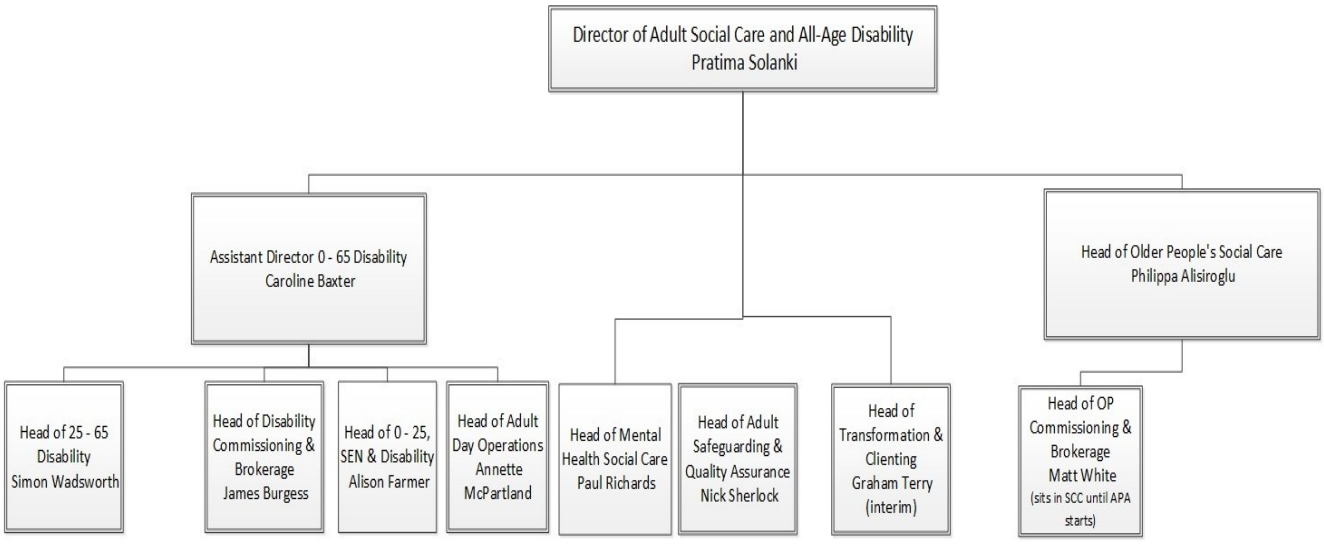
Out of the 44 service users who are eligible to access Heather Way, only 30 actually use the provision. All 44 users are to be reassessed and alternative solutions are being found for them. Therefore there is a decrease in the running costs month by month for the service.

2.5 Service Management:

The new management structure for the All Age Disability Service is now in place. This team are working on delivering the new structure for the service that will bring innovation, joined up pathways from birth to old age enabling people who use the service and their carers to achieve 'a life not a care plan'.

New management structure for All Age Disability Service.

The majority of this team commenced work with LBC in October or November 2016



Moving Forward: review processes and ongoing evaluations:

Risks

A detailed evaluation of the savings plans is being undertaken and further savings options are being developed to replace any savings plans that are likely to under-deliver due to changes in circumstances. Work is being undertaken in conjunction with the Gateway programme and Managing Demand Programme to identify areas where cost reduction savings can be obtained. More info will be available by the end of May.

Options

The budget savings were identified as part of the 2016/17 budget setting process, during which a number of options were identified and evaluated. These savings have been reviewed and updated where circumstances have changed, as part of the 2017/18 budget setting process.

Future savings/efficiencies

The programme will review savings options on a monthly basis to ensure they are on target to deliver, where delivery is not possible, alternative projects are identified and where possible further savings are identified and achieved.

Working towards standardising the way that we work –

Staff predominantly from across Adult Social Care within LBC told us they needed guidance and that our policies were out of date. Policies needed updating because of the implementation of Care Act. We have engaged with a number of staff in order to create Standard Operating Procedures (SOPs).

The SOPs describe and outline guiding policies, processes and pathways that operate within Adult Social Care.

They cover everything staff need to know to perform practitioner tasks.

The SOPs will be regularly updated. The SOPS are available on the Intranet on the "People" homepage.

To provide consistency and improve quality of practice

New assessment forms have been developed in partnership with the Making a Difference Group, CASUP and other user led organisations.
On-going monitoring of quality of practice and delivery of service will be embedded into workflows, reviewed and reported on regularly.

Assessment form has been developed in association with the Making a Difference Group and is due for launch in February

3 Update on Transforming care

3.1. Background

Post Winterbourne view and the Transforming care reports – a further publication Building the Right Support (October 2015) indicated a requirement for CCGs and local authorities to work together to prevent in patient admission and to ensure that there is support to enable individuals to access their communities in their local area inclusive of health, social care, housing and the wider community.

NHSE put in place an ambitious programme of work for commissioners to transform learning disabilities care and reduce the number of people being treated in hospital.

On 14th October 2015 Croydon CCG submitted their national return to NHSE and this document outlined the progress on achieving against the four key areas, which underpin the seven commissioning standards:

- Ensuring appropriate discharge planning for inpatients
- Preventing inappropriate admissions to inpatient services
- Delivering effective case management and discharge planning
- Ensuring governance and oversight of programme delivery at a CCG and provider level

Croydon self-reported non-achievement against each of the seven indicators at the time but since then has made significant improvements.

Eight people with learning disabilities were originally identified by Croydon as patients meeting the criteria for Transforming Care. Four were in Hospital in Essex, one in London, one in Wales, one in Nottingham and one in Northampton. Placements for these individuals were funded by Croydon Clinical Commissioning Group (CCG). The length of stay for these individuals ranged from one year to thirty and averaged 3¾ years.

Since this original cohort was identified other patients have been flagged by NHS England (NHSE) as individuals they are funding who potentially will require support from Croydon CCG once NHSE is no longer funding their care. Four people with learning disability were identified as part of this group. Additionally, there are seven people with learning disability in complex residential placements in Surrey & Borders Partnership NHS Foundation Trust.

The reported number of people being treated in a hospital setting raised concerns for the CCG along with a lack of sufficient progress in safely discharging clients to more appropriate community settings.

3.2. Progress made to date

In response the CCG committed additional resources to progress the work both strategically and operationally and undertook an independent review jointly with the council. Governance arrangements have consequently been strengthened with the creation of a Transforming Care MDT Meeting (for joint health and social care reviews) and a Transforming Care Funding Panel.

A key focus of the work has been around transforming care and building the right support for people with complex learning disabilities, autism, mental health and challenging behaviour

The eight people identified were not actively case managed by Croydon CCG and Social care. Commissioners attended Care Programme Approach reviews when possible but there was no coordinated tracking or planning for these individuals. Care & Treatment Reviews (CTRs) were introduced in October 2014, which are used to check if the person is safe, that they have good quality care and clear plans for the future including move to community based care. The quality of care was variable, sometimes with little evidence of assessment or treatment. All the care could be provided in the community but none had clear plans for this to be actioned.

Croydon CCG initially invested in two Complex Case Reviewers to focus exclusively on supporting this cohort to carry out the recommendations of the CTRs and follow up the work and Move On initiated by social care. A further appointment of a part time senior complex reviewer and a full time commissioning support officer and a temporary reviewer with Continuing Health Care background further increased the ability to move people on to more appropriate settings of care. Some reviewing activity is also undertaken with the Council High Needs review team.

Of the 8 people reported to NHSE under Transforming care in July 2015. There have been seven discharges from CCG funded in patient placements and one from NHSE step down. The destinations of these clients has been to mainly residential placements with one to supported living. A number of the Move Ons have also been cited by NHSE as exemplars of positive person centred approach.

The CCG are currently reporting 3 remaining in patients. There are two of the original cohort in hospital – one is delayed discharge pending clarity of removal of Ministry of Justice section and return to Croydon and the other is a delayed discharge because of lack of alternative provision and their family wish them to live local to them in West Sussex.

One discharge was an NHSE step down to residential and one to a community locked rehabilitation unit.

With each discharge back to the community lessons are being learned and processes adapted. As more panels and MDTs are convened fine-tuning has occurred and expectations made clearer. Consulting between providers and Croydon's clinical teams has helped develop guidelines and move on plans. Where clients & family are able to engage the plans are more person-centred and focused. The outcomes for those that have moved have been positive. Their quality of lives has improved immensely. They are engaged in more activities, have more choices & opportunities and, for those with families, regularly local contact is more possible. They are more accessible to clinicians and social care and therefore less 'out of sight & out of mind'. The costs are also lower. Thus far the project will save nearly £400,000 this year and with further discharges the savings could be greater. The key outcomes also relate to the improved quality of life for the individual and better quality of care in a least restrictive environment.

3.3. Clinical and financial Governance

A fortnightly Transforming Care Multidisciplinary team now scrutinises all proposals for Move On and provides additional clinical insight and suggestions where obstacles to discharge exist. Stakeholders include specialist Mental Health and learning disability teams as well as community learning disability team, commissioning and social care. This group also has oversight of a Risk register that look at individuals at risk of placement breakdown and hospital admissions.

Additionally funding applications are made to an LD funding panel to support Move Ons to community settings.

3.4 Risks, gaps and mitigations

There are three cases that are subject to transfer to social care as they no longer require total health funding. Discussions on joint funding arrangements have between the Council and CCG are ongoing but have not yet been resolved. There also remains a risk to health and social care budgets that are insufficient commissioned services to ensure avoidance of individuals being placed outside of Croydon and no local commissioned inpatient beds for people with LD and/or forensic presentations should one be required.

A Croydon LD Strategic review undertaken in 2015 and the South West London Transforming Care Partnership plans indicate a need to develop support and services to support people closer to home and prevent hospital admission.

As part of the conversation about resources and the possible integration of specialist pathways Croydon CCG are therefore actively reviewing current specialist contracts with South London and Maudsley NHS Foundation Trust who provide specialist Mental Health and learning disability services as well as Croydon Health Services who provide the community learning disability specialist health services to facilitate more coordinated approach to supporting people with complex needs

There are a cohort of individuals (circa 15 including 4 young people) all currently funded from NHSE specialist commissioning who will become a Croydon responsibility

and require step down to the Croydon and community pathway in the next 2-3 years They are in low, medium and high secure units often with forensic background.

Under the TCP plan there is an active modelling exercise underway to look at the impact of this next cohort on budgets and proposed service pathways across health and social care economy to minimise likelihood of unnecessary in patient provision. This includes ideas for intensive positive behavioural support as well as capital bids for building development. Work is underway to ensure that commissioner responsibility is clear for these clients and to begin to identify future needs at an early stage.

CONTACT OFFICER:	Caroline Baxter Assistant Director for Disability 0-65
BACKGROUND DOCUMENTS:	None

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REPORT TO:	**Health and Social Care Scrutiny Sub Committee 17 January 2017**
AGENDA ITEM:	**9**
SUBJECT:	**Outcome Based Commissioning for Over 65s – The Croydon Alliance**
LEAD OFFICER:	**Executive Director: Barbara Peacock, Executive Director, People** **Director/Head of Service: Rachel Soni, Head of Adults, Health & Integration;** **Sarah Ireland, Director of Strategy, Communities & Commissioning &** **Pratima Solanki, Director of Adult Social Care and Disabilities**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Families, Health and Social Care**

ORIGIN OF ITEM:	Cabinet Members have offered this item to the Committee by way of review of the Cabinet decision in December 2016
BRIEF FOR THE COMMITTEE:	To consider the report and the recommendations agreed by the Cabinet in December 2016.

1. EXECUTIVE SUMMARY

1.1 The purpose of this paper is provide an overview and update of the Outcomes Based Commissioning for Over 65s (OBC) programme to the Health and Social Care Scrutiny Sub Committee. The attached Cabinet paper of 12 December provides the detail of the programme and intended decisions, summarised below.

1.2 OBC brings together a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-18 and Croydon-wide End of Life Strategy 2015 and the emerging 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.

1.3 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

1.2 The following recommendations were agreed at Council Cabinet on 12 December 2016. The Leader of the Council has delegated to the Cabinet the power to make the decisions set out in the recommendations below**:**

RECOMMENDATIONS

1 To note the contents of the report and direction of travel for the Outcomes Based Commissioning for Over 65s programme.

2 Delegate to the Executive Director of People and the Executive Director of Resources in consultation with the Cabinet Member for Families, Health and Social Care and the Cabinet Member for Finance and Treasury the power to make the decisions in two phases set out below:

Phase One

- award of the Alliance Agreement; and
- award of the 'in scope' Service Contract (s) to commence on or around 1 April 2017

Phase Two

- the subsequent inclusion of the fully developed risk and benefit share mechanism into the Alliance Agreement before 31 March 2018.

1.3 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. The contracts will be for a period of 1+9 years with a total value of c£223m per annum, £44m (updated since Cabinet) of that is social care spend at year one. More detailed risk share arrangements will be developed during the transition year which will require a second delegated decision

at phase two. A delegated decision report will be completed and posted as a key decision as each decision is taken.

2. Adult Social Care In-Scope Over 65s Contracts and Spend

2.1 The in-scope contracts to be awarded are detailed in section 5.8 of the Cabinet report, to Age UK Croydon and Croydon Health Services for a value of c£1.84m per annum. The remainder of the £44m (updated since Cabinet) spend for social care for over 65s is made up of commissioned third party spend such as domiciliary care and residential and nursing placements for older people and in-house provision including assessment and case management. The breakdown of spend per sector for year one is as follows:

- Croydon Council in house provision - £11.4m
- Independent Sector - £31m
- Third Sector - £1.5m

2.2 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 modelling being completed will show this and models the requirement for growth and savings per year.

3.0 RECOMMENDATION

3.1 The Sub Committee is recommended to:

- Note the contents of this paper and the attached Cabinet Paper of 12 December 2016 and the recommendations agreed.

CONTACT OFFICER: Rachel Soni, Head of Adults, Health & Integration
(Ext. 61640, Rachel.soni@croydon.gov.uk)

BACKGROUND DOCUMENTS: None.

Appendix 1

Outcomes Based Commissioning (OBC) for Over 65s – The Croydon Alliance Cabinet paper – 12 December 2016

See Attached Report

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REPORT TO:	**CABINET** **12 DECEMBER 2016** **HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE** **17 JANUARY 2017**
AGENDA ITEM:	
SUBJECT:	Outcomes Based Commissioning (OBC) for Over 65s – The Croydon Alliance
LEAD OFFICER:	Executive Director: Barbara Peacock, Executive Director, People Director/Head of Service: Rachel Soni, Head of Adults, Health & Integration; Sarah Ireland, Director of Strategy, Communities & Commissioning & Pratima Solanki, Director of Adult Social Care and Disabilities
CABINET MEMBER:	Councillor Hall, Cabinet Member for Finance and Treasury and Councillor Woodley, Cabinet Member for Families, Health and Social Care
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT/AMBITIOUS FOR CROYDON:

Corporate Plan 2015-18

Outcomes for Residents of the Borough / CORPORATE PRIORITY / POLICY CONTEXT:

The Croydon Alliance Agreement and Contract for Outcomes Based Commissioning (OBC) for over 65s support 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

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 brings together a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-18[1] and Croydon-wide End of Life Strategy 2015[2] and the emerging 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 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 contractual arrangements for OBC for the over 65s will 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 from year two 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; that will allow for a transition year to support a secure move to a capitated budget from year two.

The financial projections used to define the Maximum Affordable Budget (c£220m year one; £41m social care and £180m health) have been aligned with 2016 Quarter 3 planning assumptions and models.

The budget includes annual contract inflation, demographic growth and non-demographic growth.

There are defined efficiency savings in the early years of the contract which align with the Council's agreed savings programme plus 5% social care efficiency built in for future years. The financial model projects the 10 year position for the whole system, aiming to demonstrate the 'Do Nothing' scenario against transformation assumptions.

The Croydon Alliance Agreement will set out proportionate risk share arrangements that the Council will share through its position as Provider and Commissioner of adult social care in the Alliance.

1 https://www.croydon.gov.uk/sites/default/files/articles/downloads/Independence%20Strategy%202015-18.pdf
2 http://www.croydonccg.nhs.uk/news-publications/publications/Documents/End-of-Life-Care-Strategy.pdf

KEY DECISION REFERENCE NO.: The recommendations in this report are not key decisions. At the point of awarding the contracts as detailed in this report, this will then constitute key decisions and there will be a requirement for them to be published accordingly.

The Leader of the Council has delegated to the Cabinet the power to make the decisions set out in the recommendations below**:**

1. RECOMMENDATION

1.1 To note the contents of the report and direction of travel for the Outcomes Based Commissioning for Over 65s Programme.

1.2 Delegate to the Executive Director of People and the Executive Director of Resources in consultation with the Cabinet Member for Families, Health and Social Care and the Cabinet Member for Finance and Treasury the power to make the decisions in two phases set out below:

Phase One

- award of the Alliance Agreement; and
- award of the 'in scope' Service Contract (s) to commence on or around 1 April 2017

Phase Two

- the subsequent inclusion of the fully developed risk and benefit share mechanism into the Alliance Agreement before 31 March 2018

2. EXECUTIVE SUMMARY

2.1 The purpose of this report is to update the Cabinet on the progress of commissioning (with Croydon Clinical Commissioning Group) a 10 year contract to develop an Integrated Health and Social Care system for the over 65s population in Croydon and to also provide Members with the detail about the recommendation to delegate authority to enter into a Croydon OBC Alliance Agreement and award the Services Contracts in scope. As the delegated decisions take place, these key decisions will be published accordingly and further communications issued regarding the development and delivery of the model of care and the contractual arrangements. We would anticipate providing an update report within the next six months.

2.2 Croydon's vision is for all partners (statutory, voluntary & community) to come together to provide high quality, safe, seamless and personalised care to the older people of Croydon that supports them to stay well and independent. Croydon's local residents have specified the outcomes they want to see delivered and commissioners have ensured these are embedded in the outcomes framework that will measure the success of these arrangements over the long term. Engagement

of local people who use services is continuing to support the programme and design of Croydon's new models of care.

2.3 In September 2014 Cabinet approved the strategy for the procurement of integrated health and care provision for over 65s using the Most Capable Provider approach permitted under the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (2013 Regulations) and to proceed to phase 3 of the 'Improving Health and Social Care outcomes for over 65s programme.

2.4 Evidence and policy to support integration of health and social care systems include:

- The Independent Commission on Whole Person Care ('One person, one team, one system' 2014) that suggested the health and social care system needs to align incentives and performance measures to reward early intervention and prevention and - in the long term – the sustained wellbeing of older people.

- The Five Year Forward View published in October 2014 (the "Forward View") sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".

2.5 Devolution, announced in the Government's Spending Review in October 2015 allows local areas to secure more control of their spending, further enabling the integration of health and social care and the subsequent signing of the Devolution Agreement in December 2015. More than 38 cities and regions have submitted bids to government for such powers. The move locally to OBC under the Alliance model, leads Croydon towards a greater ability for a successful bid for devolution, should this be its' future ambition.

2.6 There are many local challenges in delivering health and social care to the over 65s population including:

- Croydon has both a growing and ageing population, older people represent 13% of Croydon's total population and this is projected to grow by 10% in the next 5 years. The number of people over 65 living in care homes in Croydon is projected to increase by 24%[3], and increasing numbers of people are living with long-term conditions.
- There is great potential for Croydon to improve its performance in terms of care for people over 65.
- People over 65, when compared to the general population, are high users of health (£180M) and social care services (£41M) and currently account for £220M of spend per annum.
- The Council's Adult Social Care system has significant financial savings targets to achieve as national funding to Local Authorities continues to reduce.

3 Croydon CCG Commissioning for Outcomes for over 65s in Croydon, Case for Change, P7

- Croydon CCG and the Croydon Health Services face significant financial deficits, both being placed in financial special measures in September this year by the health regulators, contributing significantly towards a c£60-70m pressure over the whole system.

