REPORT TO:	**Adult Social Services Review Panel** **9 February 2016**
AGENDA ITEM:	**6**
SUBJECT:	**The Better Care Fund (BCF) Plan 2015-17**
LEAD OFFICER:	**Brenda Scanlan, Director, Integrated Commissioning Unit**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Families, health and Social Care**
WARDS	**All**

BRIEF FOR THE PANEL:	**To review developments and outcomes**

CORPORATE PRIORITY/POLICY CONTEXT:

Croydon Council (the Council) and Croydon Clinical Commissioning Group (the CCG) are required to produce and implement a joint plan for the delivery of an integrated approach in transforming health and social care services to be delivered in the community (the BCF Plan) using pooled funds (the BCF) transferred from the CCG's revenue allocation and the Council's capital allocation. The joint plan gained approval from NHS England (NHSE) in January 2015

This report acts as an up-date to the Adult Social Services Review Panel on key issues and performance on the implementation of the plan and key metrics. The Panel previously received an update on BCF at their meeting on 11th November 2015.

FINANCIAL IMPACT:

n/a

FORWARD PLAN KEY DECISION REFERENCE NO: This is not a key decision

1. RECOMMENDATIONS

This report recommends that the :

1.1 Note progress made in implementing the Better Care Plan
1.2 To note the mitigations on performance identified in Section 5.2

2. EXECUTIVE SUMMARY

2.1 The Better Care Fund (BCF) is a national initiative which 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 and by doing so reduce demand on acute services.

2.2 A previous report on the Croydon BCF Plan 2014-16 was presented to the HSCH Scrutiny Committee on 9th December 2014.

2.3 Croydon BCF budget for 2015/16 is £24.14m, with the majority of this being pre-existing funding re-badged as BCF The funds are managed via a s75 pooled budget arrangement, hosted by the CCG.

2.4 The BCF plan comprises a wide range of schemes across health and social care which are delivering against 6 key metrics. Though there are individual scheme successes, mitigation actions are ongoing to bring delivery on track to achieve the metric targets.

2.5 Planning for 2016/17 BCF is underway, informed by a recent peer review. The 2016/17 plan is to be presented to Croydon Health & Wellbeing Board for approval during April 2016.

3. THE BCF PROGRAMME

3.1 BCF is a national initiative which 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 and by doing so reduce demand on acute services.

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

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

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

3.5 BCF delivery is via a range of health and social care schemes which are summarized in the following table. Most of these were already in place before BCF.

3.6 Croydon's BCF plan should be considered in the context of its Outcomes Based Commissioning (OBC) programme for over-65s service provision which will be an integrated programme covering spend totaling approximately £199m per annum across health and social care. The table of BCF schemes indicates whether the scheme is likely to be wholly or mostly covered by OBC.

3.6 Summary table of BCF schemes

Ref	Scheme name	Lead commissioner	Amount £000	In scope of OBC (all or mostly)	Description
1	Intermediate Care Beds	CCG	480	Yes	12 intermediate care beds located in a local nursing home, with community geriatrician and therapy input. Can be used as step up (admission avoidance) or step down (rehabilitation after discharge).
2	Step Down & Convalescence Beds	Council	500	Yes	There are a range of step down and convalescence beds for service users who do not need to be in hospital, but who are not yet ready to return home.
3	Transforming Adult Community Services (TACS)	CCG	2,406	Yes	A programme that has successfully supported the delivery of integrated care in Croydon over the past year, with patients being seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.
4	TACS – Nursing Homes	CCG	200	Yes	Workplan that co-ordinates services supporting Nursing and Care Homes improving on current patient care plans.
5	TACS – GP Roving Service	CCG	200	Yes	Roving GP for patients urgently at risk of being admitted to acute hospital. Immediate access to a GP medical opinion will allow the patient to remain at home or be placed into a community bed.
6	TACS – Social Work Input	Council	450	Yes	Social workers assigned to each of the 6 GP clusters in Croydon who attend the Multi-disciplinary team (MDT) meetings held at GP surgeries to consider 5-8 patients per month where early intervention can make a difference regarding hospital admission. The social workers carry out the resulting assessments of care

