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.

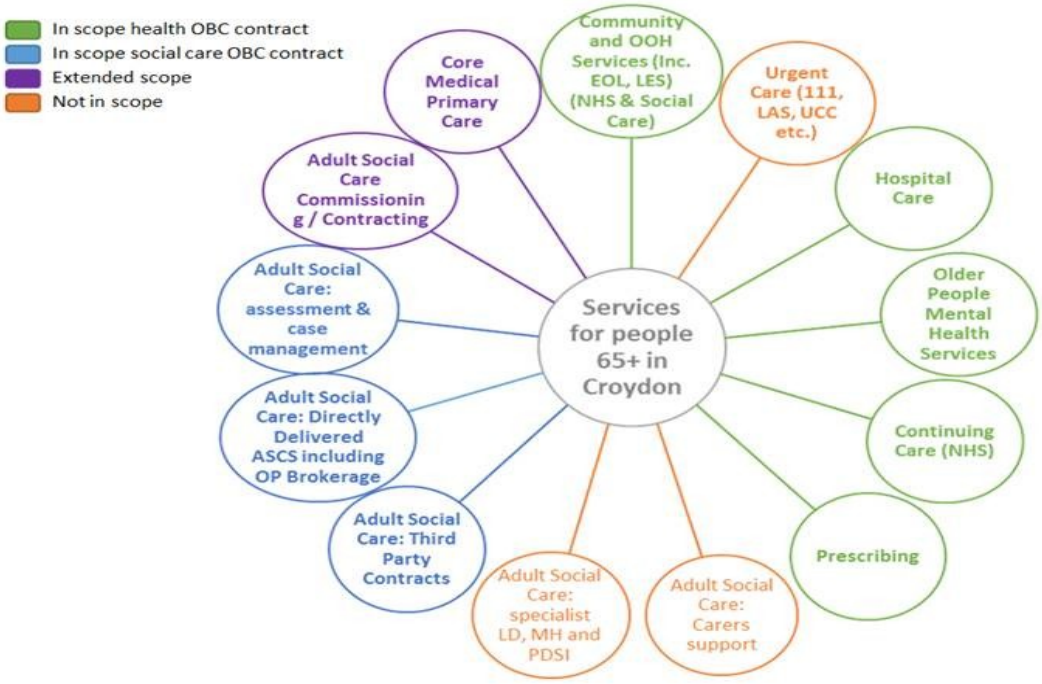
- Staying healthy and active for as long as possible
- Having access to the best quality care available in order to live as I choose and as independent a life as possible
- Being helped by a health and social care team that has had the training and has the specialist knowledge to understand how my health 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. <u>THE SCOPE OF OBC</u>

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.