2.7 The benefits of integrating health and social care through OBC and delivering services for the over 65s population through a whole system include:

- delivers the Council's Independence Strategy
- supports the Ambitious for Croydon goal of helping residents to be as independent as possible
- a more financially sustainable system for the long-term
- supports the journey to devolution
- shifts delivery from activity to outcomes that people want
- significant system transformation through integration
- maintains local leadership due to ability to work within Croydon's co-terminus local social and health care economy with one CCG, one Local Authority and one Acute & Community provider.

2.8 Outcomes Based Commissioning and the contracting arrangements set out in this report provide the stepping stones for a different way of delivering services to the residents of Croydon, which could be applied across the wider population. It will bring benefits for the provision of services for over 65's and learning for the wider system.

3. BACKGROUND AND RATIONALE

3.1. SEPTEMBER 2014 CABINET APPROVAL SUMMARY

3.1.1. In September 2014 Cabinet approved the progression of the Outcomes Based Commissioning for over 65s process and commencement of the Most Capable Provider Process and noted that a further report would be brought to seek approval to enter into contracts.

3.2. There is a strong case for paying special attention to the group of people who are aged 65 and over. 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[4] 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[5]. A third of this group of people suffer from one or more long term health conditions, imposing significant long term costs on the NHS and Social care to varying degrees.

4 Croydon CCG Primary and Community Strategy, v3.1

5 Croydon CCG Commissioning for Outcomes for over 65s in Croydon, Case for Change, P7

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[6].

3.3. There are also practical reasons for focusing on over 65s as a group. They are a more stable group, with lower 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.

3.4. For several years, the Council and CCG have been working in partnership to achieve integration both in commissioning and at the point of service delivery. Recently this has been exemplified in the Better Care Fund (BCF) programme and through the establishment of multi-disciplinary health and social care teams, including the Transforming Adult Community Services (TACS) model. In 2013, to realise further benefits of integration, the Council decided to work with the CCG and commit to a process looking at the whole of the health and social care system for older people. Instead of simply redesigning services and customer journeys, the Council and CCG decided to go back to first principles and ask Croydon people what outcomes they are seeking from the whole system.

3.5. Commissioning for outcomes rather than activity allows services to be delivered in a personalised way, and designed to focus on wellbeing. It enables providers to truly transform care, as it removes existing payment mechanisms that can be barriers to integration. It rewards both value for money and delivery of better outcomes.

3.6. Rationale for an Outcome Based Commissioning approach:

3.6.1. OBC puts resources in the right place in the system to maximise value and will deliver outcomes that matter to residents.

3.6.2. Improving health and care services through innovation, collaboration and integration: People, particularly those with long-term or complex conditions interact frequently with health and care services.. OBC improves care to be more joined up across providers and commissioners, providing more consistency in quality of services, as well as being an enabler for whole person care and support.

3.6.3. Realising efficiencies in the system. Outcome based commissioning is based on the premise that there are opportunities to improve efficiencies within the current system. The evidence base from other developed systems (Internationally and in the UK) is showing that capitated and outcomes based contracts with integrated delivery has led to improved outcomes for people and efficiency savings of 10-20% or more, depending on scope[7].

3.6.4. Croydon Council, Croydon CCG and Croydon Health Services have begun to look at opportunities around health devolution and how this could support Croydon as a place to support delivering against our commitment to our residents. OBC for over 65's fits well with this thinking. .

6 Imison et al, 2013, 'Older People and Emergency Bed Use: Exploring Variation'. The Kings Fund
7 Croydon CCG Commissioning for Outcomes for over 65s in Croydon, Case for Change, P46

3.7. VISION

3.7.1. A shared vision has been developed between the Council and Croydon Clinical Commissioning Group 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. People will have a co-ordinated, personalised experience that meets their needs in the context of their family circumstances.

3.7.2. To support this vision, extensive consultation with local people was undertaken to develop the outcomes.

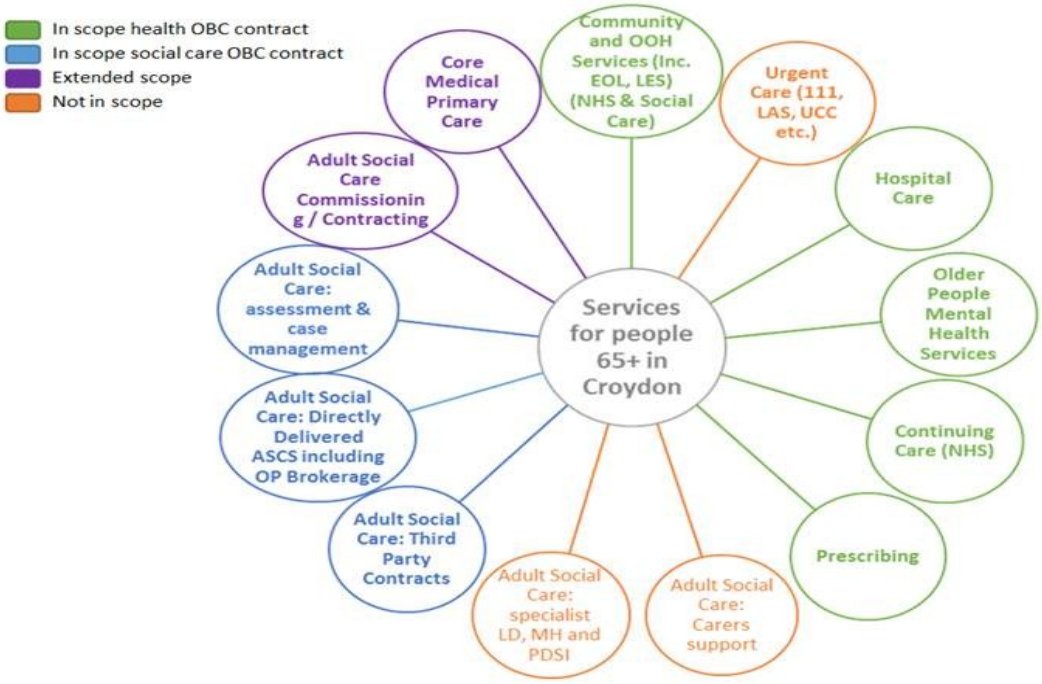
- Staying healthy and active for as long as possible
- Having access to the best quality care available in order to live as I choose and as independent a life as possible
- Being helped by a health and social care team that has had the training and has the specialist knowledge to understand how my health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

3.7.3. Central to the delivery of the vision is the concept of moving away from counting activity and moving towards realising better outcomes. Improved outcomes are a consequence of effective interventions that build on the individual's strengths and promote personal responsibility. Reducing demand can be achieved by getting it right for the individual the first time; this reflects the Council's Transforming Adult Social Care programme, which aims to manage this process far more effectively, and reduce demand while improving people's experience of care. Importantly, integration for over 65s will be about managing demand in the 'right place' at the 'right time' in the most efficient part of the system that will provide the best outcome for the person.

4. THE SCOPE OF OBC

4.1. The following diagram in Figure 2 shows an overview of the scope of the over 65s OBC programme. Underpinning this is a comprehensive Contract Map of all Council directly-delivered and commissioned services that are in scope.

Figure 1 – OBC Over 65s Scope



4.2. The social care scope includes directly-delivered adult social care services (ASCS) by the Council, including assessment and case management, budget for direct payments, older people's brokerage, day services and services such as Careline Plus and Occupational Therapy; the budget for these services will be allocated to the Croydon Alliance.

4.3 It is the intention to delegate the Council's relevant statutory duties of care and related duties to and between the Alliance Providers as deliverers of services to promote flexibility in the system as it transforms.

4.4 The Council commissions a number of Third Party social care contracts from a range of private and voluntary sector organisations, these include: Integrated Framework for home care, residential and nursing care placements, meals and preventative services. The Council will remain the contracting party and purchaser of these services with the third party providers but will allocate the budget to the Providers in the Alliance to incentivise Providers in the Alliance to maximise the use of the these contracts. Risk share arrangements will be formalised during the transition year through the Alliance Agreement in respect of these budgets. The Council as Commissioner and Provider in the Croydon Alliance will formalise collaborative arrangements for managing these third party contracts to maximise the quality and value for money of these contracts through the delivery of the new model of care.

4.5 Specialist social care services and budget for: people with Learning Disabilities (LD); Mental Health (MH) needs and those with a Physical Disability & Sensory Impairment (PDSI) who happen to be over the age of 65, are out of scope for OBC. Currently the social care budget for people over 65 using specialist LD, MH or PDSI services is held within the working age budget and this is proposed to continue. Services commissioned through Mental Health Older Adults (MHOA) team are in

scope.

5.0 SELECTION PROCESS TO FORM THE ALLIANCE

5.1 The following Providers were identified by Commissioners as potentially the "Most Capable" following an initial Most Capable Provider (MCP) assessment led by the CCG and the Council as commissioner in April 2015:

- 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

5.2 A Memorandum of Information was issued to the identified providers, inviting them to take part in the next stage of the MCP process for OBC. The providers (together,, the Accountable Provider Alliance or APA) accepted this invitation.

5.3 The first stage of the Capability Assessment (CA1) assessed how the Providers would work together effectively and how they could collectively develop the required capabilities and competencies to deliver an OBC contract. They submitted a letter of intent and self-assessment, and following Commissioner Evaluation, passed CA1.

5.4 The second stage of the Capability Assessment Process (CA2) took place during dialogue and required the APA to submit a final memorandum of understanding, a response to the organisational capabilities toolkit and a vision and roadmap for their delivery model.

5.5 The APA submitted documents under the "Capability Assessment 3" (CAP3) evaluation process in January 2016. This was followed by a second submission in February 2016. The Commissioners fed back the results of the evaluation to the Board to Board on 3rd March.

5.6 Through further discussions, it was agreed that the CAP3 process would be extended to July 2016 using the proportional intervention set out in the Contract Information Pack (CIP). The MCP process concluded in July 2016 with a log of all remaining conditions. A letter confirming this was issued to the APA on the12th August 2016.

5.7 Transition to a Croydon Alliance Agreement

5.7.1 It was agreed that commercial structure of the Alliance should change to address the conditions specified through the Capability Assessment process. The proposal to form 'The Croydon Alliance' with Commissioners joining the Alliance Provider partners was agreed at the Board to Board on 18 August 2016. Commissioners joining is aimed to be an interim step to enable the Providers in the Alliance to develop into an organisation that can be accountable for the whole health and social care system for the over 65 population through a capitated budget as part of an

outcomes based contract.

5.7.2 As part of the shared commitment to meet the conditions it was also agreed that the Commissioners would work together with the APA to develop the system wide financial model.

5.7.3 A key objective for the Alliance Agreement is for the providers to explore the establishment of an Accountable Care Organisation (ACO) which would see the Commissioners leaving the Alliance and the Alliance Agreement transitioning into an ACO contract.

5.7.4 The benefits of a Commissioner/Provider Alliance include:

- Brings Commissioner system management capabilities into the Alliance
- Builds upon the work undertaken by APA whilst maintaining momentum/pace;
- Enable conclusion of the MCP process
- Support assurance with NHS England and NHS Improvement;
- Enable links across to the South West London Sustainability and Transformation Plan (SWL STP)
- Manage and mitigate system risks more effectively;
- Use the Alliance approach developed elsewhere Help in transition of Commissioner function

5.8 The Commercial Structure and Governance of the Alliance

Alliance Agreement

5.8.1 A legally binding Croydon Alliance Agreement has been jointly developed by Commissioners and Providers setting out the principles and roles and responsibilities of all members, as well as terms and conditions covering contractual details such as termination, exit, and default and dispute resolution. The overarching Alliance Agreement commits the Croydon Alliance members to the delivery against the Outcomes Framework, delivery within the maximum affordable budget, methodology for risk and benefit share and the overall governance arrangements. It is proposed that the Council will enter into this agreement as Commissioner and Provider of Adult Social Care with the other parties on or shortly after the 23rd December 2016 with a proposed commencement date of April 2017.

Change Control

5.8.2 The Service Operations Manual (SOM) is the central location for all common elements of the services contracts, it will enable the effective allocation of resources for service redesign to meet the new Model of Care and system transformation objectives, ensuring a live record of specifications and a change mechanism. The SOM will be managed by the Croydon Alliance Board and Programme Delivery function.

Service Contracts and Service Level Agreement

5.8.3. There will be Service Contracts between the Commissioners and Providers in the Alliance for services that are directly-delivered by the Providers in the Alliance to ensure that Croydon Alliance members are accountable for delivery. The new Council service contracts planned to be entered into on or shortly after the 23rd December 2016 with a commencement date of April 2017 are as follows:

- Service Contract with Age UK Croydon merging the four current contracts into one OBC Over 65s Service Contract for:
    i. Information, Advice and Advocacy currently -£375k per annum value
    ii. Hospital discharge support to be developed as part of the Model of Care – currently £80k per annum value.
    iii. Prevention - currently £8k per annum
    iv. Healthwise – exercise and healthy eating advice for older people - £75k per annum

5.8.4 A Service Level Agreement (SLA) between the Council as Commissioner and the Council as Provider of c.£9m a year will be in place to formalise the arrangements for the Council's directly-delivered adult social care and specify the requirements. This Social Care SLA will set out the roles and responsibilities for both the Provider and Commissioner functions of LBC within the Croydon Alliance.

5.8.5 The remainder of the c.£41m spend in social care contracts are:

- Jointly commissioned services and section 75s with the CCG and Croydon Health Services (CHS), at a value of c£1.3m per annum in value.
- Third party commissioned providers of Adult Social Care – c£30m value. There will be no change to current contractual arrangements. Any recommissioning or contract awards would continue follow the Council's Tender and Contracts Regulations.

5.9 Governance

An Alliance Board has been established as part of the Governance Framework, an independent chair is due to be appointed. The Executive Director of People and Director of Adult Social Care and All Age Disability will both be on this Alliance Board. An OBC Delivery Board will report to it attended by all Alliance members that will establish a way of working that helps to deliver the OBC programme at pace.

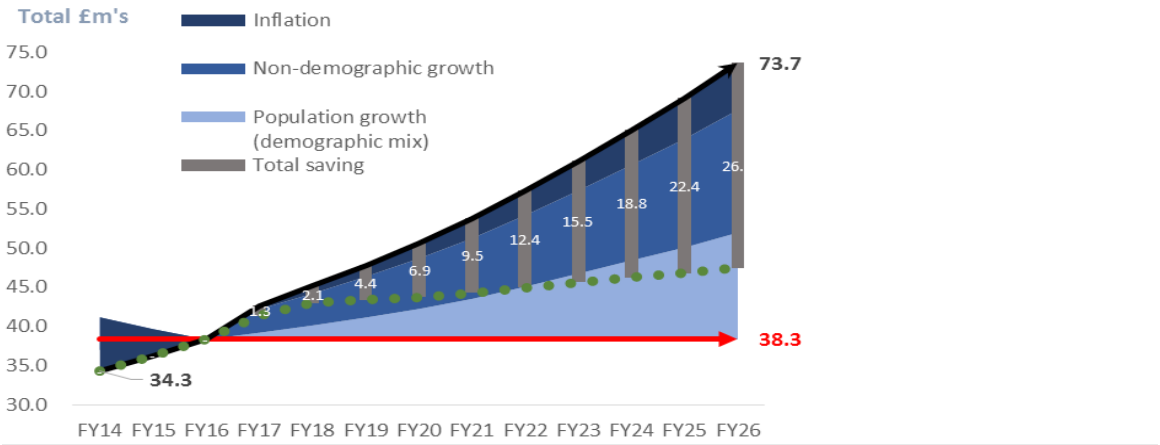
5.10 Contracting

It was agreed at the Alliance Board held on 17 November 2016 that to ensure the OBC contract can be signed to commence on 01 April 2017 that a one year contract with the option to extend by 9 years is the agreed commercial option. This enables the Alliance to have a transition year to develop the capitated outcomes based contract by April 2018. This aligns with the NHS Planning Guidance and is supported by NHS Regulators as both CCG and CHS are in financial special measures. Options for Payment Mechanisms in year 1 are being developed to meet the needs of the Croydon Health and Social Care economy.

FINANCIAL CONTEXT

6.1 The current annual spend in scope for OBC over 65s is in the region of £220m. This is broken down as the Council element being £41m and the CCG element is £180m from 2017/18. Over the total contract term, the anticipated total contract value is £2.2b, which equates to £410m for the Council and £1.8bn for the CCG. While completing the Contract Information Pack during the Most Cable Provider Process the financial modelling of the 'Do Nothing Scenario' for social care is shown in figure 4 below. Due to the financial year start dates changing this will change but illustrates the potential financial gap at year 10 in this scenario.

Figure 2: Shows the Do Nothing Scenario against the OBC Model

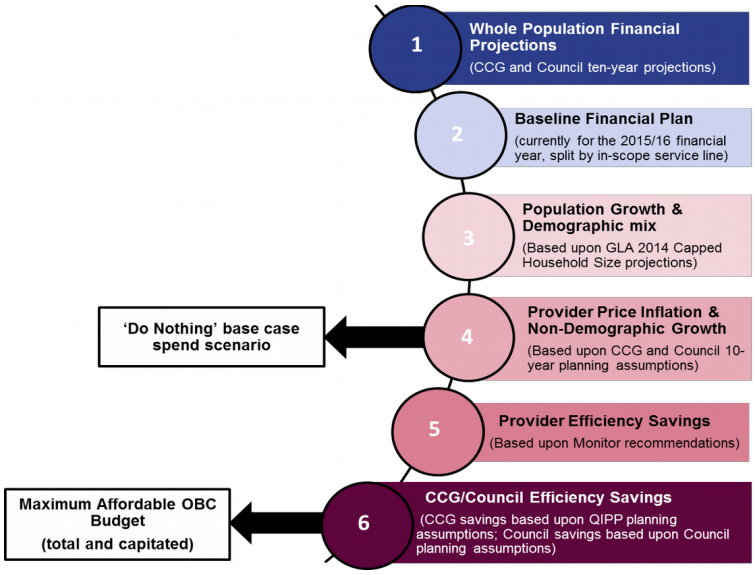


Indicative: subject to change upon finalisation of 2017/18 financial baseline and any revisions to demographic and financial assumptions or contract scope.

6.2 The gap depicted between the 'Do Nothing' and the 'Maximum Affordable Budget' scenarios illustrates the financial challenge faced by the care system in Croydon, which the OBC contract aims to address in some part.

6.3 The payment mechanism will include two distinct phases; 1) the Contract Transition phase of duration 1 year and 2) the Transformation phase which will start in year 2.

6.4 Key aspects of the methodology and assumptions underpinning the 'Do Nothing' projection and Maximum Affordable OBC Budget are outlined in the illustration below.



7 OUTCOMES FRAMEWORK

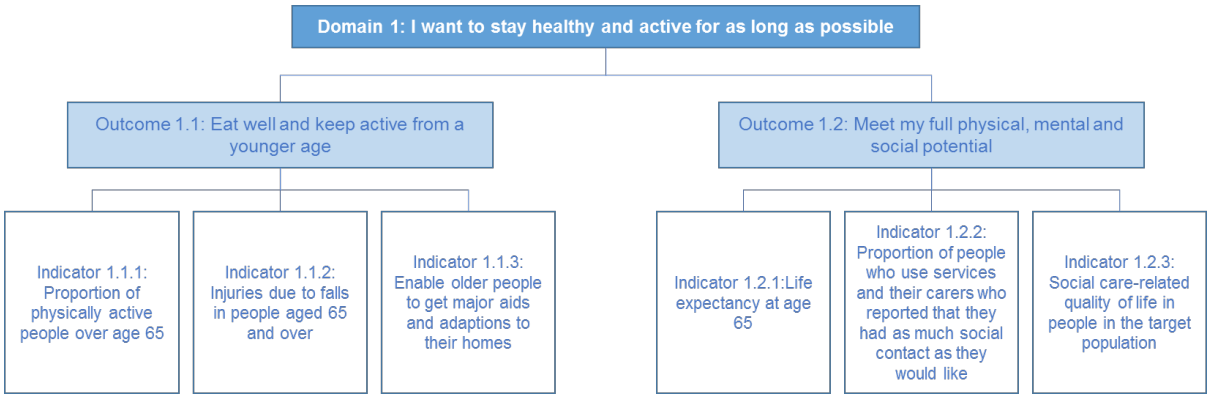
7.1 Outcomes Based Commissioning focuses on measuring and rewarding outcomes rather than inputs. Measuring outcomes and aligning incentives will enable the Commissioners to monitor performance across the whole health and care economy and, when combined with appropriate contractual and payment mechanisms, will allow providers to work together to deliver whole person integrated care and achieve a common set of goals.