					needs.
7	Mental Health – Older Adults	CCG	500	Yes	A range of mental health services for older adults including dementia advisers.
8	Diabetes – Bromley CIC	CCG	1,000	Yes (scope partitioned)	The community based Diabetes service provided by Bromley has been in place since April 2014. The aim is to provide a community service and support GPs to manage their patients better in primary care reducing the number of patients being managed in the acute setting. The service also aims to improve the outcomes for diabetic patients through educational support so that their condition is better managed and they do not become unstable and present at the acute trust.
9	End of Life – St Christophers	CCG	351	Yes	St Christopher's co-ordinate and train on the 'Gold Standard Framework' and 'Steps to Success' programmes. These support Nursing and residential homes in producing good practice for end of life care and treating patients in their own homes rather than within a hospital setting. The funding also covers training for GPs plus improved coordination of the patients care through the usage of 'co-ordinate my care' which is a virtual record of the patients care plan.
10	End of Life – social care	Council	350	Yes	This covers respite care for people in the last 12 months of life. The service is commissioned from St. Christopher's hospice.
11	Integrated Stroke Service	CCG	64	Yes (scope partitioned)	Family and carer support service for those who have suffered a stroke.
12	Falls & Bone Health	CCG	245	Yes	Building on the existing falls service to provide: robust falls pathway; preventative services including fracture liaison; home response one stop shop approach.
13	St Christopher's Hospice – Palliative Care	CCG	1,354	Yes	Provision of hospice and end of life beds for patients in need thus reducing the impact of hospital

					admissions for end of life care.
14	Crossroads – Palliative Care	CCG	121	Yes	Provision of respite care in the patient's own home during the day to allow for carers to have a break from continual care.
15	Care UK – Amberley Lodge	CCG	600	Yes	Provide in-patient care for patients with mental health conditions and/or continuing health care conditions which would otherwise need an acute hospital bed. This ensures more appropriate care and quality of service provision.
16	Basket Local Enhanced Service (LES)	CCG	455	Yes (scope partitioned)	Delivery within Primary Care additional services (such as complex leg ulcer dressing, shared care pathways with the acute hospital) that ensure care for patients with long-term conditions and reduce potential attendances and admissions at A&E.
17	Chronic Obstructive Pulmonary Disease (COPD) Community Service	CCG	510	Yes (scope partitioned)	Delivery of a whole system redesign of the COPD service including: increase the number of spirometry measurements; adopt evidence based clinical pathways; increase provision of pulmonary rehabilitation.
18	Diabetes LES	CCG	96	Yes (scope partitioned)	Increase diabetes care for patients within Primary Care that ensures the stabilization of treatment and care in the community reducing non-elective admissions and attendances at A&E.
19	Practice delivery and development Scheme (PDDS)	CCG	1,990	Yes (scope partitioned)	Practice Delivery and Development scheme offering peer review to GPS on e.g. prescribing, non-elective admissions. This follows national best practice in improving the care for patients at risk of non-elective admissions in primary care.
20	Age UK – Falls & Bone Health	CCG	10	Yes	Handyman service to remove trip hazards from service users' homes.
21	Mental Health – Liaison Psychiatry	CCG	1,557	No	Ensuring rapid access to Psychiatric assessment for those patients attending A&E thereby reducing