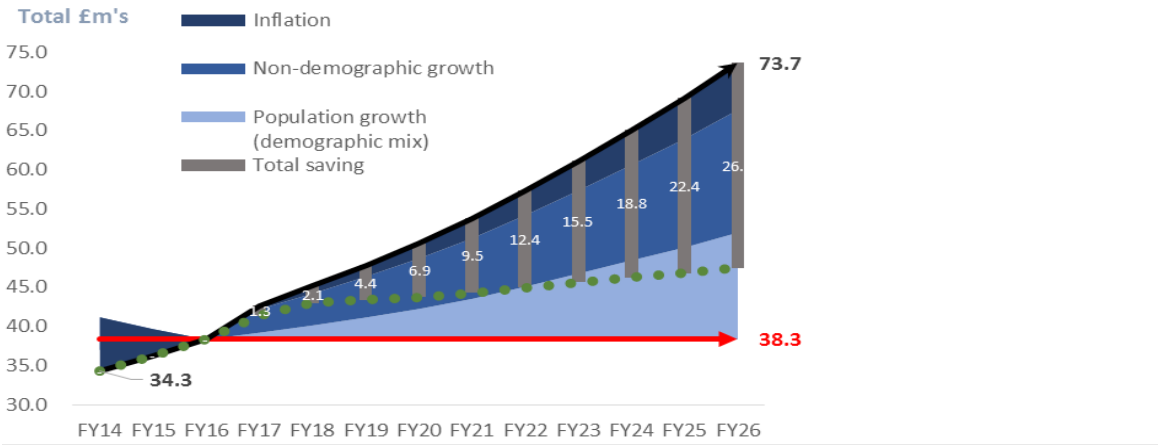
5.10 Contracting

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

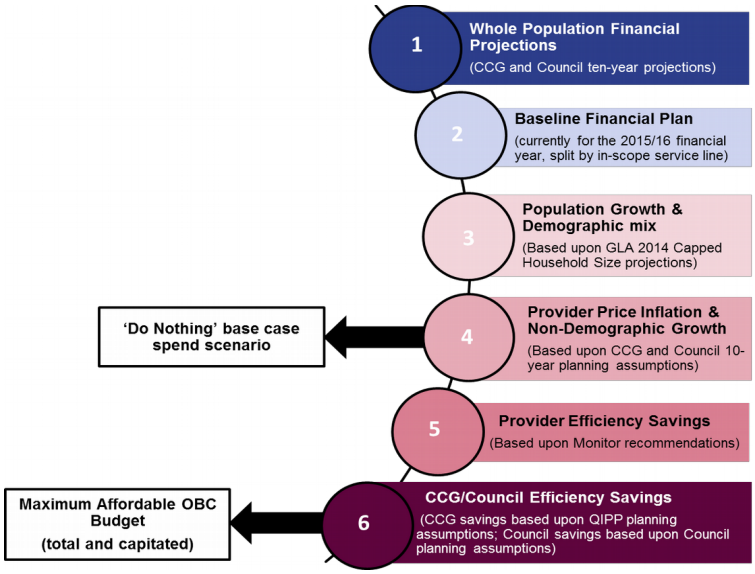


Indicative: subject to change upon finalisation of 2017/18 financial baseline and any revisions to demographic and financial assumptions or contract scope.

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

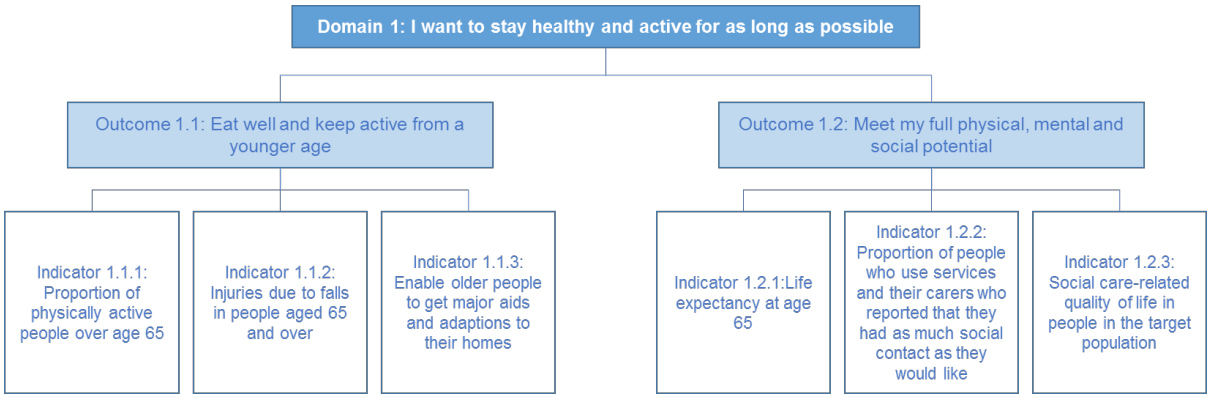
7.1 Outcomes Based Commissioning focuses on measuring and rewarding outcomes rather than inputs. Measuring outcomes and aligning incentives will enable the Commissioners to monitor performance across the whole health and care economy and, when combined with appropriate contractual and payment mechanisms, 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.