7.2 People in Croydon were consulted with in the development of the five high-level Outcomes; these outcomes reflect the following 'I' Statements from the consultation, forming the OBC Outcomes Framework (see background papers) Domains:

Figure 3: OBC Over 65s Outcome Domains:

7.3 These outcomes are supported by goals and indicators (incentivised and non-incentivised) that demonstrate achievement. As an illustrative example, presents one domain, the outcomes for this domain and the indicators that will demonstrate the delivery of the outcomes.

Fugure 4: Summary of Domain 1 with outcomes and indicators



7.4 The indicators have been identified from a range of sources including national Outcomes Frameworks, quality standards, local data sources, national guidance and research on patient experience and outcomes. Many of the indicators draw upon data that is currently collected and reported by the Providers of the Alliance. This approach has been adopted to reduce duplication and the unnecessary development of new indicators which can be time consuming and costly. Where measures will need to be developed or enhanced locally this will be done in the early years of the contract.

7.5 In addition to the outcomes framework local indicators will be specified in the Service Level Agreement and the Service Operating Manual, these will include Social Value Performance Indicators and internal measures for ASC operational effectiveness i.e. timeliness of assessments. There is also a requirement for the directly delivered social care providers awarded through OBC to pay the London Living Wage.

7.6 Commissioners and Providers have (during dialogue) agreed and formally signed-up to the Outcomes Framework and the formal technical specifications for each of the incentivised indicators have been developed. The specifications include proposed data sources, methodology for calculating the indicator, and recommended sample sizes (where relevant).

7.7 The Croydon Alliance will revisit the indicators and outcomes within the framework to ensure that these are amended to include new indicators as appropriate at the end of each phase of the contract e.g. years 3 and 7. Please see background documents for the full Outcomes Framework and Indicators.

8 CROYDON COUNCIL AS PROVIDER AND MODEL OF CARE INITIATIVES

8.1 Croydon Council as Adult Social Care Provider

8.1.1 The Council is unique in the Alliance as Provider and Commissioner in the Alliance. . The proposed Governance of OBC consists of:

- OBC Alliance Board with an independent chair, with Executive Director People and Director of Adult Social Care and All Age Disability attended by all Alliance Partners senior officers
- One Council vote, with two representatives (Commissioner & Provider) with unanimous decision making so the Council will have the right of veto as will all partners
- OBC Programme Delivery Board attended by all Alliance partners to report to the Alliance Board

8.1.2 A Joint OBC Contract Management Framework is in development that will ensure the main OBC over 65s contract is managed effectively by the Council and CCG, cross referencing the third party contract management process.

8.1.3 An SLA will be entered into at c£9m for year one between the Council as Commissioner and Council as Provider to hold our own Adult Social Care Service to account for the quality and delivery of services within the maximum affordable budget.

8.1.4 The Council will sign the Alliance Agreement as one legal entity.

8.2 The Provider Vision:

8.2.1 The ambition is to have a significant improvement in care for older people that is better coordinated, of higher quality and is delivered with compassion and respect for dignity. In order to deliver this ambition there will need to be a significant shift in the balance of where care is provided, that focuses on how care can be better provided around the needs of individuals. This will require removing barriers to integrated care and allowing sufficient time to embed locally.

8.2.2 The ageing population and increased prevalence of chronic disease requires a strong reorganisation. It requires a move away from the current emphasis on acute care, toward one of prevention, self- care, consistent standards of primary care, and care that is well co-ordinated and integrated. The introduction of the Croydon Alliance is an opportunity for providers to tackle some of the very real challenges facing health and social care in Croydon and make a real difference to peoples' lives. The vision is to transform services from a focus on illness and crisis intervention, to services that enable individuals to manage their own health and social wellbeing, develop personal resilience, and be independent.

8.2.3 The Voluntary and Community Sector organisations have an important contribution to make in developing new models of care. The result would be to make a reality of care closer to home and reduce the use of acute hospitals and services.

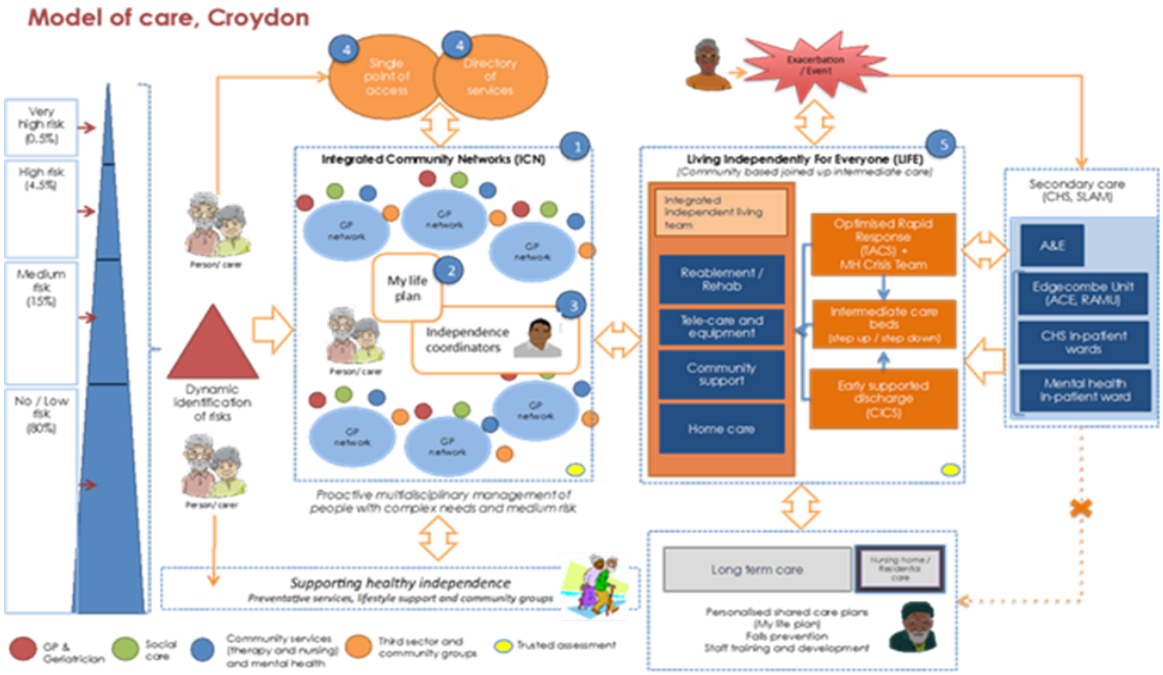
8.3 The Model of Care

8.3.1 The New Model of Care will take forward the ambitions of the Alliance and

introduce a whole system transformation through the Model of Care programme. Work has been undertaken to develop the Model of Care which is described in the following initial five initiatives.

- Integrated Community Networks
- My Life Plan
- Personal Independence Coordinators (PIC)
- Point of Access and Information to Voluntary Sector, Health and Council
- Living Independently for Everyone

Fugure 5: OBC early Model of Care



8.4 The Model of Care is progressing now before entering the formal Alliance and the benefits for Croydon are already becoming evident. The six new Personal Independence co-ordinators detailed below commenced in Croydon University Hospital and New Addington GP networks on 14 November offering a continual supportive presence for people, ensuring services and support are delivered in a personalised, co-ordinated, relevant and timely way delivering the result that every person has someone to speak to. Successful fast tracking of elements of the Model Care has been possible through the strong relationships developed across partners such as the acceleration of the LIFE service that helps people return home from hospital safely, resulting in the assurance that people are supported to regain their independence. These developments will continue and scale up at pace through transition. The early initiatives are described below.

8.5 Integrated Community Networks

8.5.1 Integrated Community Networks (ICNs), which are aligned to the existing six Croydon GP networks, will bring together health, social care and the Voluntary and Community Sector services together in virtual teams to deliver coordinated care and support. ICNs will focus on preventing ill health and enable individuals to support their own health and independence.

8.5.2 These networks will build on the existing GP multidisciplinary team (MDT) care Practice Development and Delivery Scheme. The networks will be supported to by the creation of two Complex Care Hubs to manage the care of people through proactive case management and care coordination.

8.5.3 The networks will also be supported by the other initiatives to promote self-care and prevention behaviours and wider engagement with voluntary and community services.

8.6 My Life Plan

8.6.1 The vision for a 'My Life' plan (MLP) is for a dynamic care plan based on input from the person through guided conversations. This would include the opportunity for every person over 65 in Croydon (and their carer) to have access to a website / app or hard copy that takes them through a systematic process of developing a personalised MLP.

8.6.2 The initial focus is to prototype the model by ensuring all people assessed as having complex health and care needs to have a shared care plan using the freely available "Coordinated my Care" model. The person will retain control over the information recorded and who will have access to the information in their plan.

8.7 Personal Independence Coordinators (PIC)

8.7.1 The PIC will be a member of the multidisciplinary team (MDT) working in the ICNs. They will be employed by the voluntary sector and independent of social services and the NHS, not part of the person's family or friends. They will work intensively with people with long term conditions, if necessary, on a one to one basis. The PIC and their volunteer support workers will work with the MDT, preventing people from returning to hospital or organising the support person required to enable them to be discharged from hospital or remain independent in their own home.

8.8 Point of Access and Information to Voluntary Sector, Health and Council

8.8.1 Within each GP network, there will be a point of access and information for all physical, psychological and social needs. A single telephone number and point of contact will be available, supported by a central directory of services. Trained frontline workers will either deal with their issue directly or arrange a discussion/appointment for the person with the relevant service that they require. It will not simply be a signposting service but will provide an active role in care giving.

8.9 **Living Independently for Everyone service**

8.9.1 A Living Independently for Everyone Service ('one team, one name, one budget') will be introduced. This will include rehabilitation/reablement, telecare and equipment, community support, home care, rapid response, intermediate care beds and early discharge support. These teams require different skills and so will need to remain separate. To the user the service will appear as a single enterprise.

8.9.2 Access to this service will be based on the person's need and will approach person care holistically through a matrix of whether they have a physical, psychological or social need and whether the need is acute, long term or a permanent change in function. All teams and professionals within the service will accept one trusted assessment.

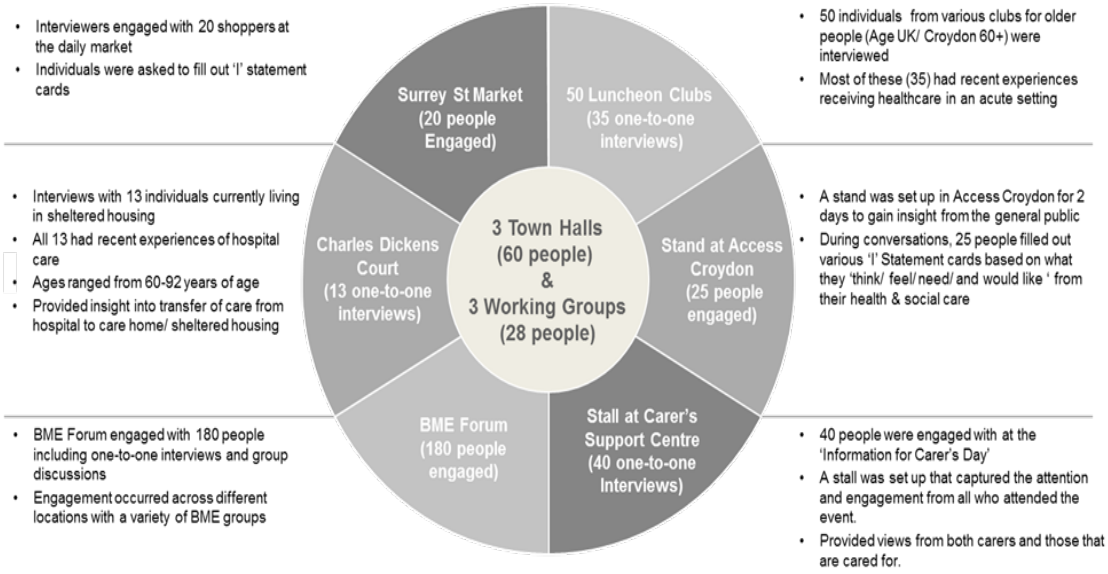
8.9.3 A two phased approach to care will be put in place. The first phase is to stabilise the person and the second to assess the need for longer term care. Voluntary groups will be integrated to support with areas such as transport and hospital to home support. Finally, a review of new telehealth and telecare services will bring to light new ways of using these areas to improve outcomes.

8.9.4 The Model of Care will support system changes that will provide a foundation for the transformation required to successfully develop a wide range of community and out of hospital projects from early intervention and prevention such as falls prevention to more complex care needs including improved End of Life Care.

9 **CONSULTATION**

9.1 Outcomes based commissioning (OBC) is a way of recognising the importance of working with the community to identify the results they want to see achieved in relation to health and care services; these outcomes then set the framework within which providers of services can design solutions to achieve them.

9.2 In line with the general duty to involve individuals and the wider community, an extensive phase of testing and co-design was put in place. The town hall events and working groups were central to the co-design and these were supported by a number of additional activities that are summarised below. Overall 400 individuals provided input and the views and opinions gathered were fed back into the process to support the development of and verify the detailed outcome design.



9.3 The outputs from the consultation and engagement exercise set out above directly informed the development of the outcome framework.

9.4 The Service User Specialist Engagement Group has been meeting on a monthly basis with representatives of the OBC Programme and APA, to contribute to the consideration of how the APA would 'meet the needs of the service users' (CIP requirement). Both commissioners and providers have a requirement to involve people and build their feedback into the design, delivery and monitoring of services. The public engagement meetings have been structured to:

- Gain feedback from OBC commissioners on progress in developing the contractual requirements for the new way of working;
- review engagement activity conducted since June 2015 and contribute to the development of further engagement activities;
- hear from APA leads about the development of the Model of Care;
- discuss and contribute to the potential initiatives for year one of the new service and consider the priorities and possible gaps within the initiatives.

9.5 Four members of the group attended a follow up session from the first 'hothouse' sessions in December with other stakeholders, where the next steps in the development of the Model of Care was shared and they worked - with providers - through patient scenarios, to consider how the integrated working of the new model would ensure an effective service, meeting the needs of the people of Croydon.

9.6 Further engagement has taken place in February and March 2016, jointly facilitated by the OBC Engagement Team and APA, with members of the SUSEG in attendance to support the facilitators. This took place with five groups:

- Carers Partnership Group
- PPG Network Group
- Asian Community Elders Forum
- Gentleman's Probus
- Lahona Community Group

10 COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

10.1 The Solicitor to the Council notes that the below represents the advice received for the Council's external legal advisors.

10.2 When the procurement of OBC for the over 65s commenced, the option to use a Most Capable Provider (MCP) process existed by virtue of provisions in the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (now superseded by the 'Light Touch' procurement regime under the Public Contracts Regulations 2015). The MCP process required Commissioners to identify the provider(s) most capable of providing health care services with a view to improving the quality and efficiency of those services while achieving best value for money. It was not a requirement for the Commissioners to formally compete the opportunity, subject to the contract being awarded to those provider(s) who were most capable of delivering the contractual obligations in line with the requirements of the 2013 Regulations.

10.3 The Council was able to be involved in the MCP process since that the Public Contracts Regulations 2015 did not, at the time, apply to procurements of health care services. Given that the predominant component of the jointly commissioned OBC arrangements is NHS-funded health care services, legal advice at the time confirmed that the Council was able to join the MCP process being run in accordance with the 2013 Regulations[8].

10.4 The form of MCP process used to procure OBC for the over 65s was devised to ensure that the envisaged OBC contract was procured in a transparent, fair, non-discriminatory and proportionate manner. It comprised an initial process to identify potential MCP providers of the relevant services, followed by three successive assessments to test the capability of these potential MCP provider(s) to work together as an accountable provider and successfully deliver an OBC contract. The potential MCPs came together as an accountable provider alliance (APA) which would work together to respond to the MCP process.

10.5 It is noted that Commissioners have always been clear that the outcome of the MCP process could be a determination that the potential MCP providers (i.e. the APA) were not, in fact, capable of delivering an OBC contract and that an OBC contract

8 Legal advice in March 2015 confirmed that the joint commissioning envisaged by the older people's programme is a "contract award procedure that… relates to the procurement of health care services" despite also relating to social care. The procurement is therefore governed by the NHS 2013 Regulations.

would therefore need to be competitively tendered.

10.6 The outcome of the CAP3 assessment provided sufficient assurance to Commissioners that through the application of conditions the underlying information and systems could be sufficiently developed to enable an OBC contract to be delivered with the support of the Commissioners. This conclusion was strengthened by the changing context of the commissioning of health and care services away from accountable providers to broader, whole-system approaches. Accordingly Commissioners decided to build on the work undertaken by both the APA and Commissioners during the MCP process with a view to initially delivering the services under the aegis of a whole-system Croydon Alliance of which both the Commissioners and the Providers are members.

10.7 The Council is advised that in relation to the delegation of statutory functions Section 79 of the Care Act 2014 (the Care Act) permits the Council to delegate most (with limited exceptions) of its Part 1 Care Act functions to other bodies (which includes NHS, third sector and private providers).

10.8 Section 8(2) of the Care Act expressly permits the Council to meet the needs of care and support (for adults) by arranging for a person other than it to provide a service or for the Council to directly provide that service.

10.9 To the extent that services fall outside of section 8(2) then (subject to any specific statutory restriction) section 1 of the Local Government (Contracts) Act 1997 confers a power on the Council to enter into a contract with a third party to deliver services (in relation to any of the Council's powers or duties the Council exercises). Subject to a review of the final form of service(s) contracts the Council has the power to enter into them.

10.10 Section 3 of the Care Act places a duty on the Council to exercise its Care Act (Part 1) functions with a view to ensuring the integration of care and support provision with health-related provision where it considers that this would:

10.10.1 promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,

10.10.2 contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or

10.10.3 improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

10.11 In noting the request to delegate the decision to enter into the Alliance Agreement the Cabinet must be satisfied that agreement furthers the integration for care and

health on at least one of the grounds set out in paragraph 10.10 and in approving the final form of that agreement the Delegatees should also satisfy themselves that this is the case.

10.12 The Alliance Agreement is intended to operate for 10 years and as it is designed to promote the integration of social care and health is structured to operate so the Council, Croydon CCG and providers all must agree to operational and strategic matters. Post transition year, that agreement also contains liabilities and obligations which will bind the Council for up to 10 years.

10.13 Officers are in discussions about the final form of the Alliance Agreement with the objective that it ensures: the Council's potential liabilities are proportionate; its statutory discretion is not fettered and that decision making within the Alliance reflects the Council status as both a statutory and elected body. The Delegatees in approving the final form of Alliance Agreement should satisfy themselves that these matters have been appropriately addressed.

Approved for an on behalf of: Jacqueline Harris-Baker, Acting Council Solicitor and Acting Monitoring Officer.

11.0 <u>Financial and Risk Assessment Considerations.</u>

11.1 The Financial context is set out clearly in section 6 of the report. This outlines the potential cost of the 'do nothing' option for the council and the savings that can be made from an integrated and outcomes based approach. The do nothing approach would result in costs increasing by over £40m in year 10 of the contract and therefore is not an option for the Council.