					admissions and the in-pact on the acute hospital
22	Mental Health – Reablement	Council	200	No	Pilot of a mental health reablement service offering interventions that aim to restore life skills and build resilience in meeting non-medical issues such as accommodation, income, service navigation, social inclusion and symptom management.
23	Mental Health – Packages of Care	Council	300	No	Packages of care for mental health, split between Adult Mental Health and older persons packages of care (including mental health needs).
24	A&E Triage	Council	175	No	The A&E triage team comprise 3 care managers who work a rota across a 7 day week. They facilitate discharge from A&E (instead of admission to hospital) by arranging short term packages of care, sign-posting to other services, or arranging transfer to reablement/step down and convalescence beds.
25	Hospital Discharge	Council	175	Yes	The hospital discharge team has approx 15 people, and the BCF funding covers a sub-set of these posts. The team carry out assessments and arrange packages of care for people who are ready to be discharged from hospital.
26	Improving access to physical therapies (IAPT) – Long Term Conditions Pilot	Council	175	No	This is a contribution to a larger IAPT scheme. It has been used to increase capacity and signpost access for people with long term conditions.
27	Early Intervention & Reablement	Council	1,013	Yes	This covers care for the first 6 weeks on discharge from hospital, with the intention of reabling rather than continuing as a long term care need.
28	Prevent return to acute / care home	Council	475	Yes	The BCF funding is a contribution to the budget for ongoing packages of care to allow service users to remain in their own homes.
29	Extended Staying Put	Council	120	No	This covers household tasks which are not

					adaptations, for example blitz cleans, help with hoarding issues, short term (up to 6 weeks) shopping and cleaning service, help with moving home.
30	Care Support Team nurses	Council	125	Yes	The aim of this work is to strengthen the support/preventative measures provided to care and nursing residential homes and nursing homes. Targeting those who are the highest users of acute services.
31	Alcohol Diversion	Council	60	No	This covers a nurse at the Palmer House facility working with service users and staff to reduce emergency call outs to the facility.
32	Medicines Optimisation – Community	CCG	100	Yes (scope partitioned)	Medicines use review services, with aim of reducing A&E attendances and non-elective admissions.
33	Specialist Equipment eg Telehealth / Telecare	Council	185	Yes	This covers aspects of staff, licenses and equipment relating to telehealth/care.
34	Data sharing	Council	45	No	The purpose of this work is to provide a near real-time performance dashboard of information across social care and health.
35	Demographic pressures – packages of care	Council	2,023	Yes	This is a contribution to overall funding to packages of care, recognizing demographic pressures which lead to increased demand for care services.
36	Disabled Facilities Grant	Council	1,110	No	This covers grants for major adaptations to individual's homes, enabling them to stay at home rather than be admitted to a care home or hospital. Examples include: stair lifts, level-access showers, hoists, door widening.
37	Adult Social Care Capital Grant	Council	780	No	This grant was formerly known as the social care access and systems grant and has been included in the BCF for the first time this year. This grant is used for maintaining the systems that social care uses as its main service user record, assessment tool,

					payment mechanism etc. It also funds development work on systems including integration work with NHS systems.
38	Care Act implementation	Council	845	Yes	Implementation of new statutory duties to the Council arising from the Care Act.

4. FINANCE – figures as at end Nov 2015

The BCF is governed by a section 75 arrangement. A breakdown of the pooled funds is highlighted below:

Current Funding Source	BCF Pooled Budget Lead Organisation	Allocation 2015/16 £m
Disabled Facilities Grant	LBC	1.110
Adult Social Care Capital Grants	LBC	0.780
NHS transfer (S.256) – Investment in Social Care for Health Outcomes	NHS	6.423
Transfer of additional NHS funding – currently committed in CCG budgets (including historical funding for Carers and Reablement).	NHS	15.075
Total		**23.388**

In addition to these recurrent funds, £0.8million arising from slippage on the former reablement funds has also been brought into the pooled fund. The majority of the funding has been re-allocated from existing NHS/Council sources and is not new funding.

The BCF plan included £2.9m of uncommitted recurrent funds out of the total BCF pooled budget. The current proposals against these funds are outlined below and allocations will be confirmed at the BCF Executive Group meeting on 27th Jan 2016.