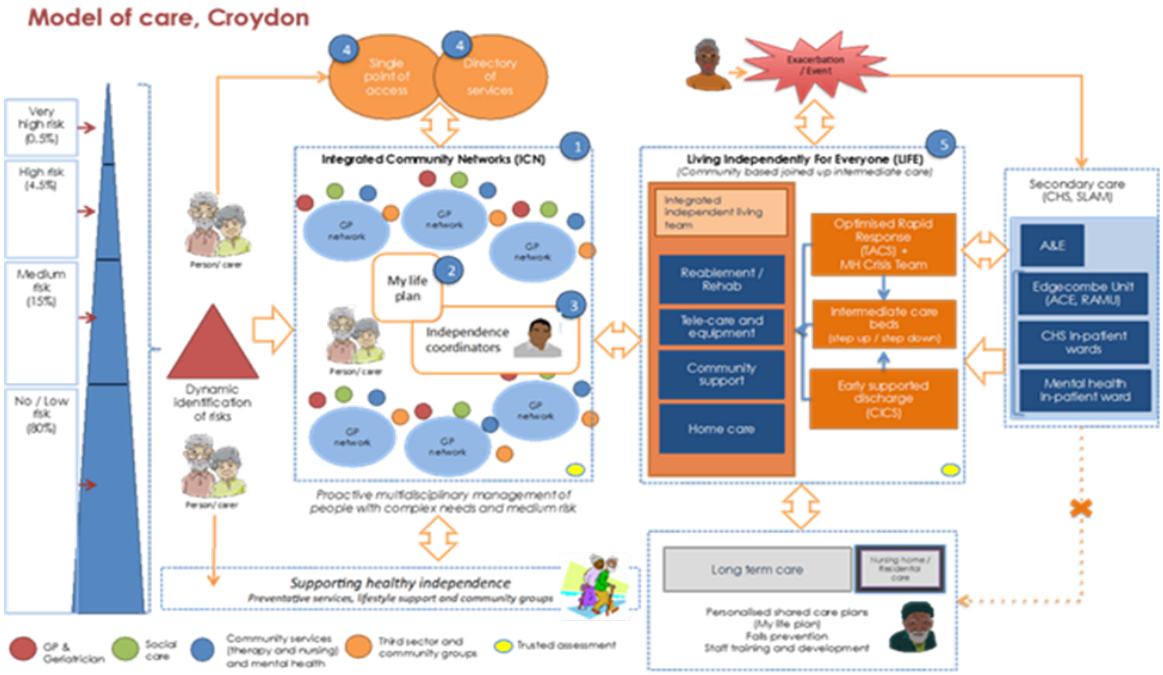
8.3 The Model of Care

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.

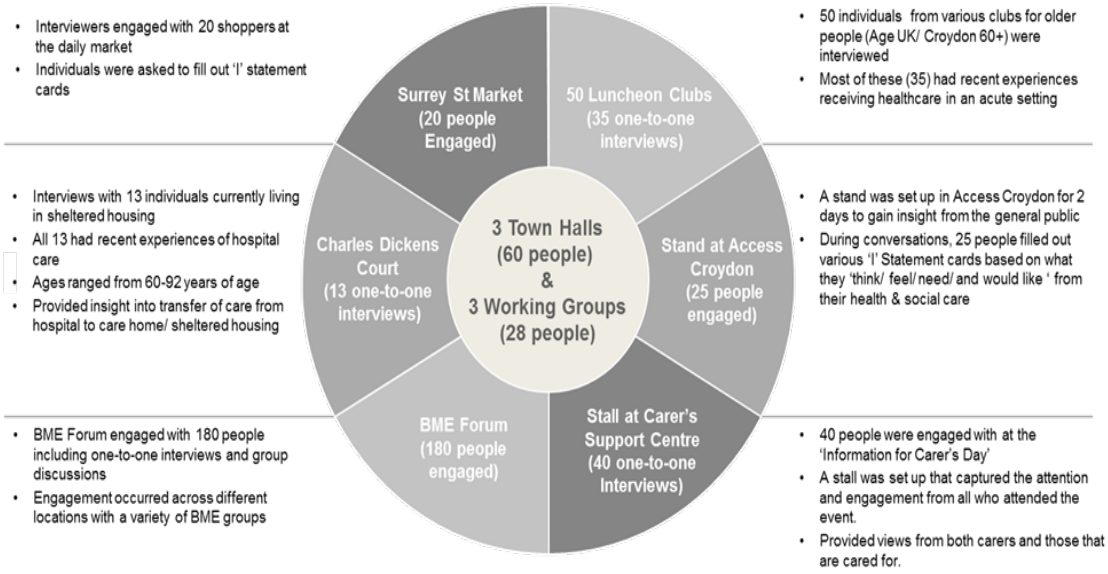
8.9.3 A two phased approach to care will be put in place. The first phase is to stabilise the person and the second to assess the need for longer term care. Voluntary groups will be integrated to support with areas such as transport and hospital to home support. Finally, a review of new telehealth and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