11.2 Currently the Council and the CCG commission a range of interdependent and overlapping services for people over 65s from a number of different providers, some of which are the same asOBC will support the joining up of services, consistency of experience and successful delivery of outcomes. It will support the prevention of increased costs as a result of being unable to achieve the full benefit from greater purchasing power.

11.3 Integrating the health and social care system for the over 65s will allow a co-ordinated approach to commissioning and provision which should meet the needs of individuals, produce measureable outcomes and system-wide economies. It will also allow funds to flow across health and social care via the Better Care Fund mechanism.

11.4 The Council budgets for the services in scope of this ten year contract are detailed in the table below, and total over £438m over the life of the contract.

11.5 The CCG budget is approx. £180m per annum in year one, and therefore the total budget per annum for services to over 65's in Croydon is in excess of £220m.

	Yr1	Yr2	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10	**Total**
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	**£m**
Maximum Affordable Budget	41.354	42.072	42.444	42.841	43.347	44.020	44.721	45.354	45.886	46.524	**438.563**

11.6 The base value for the Maximum Affordable Budget is the year zero budget relating to in-scope services for Older People. To this is added:

11.6.1 Demographic growth - based on 2014 GLA Capped Housing Size Population projections

11.6.2 Non-demographic - growth based on an in-depth analysis of historical changes within social care. It relates to pressures cause by increased propensity for social care, changes in acuity etc. This is independent of the effect of population growth and age profile. The value of this is to be reviewed annually

11.6.3 Provider inflation – Inflation for contracts and staff pay has been included at 1%. The percentage granted will be reviewed annually

11.6.4 Efficiencies – Years 1 and 2 are a fixed value, in subsequent years 5% is applied.

11.7 The maximum affordable budget (MAB) calculated by commissioners is on a per capita basis. This gives a level of certainty to both providers and commissioners and helps manage the deliverability of services. The MAB is adjusted annually to reflect demographic and non-demographic changes.

11.8 The Council require its provider element of the contract to achieve a 5% annual saving from years 3 to 10 with a slightly lower amount in the early years while the contract is being established and embedded.

11.9 This contract will allow for a new model of care which will enable focus on the community and preventative care thus reducing hospital admissions. This will require additional input for Adult Social Care funded by health using the Better Care Fund as the mechanism. The combining of health and social care budgets in this way will enable efficiencies to benefit both sectors.

Risks

11. 10 Croydon CCG and Croydon Health Services were placed into special measures in July this year. Both have to prepare a financial recovery plan which we need to be assured does not have unintended consequences to their partner organisations. These health financial recovery plans and the NHS Sustainability and Transformation Plan (STP) will, it is believed, require savings to be achieved sooner than was originally envisaged which may put considerable pressure on social care.

11.11 In recent years Adult Social Care has experienced increasing pressures caused by increases in demand, rising costs and increases in propensity and acuity. These pressures are only likely to increase over time, to do nothing is not an option. Radical change across the health and social care system is the only viable option.

11.12 The risk and benefit share agreement is currently being drafted by all the parties involved. This agreement will allow the transfer of funds to the Council for additional costs of social care generated by changes in the system model of care.

11.13 In addition, we will ensure that, as part of this contract, the council is not exposed as a Provider or Commissioner to any risks due to CHS or CCG overspends, through the following:

11.13.1 The Council has set its budget and entered this into the draft 10 year financial model. The transition arrangements will set out the management of risk and benefit and how to move resources around the system as required through the development of business cases. Key principles protect the parties in the Alliance and mitigate against the Council being impacted by a worsening of the Croydon health economy:

- Each organisation retains its own statutory duty
- Where transformation requires one party to accept more demand, this investment will be made through a business case process and mechanisms such as the Better Care Fund
- As Commissioner and Provider in the Alliance we can effectively manage demand.

11.13.2 Being part of the Alliance will support the whole system transformation and sustainability as services move to be delivered in the most efficient part of the system. As we move to a capitated budget this shift will need to increase. Risk share and investment principles will be binding in the Alliance Agreement as it matures during transition. The 'Do Nothing' scenario exposes the Council to a greater risk of cost transfer from its health partners as they need to reduce activity in the acute sector by avoiding admissions and ensuring early discharge. Planning these service changes in partnership provides the least risk so that demand can be planned for and modelled and invested in appropriately.

11.14 The Council with the Alliance partners have agreed the principles for contingency should the Alliance not be able to progress due to any unforeseen circumstances in the health and social care landscape. Seamless services with outcomes focus are central to all plans for future delivery. We would continue to work in partnership across the system to mitigate the impact to our residents should this contracting arrangement not progress as set out, ensuring continuity of services and improvement in outcomes for the over 65's. The commercial structure and contracting arrangements of Service Contracts in place through OBC or the status quo protect continuity of provision and management of the quality of services.

Approved by: Lisa Taylor – Assistant Director of Finance and Deputy S151 Officer

12 HUMAN RESOURCES IMPACT

12.1 There is no immediate HR impact on LBC staff as a result of the recommendations in this report. However in future, the Council would need to determine the most appropriate way to ensure that it optimally adapts to working in this efficient and outcomes driven way; in this regard any proposals that would subsequently have a material impact on staff would need be referred to Human Resources and adhere to the relevant Council policies and procedures.

Approved by: Jason Singh, HR Business Partner on behalf of the Director of Human Resources

13 EQUALITIES IMPACT

13.1 As reported to Cabinet in Sept 2015 Section 1 of the equality analysis (EqIA) has previously been completed, and this has been refreshed in line with Phase 3B of OBC.

13.2 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.

13.3 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.

13.4 The updated EqIA (please see background papers) will include actions detailing how potential impacts are being responded to and how future arrangements will continue to identify and address equality monitoring and performance requirements.

13.5 Consultation with the public and people who use services on the development of the outcomes and development of the programme has been ongoing throughout to ensure a diverse representation of views and experiences. Please see section 9 for the detail.

14 ENVIRONMENTAL IMPACT

14.2 There are no immediate environmental impacts as a result of this report.

15 CRIME AND DISORDER REDUCTION IMPACT

15.2 There are no direct Crime and Disorder reduction impacts as a result of this report.

16 REASONS FOR RECOMMENDATIONS/PROPOSED DECISION.

16.2 The delivery of an integrated health and social care system together with transformed adult social care and acute and community provision that is both financially sustainable and improves outcomes is essential. The Council and CCG as commissioners and the Council and other providers in the Alliance have taken service alignment and service efficiency as far as it can go without fully transforming the system. Without a transformation that moves resources around the system into community provision, the future of health and social care is very unstable.

16.3 The financial modelling undertaken shows that there could be a financial gap of c£40m for social care by 2026 in the 'do nothing' scenario. OBC supports the shift from acute services to those closer to home and aims to enable sustainability of our care services to our residents; in ensuing people are not delayed in hospital and avoid admission if at all possible and receive a service at, or close to home that is proactive and preventative in nature with a focus on self-management, independence and good quality outcomes.

16.4 Joining with our partners to develop joint solutions will support our journey towards health devolution and break down the barriers to integration and the delivery of care that is truly person centred.

17 OPTIONS CONSIDERED AND REJECTED

17.2 Open procurement for an alliance of providers was considered but rejected to follow a Most Capable Provider process.

CONTACT OFFICER: Rachel Soni, Head of Adults Health & Integration, x 61640

BACKGROUND PAPERS - LOCAL GOVERNMENT ACT 1972:

Equality Analysis
Croydon Outcomes Framework

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REPORT TO:	**Health and Social Care Scrutiny Sub Committee** **17 January 2017**
AGENDA ITEM:	**10**
SUBJECT:	**CCG Progress Report on The Primary Care Variation Reduction Strategy**
LEAD OFFICER:	**Paula Swann, Chief Officer, Croydon CCG**
CABINET MEMBER:	**N/A**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Paula Swann, Chief Officer, Croydon CCG** **Stephen Warren, Director of Commissioning Croydon CCG**

ORIGIN OF ITEM:	**This item has been suggested by the Committee as an update on work programme for 2016/17, to monitor the progress of GP performance and variation.**
BRIEF FOR THE COMMITTEE:	The Primary Care Variation Reduction Strategy aims to optimise the delivery and quality of primary care in Croydon. This is central to supporting the delivery of a number of the CCG's strategic goals We would want to share with the committee: ▪ The progress made to date against this strategy
CORPORATE PRIORITY/POLICY CONTEXT: This strategy supports: • Maintaining and improving safety and quality of care. • Transforming the way care is delivered for the future. • Achieving financial sustainability.	
FINANCIAL IMPACT N/A	
FORWARD PLAN KEY DECISION REFERENCE NO: This is not a key decision	

1. Introduction

The Primary Care Variation Reduction Strategy aims to optimise the delivery and quality of primary care in Croydon. It is central to supporting the delivery of a number of the CCG's strategic goals and is a key enabler in achieving transformational change within primary care, contributing to Quality, Innovation, Prevention and Productivity agenda QIPP projects, reducing inequalities and improving the health

and overall experience of healthcare for the people of Croydon. It is inextricably linked to the clinical engagement work stream with networks and practices.

This paper reports progress on implementation of the strategy a year on. In summary the work of the variation team agenda has supported the delivery of a number of the CCG's strategic goals including achievement of quality premiums and continues to be a key enabler in achieving transformational change within primary care, contributing to QIPP projects, reducing inequalities and improving the health and overall experience of healthcare for the people of Croydon.

The team have been involved in a wide range of projects both initiated by the team itself and also supporting CCG wide projects and initiatives.

In order to maximise impact the variation team have been working on building relationships with the practice teams they are responsible for, covering all 58 practices in the borough.

The team have utilised a wide range of data and information sources including public health practice profiles, national GP patient survey data, local patient feedback, Healthwatch information, NHS Choices reviews, Right Care data and a range of relevant dashboards to inform their work.

The key vehicles for implementation of the strategy have been:

- Engagement with primary care through three levels of practice visits
- Installation of PRIMIS software in all GP practices to support reducing variation in prevalence and management of common long term conditions e.g. diabetes, COPD and asthma.
- GP Practice Development and Delivery Scheme
- GP Practice Local Incentive Schemes
- Support for implementation of clinical pathways

More detail on achievements in these areas is provided below.

2. Background

The strategy was presented to the CCG SMT, Clinical Leadership Group and Governing Body in September 2014 and was approved as one of a number of work streams contributing to improving the outcomes for all patients as part of the CCG strategic goal to deliver longer, healthier lives for the residents of Croydon and support out of hospital care.

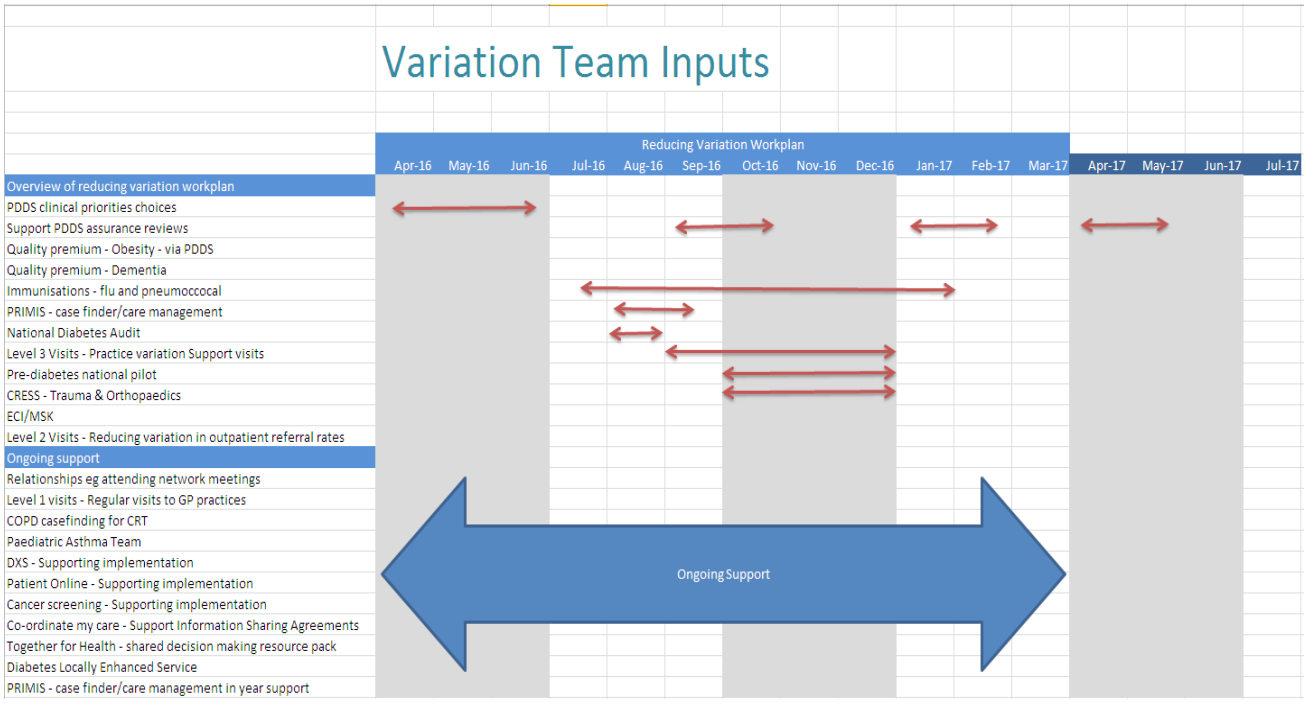
In December 2015 the Overview and Scrutiny Committee received a report on progress with the Primary Care Variation Reduction Strategy 2014. It set out the CCG's Primary Care Variation Reduction programme for 2015-16 with the aim of optimising the delivery and quality of primary care in Croydon

- It is inextricably linked to the clinical engagement work stream with networks and practices
- The Variation Team were appointed in late 2015 under the Chief Pharmacist in the Medicines Optimisation team.
- The Variation Steering Group was set up in early 2016 to drive forward this important, cross cutting agenda
- An update was provided to the Committee in June 2016 on the strategy

3. Engagement with primary care

A core work plan for the variation team is in place based on the strategy. This includes a wide range of topics and projects in line with CCG priorities see Fig 1. below. The work plan is flexible allowing for focus to be shifted as appropriate in accordance with the CCG priorities.

Fig 1. Summary of variation team work plan and inputs



Impact

In the last year over 750 activities / interactions between practices and the variation team have occurred, working with individual practices raising priority topics such as cancer screening; coordinate my care , influenza and pneumococcal immunisations, PRIMIS asthma, COPD and diabetes.

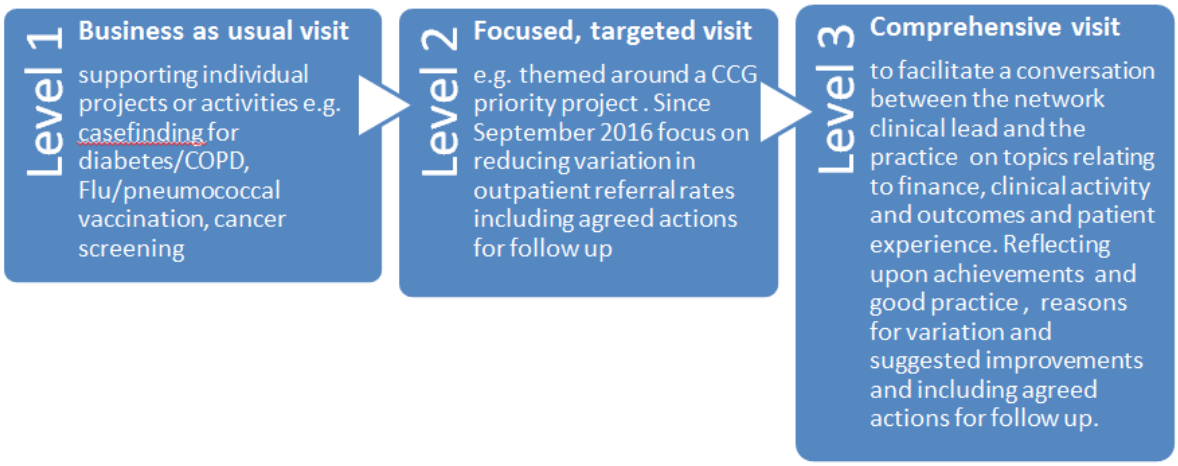
4. Collaboration and partnership working

Success of the variation team work plan has and will continue to depend upon effective partnership working. This includes with the following teams and organisations:

- Primary Care - GP practice teams and clinical leaders in particular
- Secondary health care e.g. Facilitating Croydon Respiratory Team working with practices to improve diagnosis and management of patients with COPD
- Third sector e.g. Cancer Research UK to promote cancer screening in GP practices
- Local authority e.g. with public health on primary care data profiles

The variation team workplan is structured around three levels of support for GP practices as described in Fig 2. below:

Fig 2.Engagement with practices



Level 1 support is ongoing on a wide range of topics depending on the practices activities and informed by a wide range of data including patient feedback.

Level 2 activities since August 2016 have focussed mainly on addressing the marked variation in outpatient referral rates between Croydon GP practices. A programme of visits led by the network clinical leads and supported by the variation team have been undertaken to the highest referring practices. The following has been achieved thus far:

- 20 of the 27 (74%) highest referring practices were visited by end of November. This is 34% of all Croydon Practices.
- By mid-December 2016 100% of the 27 practices will have been visited. This will equate to 57% of all Croydon practices having received a comprehensive visit or focussed visit
- Action plans completed for all practices & date for progress update agreed
- Each visit has focussed on a number of related topics including:

- Practice peer review processes
- Shared decision making discussions with patients
- Regular audit of referrals to specialities with highest or increasing referrals
- Regular monitoring of all referrals made

- Alternative routes of condition management as appropriate including patient education, use of Apps, group consultations, internal second opinions, using in house expertise and knowledge

Level 3 support continues with 15 comprehensive practice visits completed by the end of November 2016 a further three diarised for December 2016. Action plans are completed for all practices & date for progress update agreed and followed up.

5. Programmes of work supported by the variation team

5.1 Reducing variation in prevalence and management of common long term conditions

During October 2015 – February 2016 the variation team achieved installation and implementation of PRIMIS software in all Croydon practices. This software was then used as a platform for a number of projects in relation to diagnosis and management of long term conditions including:

- Using the casefinder functionality in this software, to identify almost 6,000 patients with possible missing diagnosis of COPD, asthma or diabetes. The aim of this exercise was to support practices in preventing or reducing the likelihood of patients presenting at A&E with these long term conditions who had not previously been diagnosed.
- Supporting the Practice Development and Delivery Scheme (PDDS).
- Monitoring a local incentive schemes for diabetes and prevention of diabetes.
- Supporting practices on the prevention agenda for conditions such as diabetes.