	Proposed Utilisation of Recurrent Uncommitted funds £000s
Total of committed funds (as per previous table)	20,493
Uncommitted Recurrent Funds (per plan)	2,895
TACS - Nursing Homes	200
TACS - GP Roving Service	200
TACS - ACE +	500
Social Care Pressures	1,239
FYE of Social Care Schemes from 13/14	452
Uncommitted (recurrent)	**304**

Added Reablement Funds (Non Recurrent)	754
Total Uncommitted	**1,058**

It should be noted that the uncommitted recurrent funds incorporates the performance fund of up to £980K which has not achieved to date (refer to para 11).

5. GOVERNANCE

5.1 In line with the BCF initiative, the CCG and the Council have created a local single pooled budget to incentivise both parties to work more closely together around the provision of health and care services.

5.2 The BCF is governed by a section 75 arrangement whereby it has been agreed the CCG will host the pooled budget arrangements. Quarterly reporting on the financial performance has been agreed under these arrangements.

5.3 In January 2015 full approval was received for the Better Care Plan

5.4 The BCF Executive Group acts as the principle body to ensure the Better Care Fund meets its objectives. The Group's primary purpose is to:

> *"Monitor the delivery, performance and effectiveness of the Croydon Better Care Fund Plan to ensure that it meets national conditions and metrics, and remains aligned with the strategic plans for health and social care integration in Croydon"*

5.5 The members of the BCF Executive Group are accountable to their organisations through their respective governance arrangement, either:

- Croydon Council Cabinet
- Croydon CCG Governing Body

5.6 In line with national conditions for BCF, the Group Reports to the Croydon Health and Wellbeing Board who provide multi-agency oversight of the BCF plan. The Health and Wellbeing Board are responsible for approval of the BCF plan and quarterly performance returns.

6. PERFORMANCE SUMMARY

6.1 Performance Overview

NHSE require quarterly returns on progress including performance against 6 indicators which are intended to give an all-round picture of success in integrated care provision. Five of the indicators are mandated nationally, and the sixth is a locally chosen indicator.

The 6 indicators for Croydon's BCF are:

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

The payment for performance element of funding is linked to non-elective admissions.

In summary, Croydon's BCF performance is on an upward trajectory towards its ambitious performance targets, but performance is not yet meeting the required targets in all areas. A range of mitigating actions is in hand to bring performance to the required level.

In addition to performance against the BCF indicators (see following table), Croydon's BCF plan has enabled positive service delivery to accomplish:

- TACS – The transforming adult community services programme has successfully supported the delivery of integrated care in Croydon over the past year, with patients being cared for outside of a hospital environment. This includes a dedicated social work team and has enabled people to be seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.
- ASC reablement service – primarily a "step-down" facility of 6 reablement beds and 2 reablement flats. 82% of service users have reduced or no further care needs.
- IAPT (Improving access to psychological therapies) – improved access and capacity to support people with long-term conditions, enabling further delivery against Croydon's IAPT access target.
- Pilot of a mental health reablement service offering interventions that aim to restore life skills and build resilience in meeting non-medical issues such as accommodation, income, service navigation, social inclusion and symptom management. Of those who completed the programme, 90% were discharged to their GP.

5.2 Performance summary by indicator

The table below sets out the performance against the BCF metrics for the reporting period up to 31st December 2015.

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF1 	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	33,550	34,464 M8 YTD	R	To mitigate this performance the BCF Exec have put in place a set of service enhancements which collectively have started to demonstrate impact to reduce non-elective admissions from Nov/Dec 2015. ▪ Development of a Rapid Assessment Medical Unit (RAMU) to reduce admissions through clearer assessment of 'at risk' patients referred by A&E, Urgent Care Centre, GPs and London Ambulance Service (in place from late 2015) ▪ Enhancement, (from late 2015) of the Roving GP service for patients urgently at risk of being admitted to acute hospital. Immediate access to a GP medical opinion will allow the patient to remain at home or be place into a community bed (Step Up Beds). • Extension of rapid response service with nursing and specialist therapy support to care and nursing homes – in place from Sept 2015
BCF2	Permanent admissions of older	285.0	271.7	G	Current performance is better than target. However,