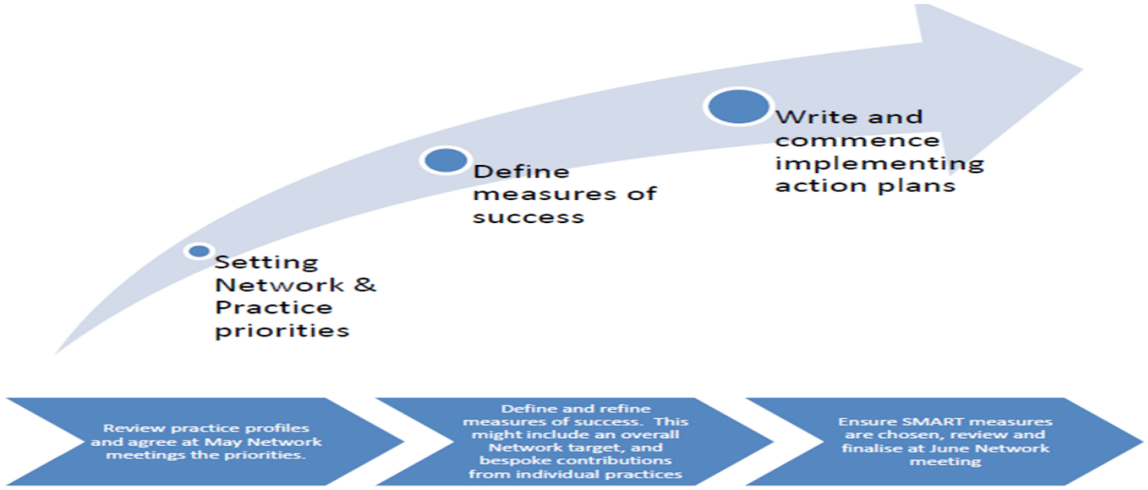
5.2 GP Practice Development and Delivery Scheme

The CCG Primary Care and Clinical Engagement team have offered this since 2014 which is designed to offer member practices an integrated scheme that supports their ongoing engagement with the CCG while supporting their development to meet the challenges within the Croydon healthcare economy. The scheme includes elements relating to financial balance, acute monitoring targets such as rates of A&E attendance and admissions, care management and coordination and clinical priorities. This year's scheme built on the positive progress made by practices in the previous years. See Fig 3

The variation team led the clinical priority element of the PDDS for 2016-17 initially with well attended workshop for practices. They then worked closely with practices and networks to develop a menu of possible priorities for practices to select from based on

national and local priorities and robust and challenging measures of success. Practices and networks chose four main priority areas overall: Tackling obesity; diabetes; dementia

Fig 3 PDDS scheme



Impact

- *Practices clinical priority choices now fully supporting CCG and national priorities*
- *Promoting increased impact as practices focusing on 4 main quality improvement areas – reduced from 23 different areas in 2015-16*
- *SMART measures for priorities designed and agreed in partnership with GP practices*
- *Positive feedback from practices on support received by the variation team*

All six GP network chose obesity as one of their PDDS clinical priorities. The variation team have supported practices in identifying patients eligible for offer of weight management service. As a result this service has demonstrated a significant increase in uptake.

Impact

- *Significant increase in referrals to weight management services since April 2016 (Approx 700 April-October 2016 compared to 1300 in total since April 2014)*
- *Since April 2016, 65% of participants have completed the 12 week weight management programme with 5% body weight lost and 83% of participants completed the programme achieving a 3% reduction of body weight.*

5.3 Flu and pneumococcal vaccination

Croydon CCG has implemented a system-wide plan to improve vaccination uptake amongst all eligible cohorts involving District Nursing Teams to deliver flu and

pneumococcal vaccinations in eligible housebound patients and their carers that are on the District Nurses caseload. A number of community pharmacies have also been commissioned to support GP practices with the vaccination of their housebound patients not on the district nurse caseload.

The variation team continue to support the broadened flu and pneumococcal agenda by delivering key messages to practices through peer review discussions at network meetings and during Variation practice visits to work with the practices to develop action plans.

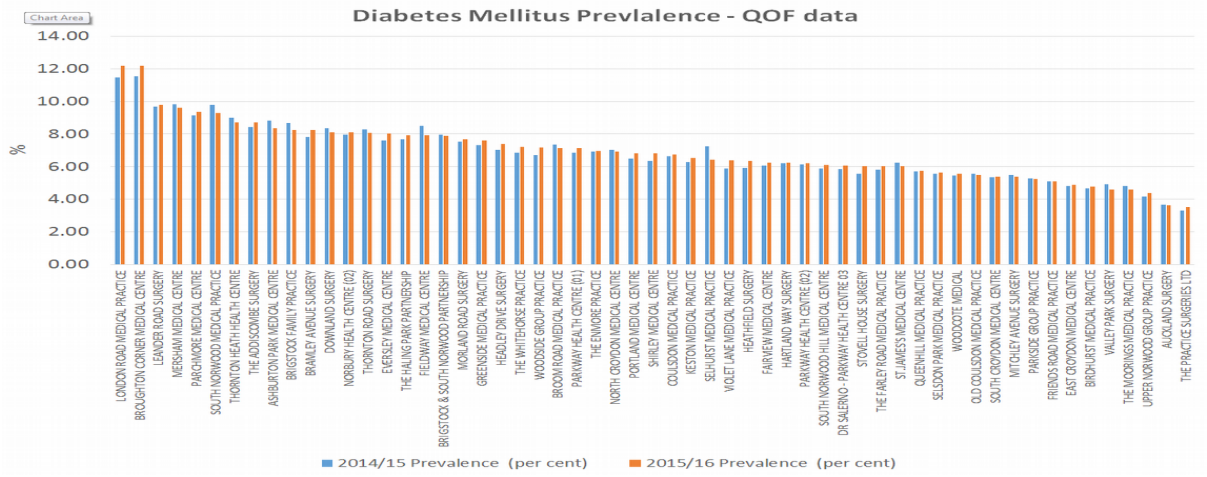
5.4 Cancer screening

The variation team continue to work with Cancer Research UK (CRUK) and Macmillan Early Diagnosis Programme engagement team to facilitate discussions with the lowest performing practices to improve early diagnosis of cancer.

5.5 Diabetes prevalence, care and prevention of diabetes

The variation team have acted as an enabler for a number of initiatives and projects relating to diabetes. These have included:

- Using PRIMIS casefinding tools in all practices, to identify patients with a possible missing diagnosis of diabetes. Identifying these patients allows earlier routine follow up and care management to take place which in turn improves care and patient outcomes.
- Using PRIMIS care management reports for monitoring of a local incentive scheme for improving care of patients with diabetes
- Supporting practices participating in a pilot local incentive scheme to identify patients eligible for the national diabetes prevention programme.
- Encouraging practices to participate in the National Diabetes Audit.
- Providing a primary care perspective on the Croydon Diabetes Steering Group.



Impact

- *80% of Croydon GP Practices participated in the National Diabetes Audit for 2015-16 up from 40% the previous year.*

5.6 COPD prevalence

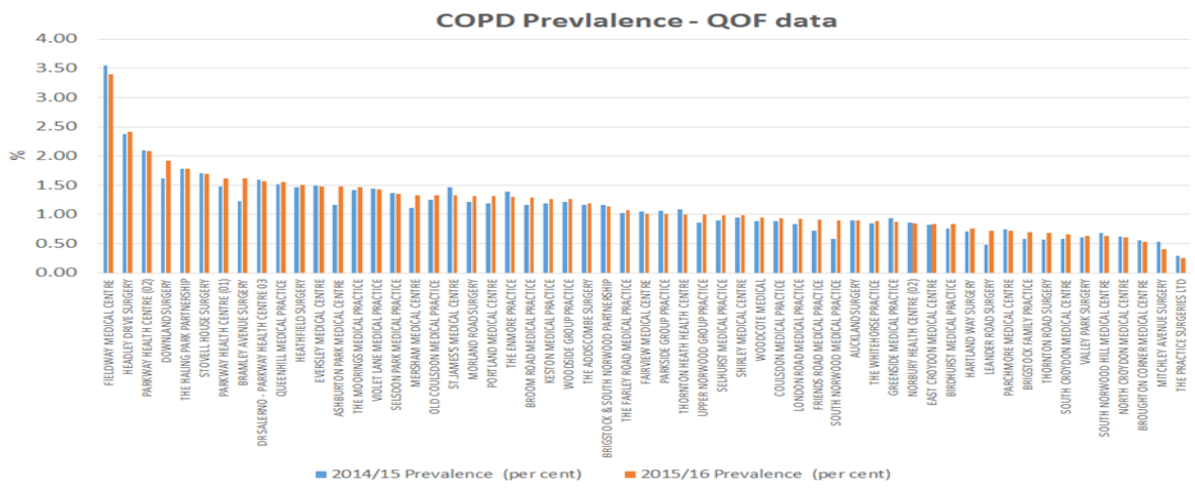
The variation team has been supporting Croydon CCG COPD improvement programme which is aimed at identifying and diagnosing patients with COPD in Croydon. The team works closely with Croydon Respiratory Team (CRT) on improving the diagnosis and management of COPD. Initially facilitating the installation of PRIMIS software in all GP practices the variation team then supported the practices in reducing variation in prevalence of COPD by identifying patients with potential missing COPD diagnosis.

The team worked as an enabler to ensure that the CRT had access to GP practices and provision of 6-12 clinical sessions over a consecutive 12-16 week period depending on practice size. By the variation team highlighting the patients with a high likelihood of COPD the CRT made more efficient use of their clinical sessions

The sessions provided by CRT include: patient review clinics, assessment of spirometry provision, identification of training needs and spirometry training if required, provision of advice regarding COPD patient management and signposting to Pulmonary Rehabilitation, smoking cessation and oxygen assessment services as appropriate.

With the support from the variation team the CRT visited 26 Croydon practices.

From the identified lists of patients potentially missing COPD diagnosis 378 patients were spirometry tested and as a result 69 were identified with COPD and added to the COPD register increasing COPD prevalence allowing earlier access to treatment..



Impact

- *With support from variation team the CRT visited 26 GP practices which contributed to provision of Croydon CCG COPD improvement programme*
- *As a result:*
  - *378 patients were spirometry tested*

6. Patient experience

During the level 3 comprehensive visits patient's experience of the practice is explored using GP patient survey data, local patient feedback, NHS Choices reviews and any Healthwatch information. Access to services is explored in terms of patient experience and also impact on other services for example accident and emergency attendances if access to primary care services is limited.

As part of the level 1 support the variation team have supported the implemention of Patient Online by encouraging practices to increase the number of patients registered and using this service.

Good practice is shared where between practices where appropriate including how patient participation groups are recruited and used by practices and actions taken in response to patient feedback.

6.1 Shared decision making

Shared decision making is a key aspect of the CCG's Together for Health programme, is promoted as best practice by the Royal College of General Practitioners and is a key aspect of General Medical Council duties of a doctor.

Shared decision making offers one method of having conversations with patients about their treatment options in an open and productive way. There is good evidence that not only do patients want to be fully engaged in decisions about their care, but that when they understand the options and pros and cons involved they will often opt for less interventional approaches and better outcomes are achieved.

The variation team have contributed to moving this agenda forward by promoting this with GP practices including the use of a GP resource pack for shared decision making. See Appendix 1.

Impact

- *Promoted shared decision making on all level 2 and 3 practice visits including*
    - *Distribution of the shared decision making resource for general practice*
    - *Encourage sharing of good examples of where shared decision making has been used and the outcomes*

6.2 Co-ordinate My Care

Co-ordinate My Care (CMC) is a clinical information sharing system between GPs and other healthcare providers for example London Ambulance Service. GPs use CMC to record the wishes of patients, how they would like to be cared for and clinical information such as medicines. In addition the service allows access to end of life information such as do not resuscitate and preferred place of death.

The Variation Team have facilitated the completion of practice information sharing agreements and training.

7. Next steps

- Continue with workplan
  The team will continue to apply the workplan across practices in Croydon, with new topics agreed via the variation steering group
- Programme of practice visits to continue building on establishes relationships action plans monitored to encourage implementation of changes.
- Work with primary care engagement, planned care, IT and business intelligence to develop regular data feeds for practices to inform new areas or practices to prioritise and the impact the variation team is having.

Shared Decision Making A resource for General Practice

Croydon CCG - Dr Emily Symington
August 2016

"There's nothing really wrong with you but I think a little surgery would make us both feel better."

What is shared decision making?

Shared decision making has been much talked about recently. It is embedded in the NHS Five Year Forward View, it is enshrined in GMC Duties of a Doctor and the NMC Code, and for the 2016/17 year it forms part of Croydon CCG's PDDS scheme. But what really is shared decision making and how to we make it a reality in the busy and often chaotic world of general practice?

Shared decision making is defined as;

> "A process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's in-formed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preference."1

At its core shared decision making recognises the equal value that clinician and patient bring to any choice regarding care and is recommended in the majority of clinical circumstances (however big or small the decision). A recent BJGP article discussed how shared decision making represents a middle ground between the extremes of paternalistic medicine and unrestricted patient autonomy, with the skill being in supporting patients to explore their values and discuss how these fit with the clinical options available.[2]

There is good evidence that patients want to be involved in decisions about their care and that where they are actively involved in decision making better outcomes are achieved.[1] Shared decision making improves compliance with medications and self-care advice. It also often results in patients choosing less interventional treatment options once they truly understand the options, reducing morbidity and financial cost.[3] Improved satisfaction with care and confidence around self-care also leads to more appropriate use of health services and reduction in repeat attendances.

NHS inpatient data from 2002 to 2009 demonstrates that almost 50% of patients would like to be more involved in treatment decisions, with this figure sadly

remaining static for the 7 years surveyed. [4] Many reasons are given as to why clinicians do not use shared decision making consistently when interacting with patients. One suggestion is that sharing of uncertainty can be uncomfortable for both clinicians and patients. Moving to shared decision making certainly requires a willingness on the part of the patient to accept an active role in the management of their condition which is a challenge for some.

The MAGIC programme run by The Health Foundation between 2010 and 2013 looked to demonstrate how shared decision making could become part of routine clinical practice. Working in primary and secondary care settings they came across several barriers to implementation of shared decision making, most consistently the challenge of engaging with senior clinicians and the perception that shared decision making was too time consuming.[6] However following training for staff, the use of decision aids and campaigns like 'Ask 3 questions' to raise patient awareness they were able demonstrate change in clinical practice.

For Croydon shared decision making forms a key part of the CCG's Together for Health strategy and underpins other aspects of this vision such as self-management. This resource package contains a collection of references, training tools and ideas to help you learn more about shared decision making and how to make it a routine part of your clinical practice. There is also an extensive list of resources which are freely available online to use with patients.

This resource will help support you to meet the shared decision making requirement of the PDDS. It can be used in conjunction with other Together for Health initiatives and in discussion with the variation team. I hope you find it useful.

1 Couler, A & Collins, A. 2011. Making shared decision-making a reality: no decision about me, without me. The Kings Fund; http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf
2 Staveley, I & Sullivan, P. 2015. We need more guidance on shared decision making. BJGP 65(641) 663-664
3 Elwyn, G. Laitner, S. Coulter, A. Walker, E. Watson, P. Thompson, R. (2010) Implementing shared decision making in the NHS. BMJ 2010; 341:c5146
4 NHS Surveys [online] Available at: http://www.nhssurveys.org/ [Accessed 2nd August, 2016]
5 Elwyn, G. Edwards, A. Gwyn, R. Grol, R. (1999) Towards a feasible model for shared decision making: focus group study with general practice registrars. BMJ 1999; 319:753

6 Ewan, K. Taylor, J. Williams, R. Vanson, T. (2013) The MAGIC programme: evaluation. An independent evaluation of the MAGIC (Making good decisions in collaboration) improvement programme. The Health Foundation [Online] Available at:

I already use shared decision making

There are few clinicians who don't agree, at least in principle, that patients should be involved in decision making around their care. Consultation tools such as ICE (ideas, concerns, expectations) are well established prompts to ensure you are directly asking patients about their priorities and values. GPs who have recently done the CSA part of MRCGP will remember that shared decision making is a key part of the assessment criteria. However despite good intentions the evidence suggests that shared decision making is not a routine part of most patient's experience of health care.

My patients are not ready for shared decision making

It is certainly the case that shared decision making requires the active involvement of both clinician and patient (or carer). Some patients, possibly based on past experience, cultural background or lack of understanding may not expect to be involved in making decisions about their care but the guidance is clear that this does not absolve the clinician of responsibility for offering that involvement. A response of 'whatever you think best doctor' (or similar) may be the active decision on the part of that patient to take the advice of the medical practitioner, but this should not be presumed.

As we know well in general practice, the relationship between clinician and patient is not the making of a single 10 minute consultation. While the patient may be taken aback by the offer of shared decision making initially, if this becomes the expected style of communication they are likely to become increasingly open to their role in the process.

Shared decision making takes too long

Any new skill takes time to master so including shared decision making in your consultations for the first time is likely to take a little while to get used to. However the experience of the MAGIC programme was that once established shared decision making does not take longer than more traditional consulting styles, and patients and clinicians came to expect it.
Also importantly, shared decision making is associated with improved outcomes and better patient confidence. While the initial consultation may take longer there is a considerable saving if that patient is how better able to manage their condition and understands the options, reducing unnecessary repeat consultations and patient worry.

http://www.health.org.uk/sites/health/files/TheMagicProgrammeEvaluation.pdf

Shared decision making myths

Shared decision making involves changing a consultation style I have developed over many years

For those who do not currently practice shared decision making routinely, incorporating this into their consultation style will require a change. This resource contains several links to on-line learning packages to support clinicians to understand shared decision making in more detail and embed it into their clinical practice. The MPS also runs a workshop on shared decision making which is free to members (more details later).

Shared decision making is only necessary for 'big' clinical decisions

While shared decision making may be particularly crucial for significant clinical decisions, practicing it at all times not only embeds it as routine communication but ensures that when those 'big decisions' need to be made both patient and clinician are ready. For ex-ample a discussion about the pros and cons of referral for knee replacement is going to be much easier with a patient who has had a shared decision making conversations about their knee pain in the past and therefore feels comfortable with the options available.

Shared decision making isn't possible in the clinical pathways available

Shared decision making is not about stepping outside of clinical guidelines and pathways. As described in the earlier definition shared decision making involves the clinician's use of evidence based practice (of which clinical pathways forms part) to inform a discussion with the patient about what of the available options is best for them as an individual in their personal circumstances.

What if the patient choses an option which is not available on the NHS?
As explained above, shared decision making is not about patients being able to demand treatment options which are not available or appropriate in a given clinical situation. It is about patients having the evidence based information so they can make an informed choice.

Many GPs are comfortable with for example mentioning therapies such as acupuncture or supplements such as glucosamine and chondroitin where appropriate to patients, making clear that these are available for patients to purchase themselves but cannot be prescribed on the NHS. In a shared decision that advice would be no different.

What if my patient makes an unwise decision?

As we are all very familiar with from the Mental Capacity Act 2005 any competent adult is entitled to make an unwise decision.

Ideas for initiating shared decision making in your practice

For many shared decision making is a lovely ideal, but it can feel like a daunting task to begin to implement in your practice. A few ideas to begin;

1. Have a practice meeting or learning session to discuss shared decision making as a clinical team. Maybe all agree to complete one of the free online learning modules before the session so you can bring an informed view to the discussion.

2. Changing practice is hard and it can be difficult to remember during a busy surgery. Agree as a practice that you will use shared decision making in one clinical setting, for example knee pain or PSA test requests. This way you can set up reminders and get into the habit. This could be an excellent practice improvement project for a trainee.

3. Start read coding shared decision making and conduct an audit. Read codes are as follows;

Version 2 READ Codes (used by all GP clinical systems except TPP SystmOne and HealthySoft Crosscare)

8Cl.	Shared decision making
8Cl0.	Shared decision making with patient decision aid
8Cl1.	Shared decision making without patient decision aid
8Cl2.	Shared decision making with decision support
8Cl3.	Shared decision making without decision support

CTV3 Codes (used by TPP SystmOne and HealthySoft Crosscare)

XaYjg	Shared decision making
XaYjh	Shared decision making with patient decision aid
XaYji	Shared decision making without patient decision aid
XaYjj	Shared decision making with decision support
XaYjm	Shared decision making without decision support

4. The NHS England website contains further advice and information about using shared de-cision making in clinical practice for those who are interested;
https://www.england.nhs.uk/ourwork/pe/sdm/

Shared decision making CPD ideas

On-line learning modules

http://www.e-lfh.org.uk/programmes/shared-decision-making/

Two brief on-line learning modules introducing shared decision making and discussing how to embed shared decision making into your clinical practice. A great overview of shared decision making for all GPs and practice nurses. Very relevant for appraisals.

http://elearning.rcgp.org.uk/course/info.php?popup=0&id=80

An on-line learning module developed by the Self Care Forum and RCGP. The module contains learning to help you develop a consultation style which promotes confidence around self-care, and includes ideas for the whole practice in ensuring patients have the information and support they need to self-care for minor self-limiting illness. Again very relevant for appraisals.

MPS course - Mastering Shared Decision Making

The MPS run a 3 hour workshop about shared decision making. This is free for members. As with all MPS courses the emphasis is on avoiding litigation through improved consulting skills. The information presented in the course is good and the opportunity to reflect on shared decision making in your own practice is worthwhile.

Being Mortal – Atul Gawande

A very accessible book written by an American surgeon. The book examines the realities of ageing, life-limiting disease and palliative care through the mixed lens of a clinician, relative and friend. A very thought provoking reflection on the limitations of modern medicine and the role clinicians have to play in supporting a good end to life.

Later chapters reflect on the conversations clinicians have with their patients and the value of understanding your patient's priorities to facilitate shared decision making.
I would strongly recommend this as a read for all GPs, whether still in training or significantly more senior.

Transactional analysis
http://www.bradfordvts.co.uk/wp-content/onlineresources/0200consultation/transactionalanalysis/transactional%20analysis%20by%20bill%20bevington.doc
http://www.lynneforrest.com/articles/2008/06/the-faces-of-victim/

Transactional analysis is an interesting frame to use to reflect on the interactions between clinicians and patients, or even the practice as a whole and its patient group. This model provides insight into the attitudes we are all too familiar with from some patients and the traps we can fall into in response.

A great starting point for a practice meeting discussion or trainee tutorial.

Health coaching

A technique based on motivation interviewing which looks to support people to develop the knowledge and skills to manage their own health. Health coaching can be delivered by a clinician or trained coach.

Several different courses in health coaching and motivation interviewing exist at varying levels.

Resources for use with patients

Shared decision making prompt - http://personcentredcare.health.org.uk/resources/ask-3-questions-materials

This link provides access to the Ask 3 Questions campaign materials

Health Help Now - http://www.healthhelpnow-nhs.net

This website and smart phone app is intended to support patients to manage their health needs and find the right support when they need it. All the health information is directly from NHS Choices and location specific information will direct patients to their nearest pharmacy, OOH service etc as appropriate.

This resource will shortly be available with Croydon specific information. In the meantime have a look online and download the app so you are ready to start encouraging your patients to use it when it becomes available. (Updates to come from the CCG.)

MSK Help - http://www.nhsinform.co.uk/msk/

This NHS Scotland developed website and app provides information about management of all musculoskeletal conditions. There is self-management advice and exercises to be used at home and guidance on when to see further medical attention.

The app is significantly easier to navigate than the website. A great resource to recommend to any patient presenting with a musculoskeletal problem and shaves on printing out exercise sheets which probably get lost.

Information prescriptions

Diabetes UK has produced an excellent range of information prescriptions for use with patients. These cover blood pressure, HbA1c and cholesterol for diabetic patients and healthy diet and being active for patients who are not diabetic. They contain easy to understand in-formation for the patient and a small amount of space for the clinician to fill in some specific details.
All these information prescriptions contain an action plan section at the bottom.

While you might feel filling this in with the patient is too time consuming during a consultation, getting

them to complete it themselves before a follow up appointment is a good way to reinforce the message.

All the information prescriptions are available to download for free here;

https://www.diabetes.org.uk/Professionals/Resources/Resources-to-improve-your-clinical-practice/Information-Prescriptions-QA/

Decision aids - http://patient.info/decision-aids

There are many decision aids available, some of which are more accessible than others. This link provides access to all decision aids recommended for use in the NHS. They are listed alphabetically by condition.

You will see they contain details of where they were developed in brackets after. Here is my personal take on their relative usefulness;

- Option grids; usual single side of paper, brief summary. Very good for reviewing with a patient during a consultation.

- Magic; developed as part of the Magic project. Often several sheets of paper but well writ-ten and comprehensive. Some are clearly more secondary care focused.

- Patient; developed by patient.co.uk. Similar to the Magic ones.

- NHS; go through to a weblink which provides a very comprehensive shared decision making approach. This would need to be completed by a patient themselves at home and is not suitable for use during a consultation. A gold standard approach to shared decision making but only really suitable for a very computer literate and engaged patient.

- NICE; based on NICE guidelines. Not very patient friendly

Self Care Forum - http://www.selfcareforum.org/

The Self Care Forum is a charitable organisation which aims to promote the value of self-care to clinicians and the general public. Their excellent website provides tips on promoting self-care in your practice, including posters which you can download and print. There is also the e-learning module mentioned previously.

The fact sheet section (http://www.selfcareforum.org/fact-sheets/) includes several

very useful information sheets which can be printed off for patients consulting for a range of rou-tine general practice conditions.

Patient accessible videos

- Jo's cervical cancer trust; excellent videos explaining the importance of cervical screening and what to expect. Videos are in English and a full range of different languages.
https://www.jostrust.org.uk/video-page

- DocMikeEvans; a Canadian doctor who has produced a series of illustrated explanations of common conditions. These are very accessible, comprehensive and entertaining. They are freely available to patients via YouTube. While intended for a Canadian market they are just as relevant for UK patients. The PSA testing and back pain ones are particularly good.
https://www.youtube.com/user/DocMikeEvans/videos

Explaining risk to patients

ClinRisk which developed the well known QRISK has a series of other risk calculators. When accessed online these generate a result with a Cates plot to help you explain risk to patients more clearly. The calculators available are;

- Type II diabetes; http://www.qdiabetes.org
- Renal failure; http://www.qkidney.org
- Hip and other osteoporotic fracture; http://www.qfracture.org
- Undiagnosed cancer; http://www.qcancer.org
- Risk/benefit of taking a statin; http://qintervention.org

Shared decision making - the links

Print out this page to have quickly access all shared decision making links.

Shared decision making prompt - http://personcentredcare.health.org.uk/resources/ask-3-questions-materials

Health Help Now – smart phone app & http://www.healthhelpnow-nhs.net

MSK Help – smart phone app & http://www.nhsinform.co.uk/msk/

Information prescriptions - https://www.diabetes.org.uk/Professionals/Resources/Resources-to-improve-your-clinical-practice/Information-Prescriptions-QA/

Decision aids - http://patient.info/decision-aids

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- Undiagnosed cancer; http://www.qcancer.org
- Risk/benefit of taking a statin; http://qintervention.org

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For general release

REPORT TO:	**Health and Social Care Scrutiny Sub Committee 17 January 2017**
AGENDA ITEM:	**11**
SUBJECT:	**Annual Report of the Director of Public Health 2016**
LEAD OFFICER:	**Rachel Flowers, Director of Public Health**
CABINET MEMBER:	**Cllr Louisa Woodley, Cabinet Member for Families, Health and Social Care**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Rachel Flowers, Director of Public Health**

ORIGIN OF ITEM:	**This report forms part of the Committee's work programme for 2016/17**
BRIEF FOR THE COMMITTEE:	**The Committee requested this report to examine the work of the Director of Public Health and to identify future areas of work for the committee in a future work programme.**

1. EXECUTIVE SUMMARY

1.1 Loneliness and social isolation can impact people across a wide range of life course groups in the population. There are strong associations between loneliness/social isolation and economic and social inequality, vulnerability, sexuality, disability, age and ethnicity. Older people, single parent households, teenage parents, and BME households newly settled in the country, especially those who may experience difficulty communicating in English, are all at greater risk of social isolation.

1.2 The 2016 Director of Public Health Report focuses on social isolation and loneliness and identifies risk factors for these issues across the life course (pregnancy and early years, children and young people, working age, and retirement and later life).

1.3 The final section of the report presents recommendations for how individuals and communities can play their part in addressing loneliness and social isolation across the various stages of the life course and uses a number of case studies to illustrate examples of initiatives in the borough.

1.4 It is a statutory requirement for the Director of Public Health to produce an Annual Report (Health and Social Care Act 2012, Section 31 (5)) and for the Council to publish this (Health and Social Care Act 2012, Section 31 (6)).

2. DETAIL

2.1 Background

There is well-established evidence for treating social isolation and loneliness as key priorities due to their adverse effects on wellbeing and links to health inequalities and social exclusion. This has been highlighted by the Opportunity and Fairness Commission:

Too many local residents live isolated and empty lives […]. This takes a huge toll on their mental and physical health but it also increases costs on local services […]. Increased [hospital] admissions and patients in beds unable to return home because they have no one to support them are the inevitable consequence of social isolation (page 7).

There are strong economic as well as social arguments for taking action to reduce and prevent social isolation and loneliness. A wide range of preventable health problems and wider social problems are known to arise out of loneliness:

- Reduced social capital and cohesion, resulting in fragmentation of communities and reduced resilience
- Increased likelihood of youth offending, especially through membership of gangs and unemployment
- More likely to develop mental ill health problems and depression
- Greater incidence of falls and need for long-term residential or nursing case
- Higher incidence of obesity, smoking, substance and alcohol abuse
- Increased visits to GPs and use of medication
- Greater use of accident and emergency service

Relationships and human interaction have a significant impact on an individual's health and wellbeing. Research shows that protective aspects of neighbourhood relationships otherwise called social capital, are important for preventing self-harm and suicide. Social capital can be defined as "the sum of positive relationships including families and neighbours that serve as buffers to the negative influences within one's immediate environment" and can build resilience and reduce the effects of other negative factors like deprivation on individuals in a community.

2.2 Report Focus

The Croydon Congress and Croydon Opportunity and Fairness Commission final report highlighted services provided by the council and its health, social care and voluntary sector partners to address loneliness and social isolation.

The Croydon Opportunity and Fairness Commission report also found that the natural inclination for most of us is to ask what more the government can do to address many social issues however, there is so much individuals and communities can do for themselves to address loneliness and social isolation:

Local services can provide the supporting framework and help nurture the best ideas but Croydon residents must play their part (page 39).

The Director of Public Health Report identifies risk factors for loneliness and social isolation across the life course at four stages:

- pregnancy and early years;
- children and young people;
- working age; and
- retirement and later life

It also recognizes and discusses that certain individuals and groups are more vulnerable than others and are therefore likely to be particularly at risk.

The final section of the report presents recommendations for how individuals and communities can play their part in addressing loneliness and social isolation across the various stages of the life course and uses a number of case studies to illustrate examples of initiatives in the borough.

2.3 Risk Factors

Risk factors for loneliness and social isolation can be categorised into four distinct areas highlighted below.

Table 1: Risk Factors for Loneliness and Social Isolation

Categories	Examples of Risk Factors
Personal factors	• Sexuality • Ethnicity • Age
Life changes	• New, young or lone parenthood • Becoming a carer (both young and old) • Retirement • Separation from a partner/bereavement • Unemployment
Health, wellbeing and disability	• Cognitive or sensory impairment • Physical or mental impairment or disability • Substance misuse problems
Wider or social determinants of health	• Domestic abuse and violence • Long term unemployed • Recent migration • Poverty and deprivation • Homelessness • Stigma and discrimination

Specific examples of issues relevant to each of the life course stages were identified:

Pregnancy and early years

- Being a new parent, young parent or parent carer
- Having a physical or learning disability
- Lack of or inadequate social networks for support during pregnancy

- Maternal depression and a lack of awareness of and how to access mental health support
- Ethnicity and deprivation or low income

Children and young people

- Adverse childhood experiences like abuse, neglect, witnessing drug or alcohol abuse or experiencing domestic violence
- Being bullied
- Being a young carer
- Being a looked after child or recently leaving care
- Being not in employment, education or training (NEET)
- Teenage pregnancy
- Sexual identity (LGBT - Lesbian, Gay, Bisexual, Transgendered)
- Having a physical or learning disability
- Ethnic identity especially those from an economically disadvantaged background

Working age people

- Unemployment
- Bereavement or relationship breakdown
- Having a physical or learning disability
- Mental ill health
- Being an unpaid carer
- Substance misuse and addiction

Retirement and later life

- Retirement/unemployment
- Becoming a carer
- Bereavement/ loss of a spouse or partner

2.4 Recommendations (Together Taking Responsibility - Quick Tips)

A number of recommendations for how individuals and communities can address loneliness and social isolation across the various stages of the life course are highlighted in the report. Examples of some of the recommendations included in the report are below:

General Tips

- Maintain frequent contact. If someone you know has hit a milestone birthday, lost a spouse or other important person, or is ill or immobile, they need more contact so make a note to call or visit often.
- Socially isolated older people may be vulnerable to a variety of unexpected problems and may have underlying issues such as dementia. Loved ones should consider informing trusted neighbours that there is a vulnerable adult in the neighbourhood so they keep a friendly eye out and check in on them regularly.
- If you know a carer or a loved one in your family shoulders the burden of caring for an elderly family member, take whatever steps you can to make that person's life easier and to allow them to have a social life of their own.

Tips For Carers

- If you are a carer, remember to take care of yourself. It is not just the person you are caring for who is at risk of social isolation, it is you.

- Peer support from people who understand can help you feel less alone, for example through a carer support group or social activities organized by a local carers organization.

Tips For New Mums

- Join antenatal classes – meet other women in a similar situation to you especially if you are the only one of your friends who is approaching parenthood and are therefore feeling disconnected from them.
- Practice positive thinking - Create positive scenarios in your head and picture your future life with your baby in a happy, fulfilling setting. You could also record positive events of the day or week - even tiny details such as laughing at a joke, enjoying lunch with friends or seeing an uplifting movie can help to combat negative feelings.
- It can be hard to break away from new day-to-day responsibilities as a parent, but you need to take time for yourself and will feel so much better for getting out of the house for a walk or a coffee with a friend/ family or an exercise class.

Tips For Children and Young People

- Find something you like doing and do more of it. Sometimes it is hard to find the motivation, especially if you don't feel confident or you worry about what other people think. Making small goals can help you to feel more positive about yourself. You don't have to be perfect at it to enjoy yourself.
- Be careful when comparing yourself to others and remember that things are not always what they seem from the outside. Social media, and the fact that we very often only see what other people want to share about their lives, can make you feel like you are the only one feeling lonely.

Tips For Parents

- Research shows that children who achieve a healthy weight tend to be fitter, healthier, better able to learn, and are more self-confident. They are also less likely to have low self-esteem and be bullied. Listen to your child's concern about their weight, they need to feel supported and loved. Five key ways to help your child achieve a healthy weight are:
    - Be a good role model
    - Encourage 60 minutes of physical activity a day
    - Keep to child-size portions
    - Eat healthy meals, drinks and snacks
    - Give Less screen time and more sleep
- Children need to understand that all of us have unique differences that make us individuals. We are all far more alike than we are different, and these differences should not be feared or ridiculed.

Tips For Working Age Adults

- Nurture your support network – do not underestimate the importance of what you have to offer.
- Expand your social network – online social sites are ideal places to meet people who share similar interests and hobbies.
- Volunteering is also a great way of maintaining and expressing a sense of purpose and staying connected with your community.
- Maintain contact with family and friends over the phone; social media or video conferencing applications can be the next best thing to being with them.

Tips For Older Adults

- Share a meal with others whenever possible.
- Undiagnosed or untreated hearing problems may lead to avoidance of social situations because of difficulty communicating or embarrassment. Have your hearing checked and hearing problems treated as needed.
- Be open to learning how to use technology to maintain connections. A computer with a camera is a bridge to anyone in the family.

2.5 Case studies (Out in the Community…)

The case studies included in the report that demonstrate how residents of various backgrounds at risk of social isolation are being supported by members of their communities are summarized below.

Table 2: Summary of case studies included in 2016 Director of Public Health Report

Life Course Group	Case Studies
Mothers	Bump Dance Fitness An initiative started by a group of New Addington residents who are passionate about safety and healthy living aimed to engage local mums from the community to make new friends, combat isolation and keep healthy and safe.
Young People	Lingua House An initiative started by members of the Afghan community who identified a need to develop English language classes to help younger members of the community develop their language skills and therefore take greater part in the wider community. Sports in the Rec An initiative started by local Broad Green residents with sporting skills and expertise who identified the need to create a safe and interactive space for vulnerable young people in the area to take part in activities. Many of young people targeted are typically unable to affordable opportunities to take part in sport.

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Appendices

Appendix 1: Annual Director of Public Health Report 2016

Social Isolation and Loneliness

Annual report of the director of public health 2016

Just BE CROYDON

Croydon Heart Town

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POLITICAL FOREWORD

Forward from the Leader of the Council

I am delighted to be writing the introduction for Rachel Flowers' first annual Director of Public Health report. Rachel has a wide range of experience at local, regional and national level and a track record of making a positive difference in the health and wellbeing of local people.

Earlier this year Croydon Council commissioned an Opportunity and Fairness Commission, a subject that I am passionate about, where Social Isolation was identified as a significant issue for some people in Croydon. In the summer, the Croydon Congress also had over 200 people attend to discuss the challenges around this issue.

Rachel has chosen Loneliness and Social Isolation as the theme of her first report as it impacts on the health and wellbeing of so many people in our communities and has identified ways in which we can all together take responsibility to reduce social isolation in Croydon. These are simple things that we can all do in our day to day lives and I would encourage you to read through and see what you can do for your family, friends and community to reduce social isolation and help us reduce the health harm that it can cause.

Councillor Tony Newman
Leader,
Croydon Council

FOREWORD FROM THE DIRECTOR OF PUBLIC HEALTH

Welcome to my first annual report as Director of Public Health for Croydon.

I heard recently that the three most important things for people's health are "jobs, homes and friends" and I think that this is a good start to think about the multitude of things that impact on people's health and a signpost about how we can improve it.

When I arrived in Croydon, it was at the time that work was undertaken for the Croydon Opportunity and Fairness Commission and I was impressed with this approach. It sadly, didn't surprise me that a major theme of social isolation was identified, as it impacts on the health and wellbeing of so many people across all ages, communities, faiths, genders, sexualities and disabilities. I felt humbled to be invited to speak at the Croydon Congress where I met and talked to so many people wanting to make a difference for the people of Croydon.

This got me thinking – what are things that all of us can do that can reduce the social isolation of people – those we know, those we live by and those we work with? This report tries to capture the risk factors and health impacts of social isolation but also provides a few ideas about what we can all do.

One thing I didn't include but feel I should is that we should try and smile a little more often at people we don't know. A smile can be contagious and for people who are socially isolated – and you can't always tell who they are – it can make such a difference.

Give us your feedback

Do let me know your comments on the report, either by emailing me at rachel.flowers@croydon.gov.uk

or by post to:

Croydon Council,
Public Health Division,
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2nd floor Zone E,
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Rachel Flowers
Director of Public Health,
Croydon Council

INTRODUCTION

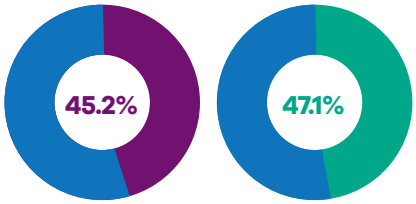
The impact of loneliness and isolation can be devastating to most people. Studies have shown *that relationships have more of an impact on individual's health than many other risk factors, such as obesity or physical inactivity.*[1] In other words, human interactions are seen as crucial to living a happy, fulfilled life.

Although the terms social isolation and loneliness are linked and are often used interchangeably, there are some important distinctions between the two terms.

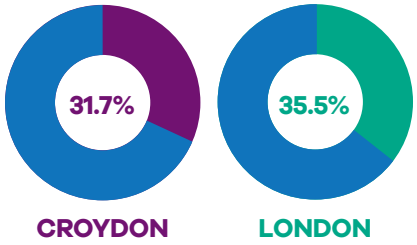
Social isolation can be defined as an objective state determined by lack of or insufficient quality and quantity of social relationships and contacts on the different levels that human interaction takes place (individual, groups, community and the larger social environment).

Loneliness is often defined as a subjective state based on a person's emotional perception of the inadequate quality of their social connections, irrespective of the breadth of their social networks. It can manifest as an anxious feeling of unmet need to connect or communicate with others.