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
	people (aged 65 and over) to residential and nursing care homes, per 100,000 population	(end Dec 15)	(end Dec 15)		provisions data is often retrospectively uploaded, and there have been significant retrospective changes since the last report. Therefore it is likely that outturns could understate the true number of admissions being made.
BCF3 	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88%	88.1% (Jan-Oct 15)	**G**	Performance is fluctuating slightly around the target level but this appears to be due to random variations rather than any underlying issue for mitigation, and Croydon are on track to meet the target over the year.
BCF4 	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	145.7 (Oct 15)	157.2 (Oct 15)	**R**	The high volume of delays being seen for 2015-16 in part are attributable to a high number of delays from the mental health commissioned service provider. Mitigation actions in place include: • Weekly meeting in the Trust to review any barriers to discharge. • Closer scrutiny of recording to ensure DTOCs correctly captured. • Greater direct liaison between the Trust and Council Housing Needs team to arrange temporary emergency accommodation. • Transfer of the mental health supporting people facility to more suitable accommodation in Dec 2015, thereby ending a temporary reduction in capacity in the lead up to transfer. Planning for greater use of the “look ahead” contract to support service users in their own homes.
BCF5	Local Performance Metric:	20%	17.9%	**R**	The indicator is under-performing and remained

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
	'% of discharges over the weekend for Croydon Healthcare Service'.		M8 YTD		consistent over the last 3 months. Behind target predominantly due to a reduction in elective discharges over the weekend which has outweighed the increase in non-elective discharges. Mitigation plan in place with action on perfect wards, golden patients and ward rounds. Whilst it is essential that discharges over the weekend are increased to provide capacity to manage patient flow and patient time to treatment, the specific target of 20% is proving difficult to deliver because of (i) the reduced number of admissions as patients treated by the rapid assessment medical unit and not classified as admissions and (ii) increasingly where ever possible patients are discharged ahead of the weekend.
BCF6 	Patient/Service User Experience Metric Social Care related quality of life (ASCOF 1A)	19	18.4 (Mar 15)	**R**	This measure is an average quality of life score based on responses to the Adult Social Care Survey covering control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. The survey is run annually and next results will be available in June 2016. The survey is based on a sample (sent to approx. 28%) of service users that received services in the financial year, across all adult (18+) age groups.

Key:

Rating	Thresholds	Trend	Meaning
G	Improvement on baseline and target met		Performance from the last two data points indicates a positive direction of travel
A	Improvement on baseline yet below target		Performance from the last two data points indicates no change
R	Deterioration on baseline		Performance from the last two data points indicates a negative direction of travel

7. PEER REVIEW

To increase learning and to improve performance the CCG and Local Authority have engaged in the Local Authority BCF Peer Review process. The Peer Review took place between the 4th and 6th November 2015 and focussed on 4 Key Themes:

1. Lead and manage better care implementation
2. Bring budgets together and use them to develop co-ordinated care provision
3. Work together across healthcare and beyond
4. Understand and measure impact

The reviewers, from London ADASS and three London Boroughs, met with managers and staff working in front line service delivery roles, from both the Council and the CCG. They found much to praise including the very positive participation by all those involved in the review, and highlighted the multi-disciplinary teams of GPs, social workers and others as an excellent scheme.

Suggested actions for further improvement included:

- Review the comprehensive set of BCF schemes and refocus on those delivering greatest impact.
- Consider a greater level of preventative activity
- Review governance to ensure joined up at all levels

Findings from the review will feed into BCF planning for 2016-17.

8. BCF Planning for 2016/17

8.1 The Comprehensive Spending Review (25 November 2015), confirmed that the Better Care Fund will continue into 2016-17 – with a mandated minimum of £3.9 billion (nationally) to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

8.2 The BCF 2016-17 policy framework was published on Fri 8th Jan and can be found here: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

8.3 Though it provides some useful information, as of 18th January 2016, we still do not have the template for plan submissions or the definitive funding allocations, despite the previously published date of 8th February for submission of first draft plans.