Loneliness and social isolation can occur at the same time, and in some instances one can be a direct consequence of the other, for example where feelings of loneliness cause a person to withdraw from their social interactions and therefore become isolated. It is however also possible for the two to occur independently, where a person is isolated but not lonely and vice versa.



45.2% of people who use adult social care services reported that they have as much social contact as they would like.



31.7% of carers reported that they have as much social contact as they would like.

Suicide rate of **8.2 per 100,000**. This is the **15th highest in London**.

10,261

Croydon residents live in one of the 10% most deprived areas in the country

33,683

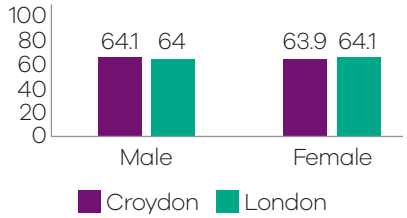
residents provide unpaid care.

6,870

of these provide over 50 hours pw.

11th highest rate in London.

Healthy Life Expectancy 2012-14



WHY IS THIS IMPORTANT?

The 2016 Croydon Opportunity and Fairness Commission[2] report highlights the growing issues of loneliness and isolation facing communities today and the need to put these issues at the heart of our local and national agenda. Of equal importance is the need to ask more of ourselves when it comes to addressing the challenges of loneliness and social isolation.

As the Opportunity and Fairness Commission report found, the natural inclination for most of us is to ask what more the government can do to address many social issues we face however, there is so much we can do as individuals and as a community to address loneliness and social isolation. In other words, **"local services can provide the supporting framework and help nurture the best ideas but Croydon residents must play their part"**.

Relationships and human interaction have a significant impact on an individual's health and wellbeing. Research shows that protective aspects of neighbourhood relationships otherwise called social capital, are important for preventing self-harm and suicide.[3] Social capital can be defined as "the sum of positive relationships including families and neighbours that serve as buffers to the negative influences within one's immediate environment."

Social capital can build resilience and can reduce the effects of other negative factors like deprivation on individuals in a community. Social capital and community cohesion are essential factors in supporting people through trying times.

HOW DO WE DO THIS?

Reduced social capital and cohesion can result in further fragmentation of communities and isolation of individuals while positive social relationships and networks can promote health for people at any age through, for example:

- providing social support to cope with life's challenges and changes such as becoming a new parent, redundancy, or retirement.
- providing people with a sense of belonging.
- sharing knowledge on how to access health and other support services when needed.

WHAT WILL THIS REPORT COVER?

It will discuss the risk factors that can lead to loneliness and social isolation at the various stages of one's life (pregnancy and early years, children and young people, working age, and retirement and later life) and present quick tips for what we can do as individuals to combat loneliness and social isolation and as a community with the support of voluntary sector organizations, and health and social care services where applicable.

EXTENT AND IMPACTS OF LONELINESS AND SOCIAL ISOLATION

Extent of Loneliness and Social Isolation

In 2013, Public Health England estimated that 20% of the older population (aged 65+) are mildly lonely and 11% are intensely lonely; with a further 7% of the 18-64 population being socially isolated.

In Croydon, there are an estimated 9,860 older people who are lonely and 5,423 older people who experience intense loneliness. There are also 17,227 people aged 18-64 who are socially isolated.

Loneliness can have serious consequences for the mental and physical health of people. It is linked to **obesity**, **smoking**, **substance abuse**, **depression**, and **poor immunity**.[4]

The effect of loneliness and isolation on death is greater than the impact of well-known risk factors such as obesity, and has a similar effect as cigarette smoking.[5]

Who is at risk?

Risk factors for loneliness and social isolation can be categorised into four distinct areas:

Personal factors

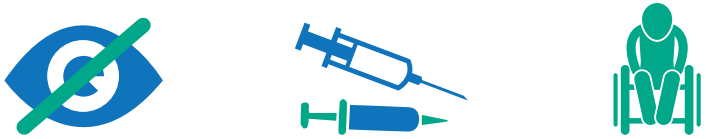
Sexuality | Ethnicity | Age

Life changes

New, young or lone parenthood | Becoming a carer (both young and old)

Retirement | Unemployment | Separation/ Bereavement

Health, wellbeing and disability



Cognitive or sensory Impairment | Substance misuse problems | Physical or mental impairment or disability

Wider or social determinants of health

Domestic abuse and violence | Long term unemployed | Recent migration

Poverty and deprivation | Homelessness | Stigma and discrimination

LONELINESS AND SOCIAL ISOLATION ACROSS THE LIFE COURSE STAGES

Throughout the various stages of one's life (pregnancy and early years, childhood and teenage years, working age, and retirement and later life), certain individuals and groups will be more vulnerable to social isolation and loneliness than others depending on factors such as physical and mental health, gender, race/ethnicity and the determinants of health inequalities such as deprivation, income, education, occupation etc.

In general, improving access to services and improvements to the wider social determinants of health like access to education, employment, and to the built and natural environment are likely to have a positive impact across all stages of the life course.

The following sections highlight the general risk factors for loneliness and social isolation across the various life course stages followed by quick tips on how to mitigate them.

PREGNANCY AND EARLY YEARS

PREGNANCY AND EARLY YEARS – FACTS AND FIGURES

In 2015 there were **5833** live births in Croydon.

There are **805** looked after children in Croydon. This is 87 per 10,000 children under 18 (Statistical neighbours 58.4%, London 52%).

64.7% of children have a good level of development at the end of reception (School Readiness). This is the 9th lowest in London.

85.9% of eligible 2 year olds had their MMR vaccination. This is the 14th highest in London.

175 babies born in 2014 had low birth weight. This is 9th highest in London.

68 babies died in their infancy between 2012 and 2014. Croydon Infant Mortality rate is 4.0 per 1000 live births. This is the 10th highest in London.

RISK FACTORS

- Being a new parent, young parent or parent carer
- Having a physical or learning disability
- Lack of/or inadequate social networks for support during pregnancy
- Maternal depression and a lack of awareness of how to access mental health support
- Ethnicity and deprivation or low income – Economic deprivation and ethnicity may impact on maternal depression and seeking help or support for depression[6]

Social isolation of mothers can lead to disadvantage across generations and can cause health inequalities over the life course. Maternal depression can severely impact early childhood development and development in early childhood has a significant impact on factors such as educational attainment and employment which in turn impact health. *Simply put, social isolation in new mothers could lead to disadvantage and therefore social, economic and health inequalities in the children and families.*

CHILDREN AND YOUNG PEOPLE

CHILDREN AND YOUNG PEOPLE – FACTS AND FIGURES

64.7%
of all pupils age 5 are achieving a good level of development. (Statistical neighbours 67.8%, London 68.1%).

54%
of all pupils age 5 who are eligible for free school meals are achieving a good level of development (Statistical neighbours 59.6%, London 59%).

There are 805 looked after children in Croydon. This is 87 per 10,000 children under 18 (Statistical neighbours 58.4%, London 52%).

96.4 PER 100,000 YOUNG PERSON
(under 18) hospital admissions for mental health conditions. This is the 13th highest in London.

313.3 PER 100,000 10-24 YEAR OLD
hospital admissions due to self-harm. This is the 2nd highest in London.

3,207 YOUNG CARERS
provide between 1-50 hours care. This is the 5th highest in London.

Under 18 conception rate is 28.4 per 1,000 girls aged 15-17. This is the 4th highest in London.

19,075 (21.1%) dependent children under 20 in Low income households. This is the 17th highest rate in London.

20.3% OF 4-5 YEAR OLDS
are either overweight or obese. This is the 9th lowest in London.

39% OF 10-11 YEAR OLDS
are either overweight or obese. This is the 11th highest in London.

3.3% OF 16-18 YEAR OLDS
are not in education, employment or training (NEET).

1,792
children have statements of Special Educational Needs (SEN) or Education, Health and Care (EHC) plans.

RISK FACTORS

- Adverse childhood experiences like abuse, neglect, witnessing drug or alcohol abuse or experiencing domestic violence
- Being bullied
- Being a young carer
- Being a Looked after child or recently leaving care
- Being Not in Employment, Education or Training (NEET)
- Teenage pregnancy
- Sexual identity (LGBT – Lesbian, Gay, Bisexual and Transgendered)
- Having a physical or learning disability
- Ethnic identity especially those from an economically disadvantaged background

CHILDREN AND YOUNG PEOPLE

CHILDREN AND YOUNG PEOPLE – FACTS AND FIGURES

Adverse childhood experiences severely impact early years development which as mentioned earlier, has a significant impact on factors such as educational attainment and employment which in turn impact health.

Teenage pregnancy may increase the risk of social isolation for parents and children because it can cause material deprivation and stigma. There is a detrimental impact on the lives of children of teenage mothers who have inadequate social networks and live in deprived areas. This poor start in life could lead to continued disadvantage through life and can cause health inequalities over the life course.

Bullying of young people who are LGBT can have a negative impact on self-image, confidence and educational attainment and lead to psychological stress and social isolation.

A young person with a physical or learning disability is at risk of becoming lonely and socially isolated because they may not have the support to connect or engage with others in their community. Similar to a young person with a disability, a young carer is also at risk of social isolation because they will not have time to see family and friends in addition to their caring responsibilities without support from others.

WORKING AGE

WORKING AGE – FACTS AND FIGURES

155
people aged 18-64 have a serious visual impairment (PANSI* estimate).

8,587
people aged 18-64 have a moderate or severe hearing impairment (PANSI* estimate).

60.6%
of adults over 16 are doing at least 150 minutes of physical activity per week. This is the 9th highest in London.

25.7%
of adults are inactive. This is the 11th lowest in London.

38,629
people aged 18-64 are predicted to have a common mental health problem (PANSI* estimate).

17,185
people aged 18-64 are predicted to have two or more psychiatric disorders (PANSI* estimate).

17,932
people aged 18-64 are predicted to have a moderate physical disability (PANSI* estimate).

5,156
people aged 18-64 are predicted to have a serious physical disability (PANSI* estimate).

63%
of 16+ population are either overweight or obese.

2,840
people claim Job Seekers Allowance in Croydon. This is 1.2% of the working age population. This is the 11th lowest in London.

970
people in Croydon have been claiming Job Seekers Allowance for over a year. This is 0.4% of the working age population and is the 16th lowest rate in London.

* Projecting Adult Needs and Service Information

RISK FACTORS

- Unemployment
- Bereavement or relationship breakdown
- Having a physical or learning disability
- Mental ill health
- Being an unpaid carer
- Substance misuse and addiction

WORKING AGE

WORKING AGE – FACTS AND FIGURES

For some ethnic minorities, increased risk of social isolation is associated with social and economic disadvantage, housing problems and language barriers. Working age adults who are unemployed are at risk of becoming isolated because of the loss of contact with colleagues and withdrawal from social engagements due to the need to cut back on expenses and because of the embarrassment of being unemployed.

Experiencing bereavement or a breakdown in a relationship can lead to loneliness and social isolation without a support network to enable the person to re-engage with people.

Research has found that many carers experience social isolation and loneliness as a result of caring.[7] This may be due to having less time to socialise due to their caring role and being unable to afford social activities. This effect can be greater the longer someone has a caring role, due to the increasing amount of care they may have to provide.

Findings from the Life Opportunities Survey Report released in 2015 show that having a physical or mental impairment appears to be associated with lower levels of social contact.[8]

Physical and mental disability can leave many unable to leave their homes due to mobility and lack of confidence issues and therefore without support many can become isolated from their family, friends and communities.

RETIREMENT AND LATER LIFE

RETIREMENT AND LATER LIFE – FACTS AND FIGURES

13% of Croydon population is aged 65+. This is the 12th highest proportion in London. This equates to 49,300 people which is the 3rd highest number in London.

6.1% of Croydon population is aged 75+. This is the 12th highest proportion in London. This equates to 23,000 people which is the 3rd highest number in London.

4,264 people aged 65+ have depression (POPPI* estimate).

1,356 people aged 65+ have severe depression (POPPI* estimate).

18,057 people aged 65+ live alone (POPPI estimate). This is 37.6% of the 65+ population.

4,324 people aged 65+ have a visual impairment (POPPI estimate). This is 8.8% of the 65+ population.

16,402 people aged 65+ are unable to manage at least one self-care activity. This is 33.3% of the 65+ population (POPPI* estimate).

20,764 people aged 65+ have a hearing impairment (POPPI estimate). This is 42.1% of the 65+ population.

20,019 people aged 65+ are unable to manage at least one domestic task on their own. This is 40.6% of the 65+ population (POPPI* estimate).

12,166 people aged 65+ with a limiting long term illness are limited a little in their day-to-day activities while 10,903 are limited a lot (POPPI* estimate).

12,877 people aged 65+ have a BMI of 30 or more. This is 26.1% of the 65+ population (POPPI* estimate).

* POPPI – Projecting Older People Population Information

RETIREMENT AND LATER LIFE

GREATER LONDON AUTHORITY (GLA) REPORT ON "PROPENSITY FOR SOCIAL EXCLUSION OF OLDER PEOPLE IN LONDON"

The report looks into the various drivers of social exclusion amongst older people (although many of these indicators are equally relevant amongst all age groups) and attempts to identify areas in London where susceptibility is particularly high. *See Appendix A for additional information used in the report*. The areas in Croydon identified to have the highest propensity of social exclusion for over 65s are indicated in the map.

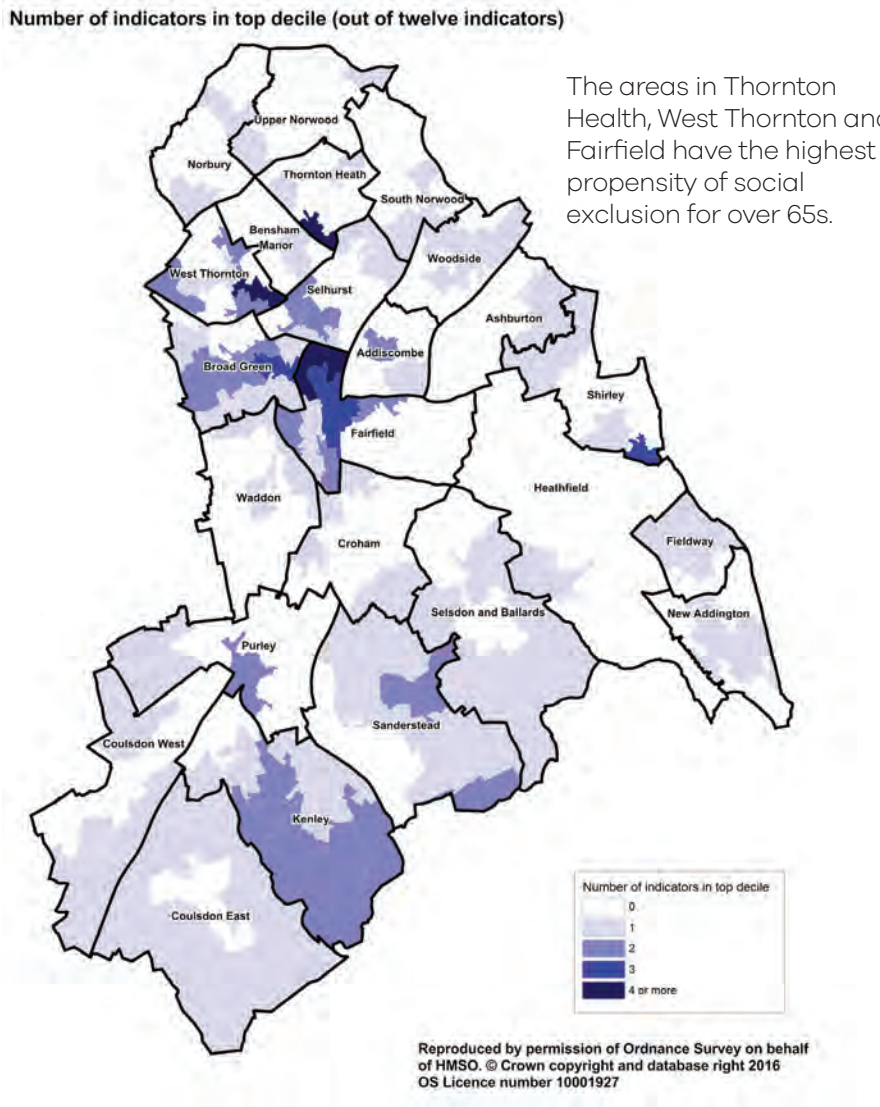
OTHER RISK FACTORS INCLUDE:

- Retirement/unemployment
- Becoming a carer
- Bereavement/ loss of a spouse or partner

For older adults, retirement and/or unemployment as highlighted for working age residents can result in losing connections with colleagues and friends, which can lead to social isolation. Retirement may also mean that there is a dependence on a smaller income and therefore a reduced likelihood of participating in social events.

Older adults can also become socially isolated as a result of reduced mobility due to a number of long term conditions like dementia and musculosketal conditions. In this age group, men are more likely to become socially isolated than women and ethnic minorities who experience language barriers and higher levels of poverty are more likely to become socially isolated than the rest of the population.

Older carers are also likely to have a lower resistance to stressors which could result in fatigue and physical inactivity which in turn increase the risk of social isolation.



The areas in Thornton Health, West Thornton and Fairfield have the highest propensity of social exclusion for over 65s.

TOGETHER TAKING RESPONSIBILITY – QUICK TIPS

The following are some quick tips on what we can do as individuals and members of our communities to combat loneliness and social isolation. They include a small snapshot of initiatives that members of communities in Croydon are taking to support each other and hopefully allows you to appreciate the value and impact this support can make to the lives of many Croydon residents.

GENERAL TIPS:

- **Maintain frequent contact**. If someone you know has hit a milestone birthday, lost a spouse or other important person, or is ill or immobile, they need more contact so make a note to call or visit often.
- **Do what you can to make your pregnant friend feel like she is still a part of the group**. Invite her to do things she will enjoy, like to tea, to a park for a picnic, or on a nice walk. Be creative and think about things that she will enjoy, not things that will require her to be a passive observer.
- Socially isolated older people may be vulnerable to a variety of unexpected problems and may have underlying issues such as dementia. **Loved ones should consider informing trusted neighbours that there is a vulnerable adult in the neighbourhood so they can keep a friendly eye out and check in on them regularly**.
- If you know **a carer, or a loved one in your family shoulders the burden of caring for an elderly family member, take whatever steps you can to make that person's life easier** and to enable them to have a social life of their own.
- **Everyone has a role to play in making an effort to recognise and understand caring, ageing and disability better** so they can recognise and support people in their communities who might need it.
- Caring is part and parcel of everyday life – **more people openly talking about caring responsibilities** would reflect this and allow everyone to understand caring better.

TIPS FOR CARERS:

- If you are a carer, **remember to take care of yourself**. It is not just the person you are caring for who is at risk of social isolation, it is you.
- You may not always feel you have time to focus on looking after yourself but **it is important that you make time to look after your physical health**, and there are many things you can do to improve it. Eat healthily, get enough rest, do regular physical activity – even a short walk can be good exercise and can help you clear your head. Take time to notice when you are becoming unwell and try to take a break and ask for help.
- **Peer support from people who understand can help you feel less alone**, for example through a carer support group or social activities organised by a local carers organisation.
- **Try asking for a small amount of help from family or friends** – help with shopping or sitting with the person you look after for a short time to allow you to pop out. Telling them what a difference it has made might result in them offering to help out again.
- **Focusing on the positives in your situation can help you feel that you have a deeper relationship and understanding of the person you care for**, and appreciate that they may feel this way about you too.
- **It is important to be realistic about what you can do**. Having a clear idea about what you can do, and accepting the things that you cannot change or do alone, helps to reduce stress and can make you feel more able to cope.

TIPS FOR NEW MUMS:

- **Join antenatal classes** – meet other women in a similar situation to you especially if you are the only one of your friends who is approaching parenthood and are therefore feeling disconnected from them.
- **Practise positive thinking** – create positive scenarios in your head and picture your future life with your baby in a happy, fulfilling setting. You could also record positive events of the day or week – even tiny details such as laughing at a joke, enjoying lunch with friends or seeing an uplifting movie can help to combat negative feelings.
- **Be honest about how you are feeling** – especially with your spouse or partner and your family.
- Take care of yourself – **find time to eat well, take regular exercise and get enough rest**.
- **Speak to a midwife about how you are feeling** and how to access antenatal classes and other support services.
- Use social media to your advantage. **Seek out websites that specialise in Mums coming together**.
- **When you meet new Mums be brave and make the first move** – ask if they would like to meet up for a coffee or go to the park with the babies. You may be making their day!
- Going to a baby group and meeting new Mums can seem daunting at first. **Just smile and fake your confidence until you become more at ease**. Babies can often make it easy to strike up a conversation.
- It can be hard to break away from new day-to-day responsibilities as a parent, but **you need to take time for yourself** and will feel so much better for getting out of the house for a walk or a coffee with a friend/ family or an exercise class.

OUT IN THE COMMUNITY

LOCAL MOTHERS – BUMP DANCE FITNESS

Led by Daisy Lennon, a group of New Addington residents who are passionate about safety and healthy living aimed to engage local mums from the community to make new friends, combat isolation and keep healthy and safe.

They developed Bump Dance Fitness at Timebridge Youth Club and to date have involved over 30 women and their children. Through increasing their networks, those attending feel less isolated and more able to gain support from others in relation to their safety. Many of those attending have experienced crime including domestic violence and report that the initiative has helped them seek support and 'take more control of their lives'.

Amina* has attended the sessions for two months and talks enthusiastically about the benefits of being a part of the initiative; "As well as helping me to lose weight, taking part in this project has given me the opportunity to get support from other parents helping me to overcome anxiety by gaining advice and being able to talk about issues. In fact I feel able to use my experience to help others. I haven't found anything like this before and the fact that it is local and run by local people has helped me feel able to take part".

**name changed*

TIPS FOR CHILDREN AND YOUNG PEOPLE:

- **Find something you like doing and do more of it** – sometimes it's hard to find the motivation, especially if you don't feel confident or you worry about what other people think. Making small goals can help you to feel more positive about yourself. You don't have to be perfect at it to enjoy yourself.
- **Be careful when comparing yourself to others and remember that things are not always what they seem from the outside** – social media, and the fact that we very often only see what other people want to share about their lives, can make you feel like you are the only one feeling lonely.
- **Focus on your positives** – you may think that you are not good at something and this may stop you from doing things you enjoy or trying new things.
- **Try to celebrate your successes** – no matter how small they may seem to you.
- **Accept compliments** – keep a note of them and look at them when you feel low.
- **Write a list of what you like about yourself** – aspects of your personality, appearance, what you like to do and remind yourself of them often.

OUT IN THE COMMUNITY

YOUNG MIGRANTS – LINGUA HOUSE

Members of the Afghan community identified a need to develop English language classes to help younger members of the community develop their language skills and therefore take greater part in the wider community. This has also allowed for conversations to take place related to a range of issues for young people who are new arrivals in the borough through language support and peer to peer guidance.

The founder of Lingua House explains that many of these young people are lonely and isolated and therefore vulnerable, so being supported by those who care and understand them is vitally important; "Being around people they trust and who understand them is so important for these young people many of whom have had traumatic times in the recent past and yet just want to play a part in the local community. How we develop what we do is based on sharing our skills and encouraging all of us to support each other".

Participants are helped to identify the future support they need particularly in relation to employment and activities they wish to undertake and the work also looks at ways in which they can offer their gifts to each other in terms of knowledge, skills, experience and contacts.

OUT IN THE COMMUNITY

YOUNG PEOPLE – SPORTS IN THE REC

Local Broad Green residents with sporting skills and expertise identified the need to create a safe and interactive space for young people in the area to take part in activities. Many young people had talked about their vulnerability and the lack of affordable opportunities to take part in sport.

They came together and developed sports activities for young people utilising the skills of parents and other young people. They use equipment to hold impromptu coaching sessions in football, basketball, cricket, boxing and martial arts in Canterbury Road Rec. The aim is to develop localised bespoke sessions that are accessible to all. This initiative is currently working with over 40 young people.

TIPS FOR PARENTS:

- Research shows that children who achieve a healthy weight tend to be fitter, healthier, better able to learn, and are more self-confident. They are also less likely to have low self-esteem and be bullied. **Listen to your child's concern about their weight, they need to feel supported and loved**. Five key ways to help your child achieve a healthy weight are:
  - Be a good role model
  - Encourage 60 minutes of physical activity a day
  - Keep to child-size portions
  - Eat healthy meals, drinks and snacks
  - Less screen time and more sleep
- **Younger children may have a harder time identifying and challenging negative thoughts**. They can however benefit from coming up with some coping statements they can say to themselves to help them cope in social situations. For example, "I can try calm breathing to feel better" or "I just need to try my best".
- **Children need to understand that all of us have unique differences that make us individuals**. We are all far more alike than we are different, and these differences should not be feared or ridiculed.

TIPS FOR WORKING AGE ADULTS:

- **Nurture your support network** – do not underestimate the importance of what you have to offer.
- **Expand your social network** – online social sites are ideal places to meet people who share similar interests and hobbies.
- **Recognize the importance of being alone and enjoying solitude** – being alone is not the same as being lonely. Enjoy peace, quiet, freedom, space and the opportunity to connect with your deeper self.
- **Just show up** – you will be surprised at how much you enjoy something you initially dreaded doing.
- **Have a sense of purpose or take up a hobby** – many hobbies and interests are inherently social in nature. Anything that involves a group, for example, playing backgammon or card games, could be said to be socially healthy.
- **Open yourself up, take risks, and allow yourself to be vulnerable** – sharing aspects of yourself, including experiences, feelings, memories, dreams, desires, etc. will help you feel more known and understood.
- **Adopt a pet** – the playfulness of pets, plus the troubles (and fun) you will experience while training them will make you forget about your troubles.
- **Encourage a positive body image** – individuals with a poor body image may decrease or cease interactions with their social networks to the point where they could be at risk for social isolation. Compliments and positive comments can go a long way to boosting the self-esteem of others.
- **Volunteering** is also a great way of maintaining and expressing a sense of purpose and staying connected with your community.
- **Get out and about** – don't wait for people to come and see you – travel to visit them.
- **Grab every chance to smile at others or begin a conversation** – for instance, with the cashier at the shop or the person next to you in the GP waiting room. If you are shy or not sure what to say, try asking people about themselves.
- **Plan the week ahead and put things in your diary to look forward to each day**, such as a walk in the park, going to a local coffee shop, library, sports centre, cinema or museum.
- **Maintain contact with family and friends over the phone, social media or video conferencing applications**. They can be the next best thing to physically being with them.

TIPS FOR OLDER ADULTS:

- **Share a meal with others whenever possible**.
- Undiagnosed or untreated hearing problems may lead to avoidance of social situations because of difficulty communicating or embarrassment. **Have your hearing checked and hearing problems treated as needed**.
- **Have regular eye checks** so that you can read generally and captions more easily.
- **Try and get out as much as possible** – go shopping/window shopping, on bus rides, swimming, for walks in the park and to museums whenever you can.
- **Be open to learning how to use technology to maintain connections**. A computer with a camera is a bridge to anyone in the family.
- **Consider taking up a hobby** like tending a garden or caring for an older animal.

FINAL THOUGHTS

There is so much we can do as individuals and as a community to address loneliness and social isolation. It's not always grand gestures that are required; a smile, a meal shared or asking or offering help can make a real difference.

Croydon has made a commitment to address social isolation; it is currently an objective within the Health and Wellbeing Board strategy and the Council will continue to form strategic partnerships with health, social care and voluntary sector organizations to ensure that actions and activities positively impact the external conditions of residents to reduce the burden of social isolation and loneliness across Croydon and in all people who live and work here.

So it's over to us...

ACKNOWLEDGEMENTS

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APPENDICES

APPENDIX A – GREATER LONDON AUTHORITY (GLA) REPORT ON "PROPENSITY FOR SOCIAL EXCLUSION OF OLDER PEOPLE IN LONDON"

The report looks into the various drivers of social exclusion amongst older people (although many of these indicators are equally relevant amongst all age groups) and attempts to identify areas in London where susceptibility is particularly high.

Six key drivers have been included with twelve indicators used in an attempt to measure these.

The majority of these indicators are at Lower Super Output Area (LSOA) level in an effort to identify areas at as small a geography as possible.

Key Driver	Indicator	Description
Economic Situation	Income deprivation	Income Deprivation Affecting Older People Score from the 2015 Indices of Deprivation
Transport Accessibility	• Public Transport	• Average Public Transport Accessibility Score
	• Car access	• Percentage aged 65 and over with no cars or vans in household
Household Ties	• One person households	• Percentage aged 65+ living alone
	• Providing unpaid care	• Percentage aged 65+ providing 50 or more hours of unpaid care a week
Neighbourhood Ties	• Proficiency in English	• Percent aged 65+ who cannot speak English well
	• Churn Rate	• Churn Rate: (inflow+outflow) per 100 population
Health	• Mental health	• Estimated prevalence of dementia amongst population aged 65 and over (%)
	• General health	• Percentage aged 65+ with a limiting long-term health problem or disability
Safety	• Fear of crime	• Percentage in borough worried about anti-social behaviour in area
		• Percentage in borough who feel unsafe walking alone after dark
	• Crime rates	• Total offences per 100 population

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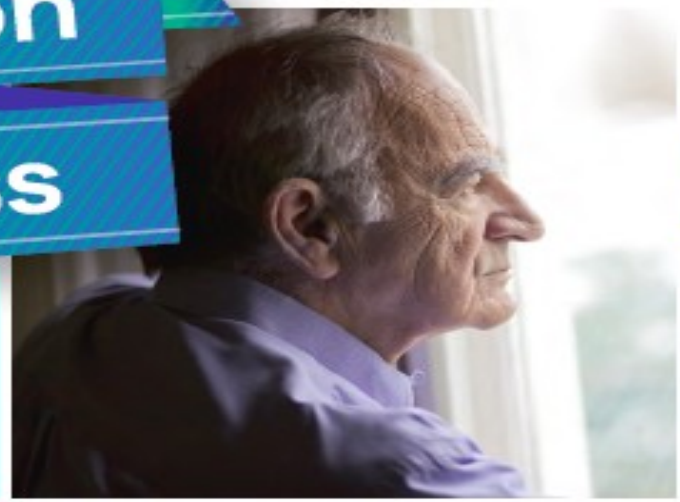
Social Isolation and Loneliness



Annual report of the director of public health 2016

Just BE CROYDON

Croydon Heart Town

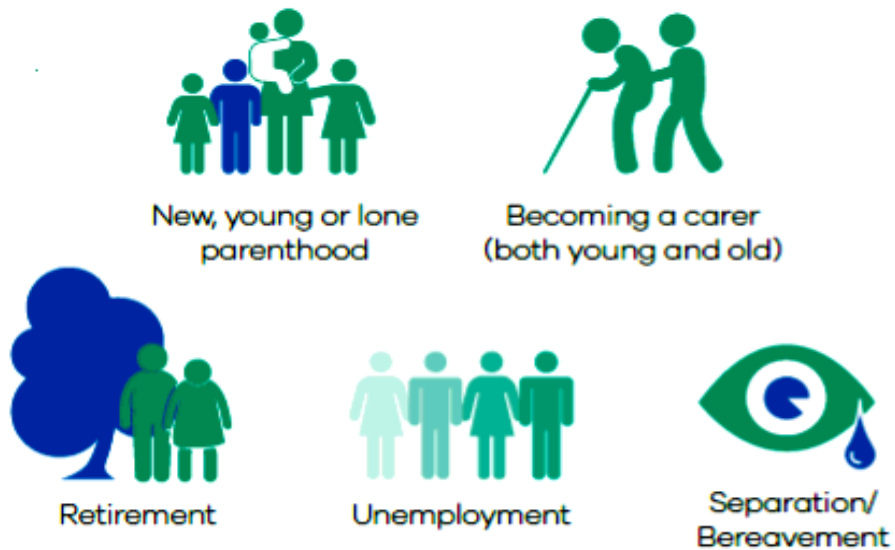
Who is at risk?

Risk factors for loneliness and social isolation can be categorised into four distinct areas:

Personal factors

Sexuality | Ethnicity | Age

Life changes



New, young or lone parenthood | Becoming a carer (both young and old) | Retirement | Unemployment | Separation/ Bereavement

Health, wellbeing and disability

Cognitive or sensory Impairment | Substance misuse problems | Physical or mental impairment or disability

Wider or social determinants of health

Domestic abuse and violence | Long term unemployed | Recent migration | Poverty and deprivation | Homelessness | Stigma and discrimination

Together Taking Responsibility…

General Tips:

- **Maintain frequent contact.** If someone you know has hit a milestone birthday, lost a spouse or other important person, or is ill or immobile, they need more contact so make a note to call or visit often
- Socially isolated older people may be vulnerable to a variety of unexpected problems and may have underlying issues such as dementia. **Loved ones should consider informing trusted neighbours that there is a vulnerable adult in the neighbourhood so they can keep a friendly eye out and check in on them regularly**
- If you know **a carer, or a loved one in your family shoulders the burden of caring for an elderly family member, take whatever steps you can to make that person's life easier** and to allow enable them to have a social life of their own
- **Everyone has a role to play in making an effort to recognise and understand caring, ageing and disability better** so they can recognise and support people in their communities who might need it

Together Taking Responsibility…

Tips for Carers:

- If you are a carer, **remember to take care of yourself**. It is not just the person you are caring for who is at risk of social isolation, it is you
- **Try asking for a small amount of help from family or friends** – help with shopping or sitting with the person you look after for a short time to allow you to pop out. Telling them what a difference it has made might result in them offering to help out again
- **Focusing on the positives in your situation can help you feel that you have a deeper relationship and understanding of the person you care for**, and appreciate that they may feel this way about you too
- **It is important to be realistic about what you can do**. Having a clear idea about what you can do, and accepting parts the things that you cannot change or do alone, helps to reduce stress and can make you feel more able to cope

Together Taking Responsibility…

Tips for Children and Young People:

- **Find something you like doing and do more of it.** Sometimes it's hard to find the motivation, especially if you don't feel confident or you worry about what other people think. Making small goals can help you to feel more positive about yourself. You don't have to be perfect at it to enjoy yourself
- **Be careful when comparing yourself to others and remember that things are not always what they seem from the outside.** Social media, and the fact that we very often only see what other people want to share about their lives, can make you feel like you are the only one feeling lonely
- **Focus on your positives.** You may think that you are not good at something and this may stop you for from doing things you enjoy or trying new things.
- **Try to celebrate your successes** – no matter how small they may seem to you.
- **Accept compliments** - keep a note of them and look at them when you feel low.

Together Taking Responsibility…

Tips for Older Adults:

- **Share a meal with others whenever possible**
- **Have your hearing checked and hearing problems treated as needed.** Undiagnosed or untreated hearing problems may lead to avoidance of social situations because of difficulty communicating or embarrassment.
- **Have regular eye checks** so that you can read generally and captions more easily
- **Try and get out as much as possible** - go shopping/window shopping, on bus rides, swimming, for walks in the park and to museums whenever you can
- **Be open to learning how to use technology to maintain connections.** A computer with a camera is a bridge to anyone in the family
- **Consider taking up a hobby** like tending a garden or caring for an older animal

Final Thoughts…

There is so much we can all do as individuals and as a community to address loneliness and social isolation, it's not always grand gestures that are required; a smile, a meal shared, asking or offering help can make a real difference.

So it's over to us …

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For general release

REPORT TO:	**HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE 17 JANUARY 2017**
AGENDA ITEM:	
SUBJECT:	**HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE WORK PROGRAMME 2016/17**
LEAD OFFICER:	**Actin Borough Solicitor and Acting Monitoring Officer,**

ORIGIN OF ITEM:	The Scrutiny Work Programme is scheduled for consideration at every ordinary meeting of this Committee.
BRIEF FOR THE COMMITTEE:	To consider any additions, amendments or changes to the agreed work programme for the Committee in 2016/17.

1. EXECUTIVE SUMMARY

1.1 This agenda item details the Committee's proposed work programme for the remainder of the 2016/17 municipal year.

1.2 The Sub Committee has the opportunity to discuss any amendments or additions that it wishes to make to the work programme.

2. WORK PROGRAMME

2.1 The work programme is attached at **Appendix 1.**

3. RECOMMENDATIONS

3.1 Agree any changes or amendments to the Work Programme.

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BACKGROUND DOCUMENTS: None.

APPENDIX 1

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE FOR 2016/17 WORK PROGRAMME

19 July 2016	Confirmation of the Chair and Vice Chairman Committee Membership, Chairing and Terms of Reference	Healthwatch Croydon nomination	Croydon Clinical Commissioning Group Summary of priorities	**Regular Items** (Initial) HSC Scrutiny Sub-Committee work programme 2016/17 SWL JHOSC and Subs update SEL JHOSC HealthWatch Croydon	
27 September 2016	Croydon CCG and Croydon Health Services Trust Special Measures	**Regular Items** HSC Scrutiny Sub-Committee work programme 2016/17 SWL JHOSC and Subs update SEL JHOSC Healthwatch Croydon			
18 October 2016	Croydon Health Services NHS Trust Financial Savings Plan	Croydon CCG Financial Savings Plan	Decommissioning Foxley Lane Women's Unit Engagement Plan	CCG Update on Urgent Care	**Regular Items** HSC Scrutiny Sub-Committee work programme 2016/17 HealthWatch Croydon SWL JHOSC and SEL JHOSC

8 November 2016	Adult Safeguarding Annual Report – to include the outcome of the CQC inspection of Croydon Care Homes based homes	CCG Outcome Based Commissioning for the over 65s	Mental Health (CCG Provision commissioning and Monitoring)	Better Care Fund	**Regular Items** HSC Sub-Committee work programme 2016/17 SWL JHOSC and Subs update SEL JHOSC Healthwatch Croydon
8 December 2016	South West London's Sustainability and Transformation Plan	CCG Financial Recovery Plan	CHS Financial Recovery Plan		**Regular Items** HSC Sub-Committee work programme 2016/17 SWL JHOSC and Subs update SEL JHOSC Healthwatch Croydon
17 January 2017	Cabinet Member for Families, Health and Social Care, Cllr Louisa Woodley ---------- Outcome Based Commissioning for Over 65s – The Croydon Alliance	CCG Progress Report on the Primary Care Variation Reduction Strategy	Transforming Services for people with Learning Disabilities	Annual Report Public Health 2016	**Regular Items** HSC Scrutiny Sub-Committee work programme 2016/17 SWL JHOSC SEL JHOSC PAN London JHOSC Healthwatch Croydon

21 March 2017	Adult Safeguarding 6month review/update	The work of SLaM including an update on substance misuse	The Work of the Health and Wellbeing Board	**Regular Items** HSC Scrutiny Sub-Committee work programme 2016/17 SWL JHOSC and Subs update SEL JHOSC Healthwatch Croydon
16 May 2017	Quality Accounts Croydon Health Services NHS Trust		Quality Accounts South London and Maudsley NHS Foundation Trust	SWL JHOSC and Subs update SEL JHOSC Healthwatch Croydon Review of the Scrutiny Sub-Committee work programme and Topics for 2017/18

Additional Items scheduled last year 2015/16
Review of services provided by Croydon Health Services NHS Trust
Childrens Mental Health Services
Committee work programme suggestions for 2016/17
Men's Health
Allied Health Professional
Outcome Based Commissioning

Council meets on
23 May (Annual Council), 18July, 17 October, 5 December, 30 January 2017, 27 February (Council Tax), 18 April (Scrutiny Annual Report)
Cabinet meets on
20 June, 11 July, 19 September, 24 October, 14 November, 12 December, 23 January, 20 February (Council Tax), 20 March, 2 May 2017