8.4 Key points from the document are:

- Mandated minimum funding has increased from £3.8 to £3.9 billion
- New money via local authorities starts in 2017-18
- The requirement for a pay for performance element of funding linked to non-elective admissions has been removed. More surprisingly, the metric relating to non-elective admissions has also been removed, potentially leading to a significant shift in emphasis for BCF delivery.

- There is a new requirement to fund NHS-commissioned out-of-hospital services. This is introduced as a new national condition.
- There is a new requirement to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The existing DTOC BCF metric remains in place, and the requirement for a local action plan is introduced as a new national condition.
- By 2017, plans are to be in place for health & social care integration for 2020 and beyond.
- "Brief narrative plans" to be submitted via "short high level template" and a "reduced amount of finance and activity information".
- Assurance of plans is to be carried out on a regional rather than national level.

8.5 The timescales for submitting Better Care Fund local plans will follow the deadlines set out in the NHS Planning Guidance:

1. First draft – 8 February 2016
2. Refresh – mid-March 2016
3. Final submission (signed off by Health and Wellbeing Boards) - mid-to-late April 2016.

8.6 As at 20/01/2016, the detailed requirements for submissions and exact timings for the March and April resubmissions had not been published. In the absence of these, work will progress as much as is practical, but as a result of the ongoing absence of requirements, submission of a meaningful first draft by 8th February becomes increasingly at risk. This is an issue for all local authority areas, not only Croydon.

8.7 In acknowledgement of the tight timescales involved, it is expected that the first draft submission of Better Care Fund local plans on 8 February will be high-level, focused around the finances and core principles, while providing sufficient detail to support Councils' budget setting processes. The detailed requirements for submissions and the exact timings for the March and April resubmissions will be confirmed in the guidance.

8.8 A review of all current BCF schemes is underway to inform investment /disinvestment decisions.

8.9 Croydon's Outcomes Based Commissioning Contract for over 65s will come into effect during 2016/17 and many of the current BCF schemes will be managed via OBC. Appropriate alignment and co-ordination between BCF and OBC will be considered during plan development.

9. CONSULTATION

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

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

- Have held a public discussion and feedback event in Fairfield Halls 24th June with 50 people attending
- Attended and gained feedback from the CCG's PPI Reference Group 25th June
- Attended and distributed leaflets at Croydon's Ambition Festival 25th July
- Met with community leaders/ groups including PPG Groups, Cultural Groups, Carer Groups, Lunch Clubs and Community Panels, Day Centres, and the general public
- Public event, held on 19th October at Fairfield Halls
- OBC survey designed and online (both websites): closed 16th October (56 responses as at 12th October)
- https://www.surveymonkey.com/r/Croydon_Survey
- Continuing to update web pages to show what engagement has taken place and how it's informed the development of the future model:
- http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx
- https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning
- Creation of the OBC Service User Engagement Specialist group that will inform the OBC Programme Board:

10. SERVICE INTEGRATION

10.1 Croydon Council, Croydon CCG, and Croydon Health Services have a history of close partnership working since 2011, and have worked together on a number of joint initiatives through the Council's Reablement and Discharge Programme and the CCG's Strategic Transformation Programme to jointly deliver innovative community-based patient/client-focused services. The BCF provides the momentum to continue this development, enable on-going joint service innovation, and facilitate the cultural change that will ensure that integration is sustained and continues to deliver the best outcomes for patients.

11. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

The level of non-elective admissions is in excess of the planned levels. The BCF guidance indicates that in this situation the performance fund contribution (up to £980k) to the pool should not be released, unless the parties explicitly agree otherwise.

As part of the final deliberations at the next BCF Executive Meeting, the commitment to investments will be balanced against the forecast performance of non-elective admissions. It is well understood that investment is necessary to

positively deal with performance and that use of the performance fund to invest in services may be preferable to withholding it.

The forecast outturn for 2015/16 currently shows the worst case scenario where all the funds are committed and the performance fund is withheld. The BCF Executive decisions will need to mitigate this worst case scenario

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BACKGROUND DOCUMENTS n/a