Item 7

Croydon Outcomes Based Commissioning Alliance for over 65s

CROYDON www.croydon.gov.uk | NHS Croydon Clinical Commissioning Group | Croydon Health Services NHS Trust | South London and Maudsley NHS Foundation Trust | Croydon GP Collaborative | Croydon age UK

6 Partners working together to deliver New Models of Care

Adult Social Services Review Panel – 13th July 2017

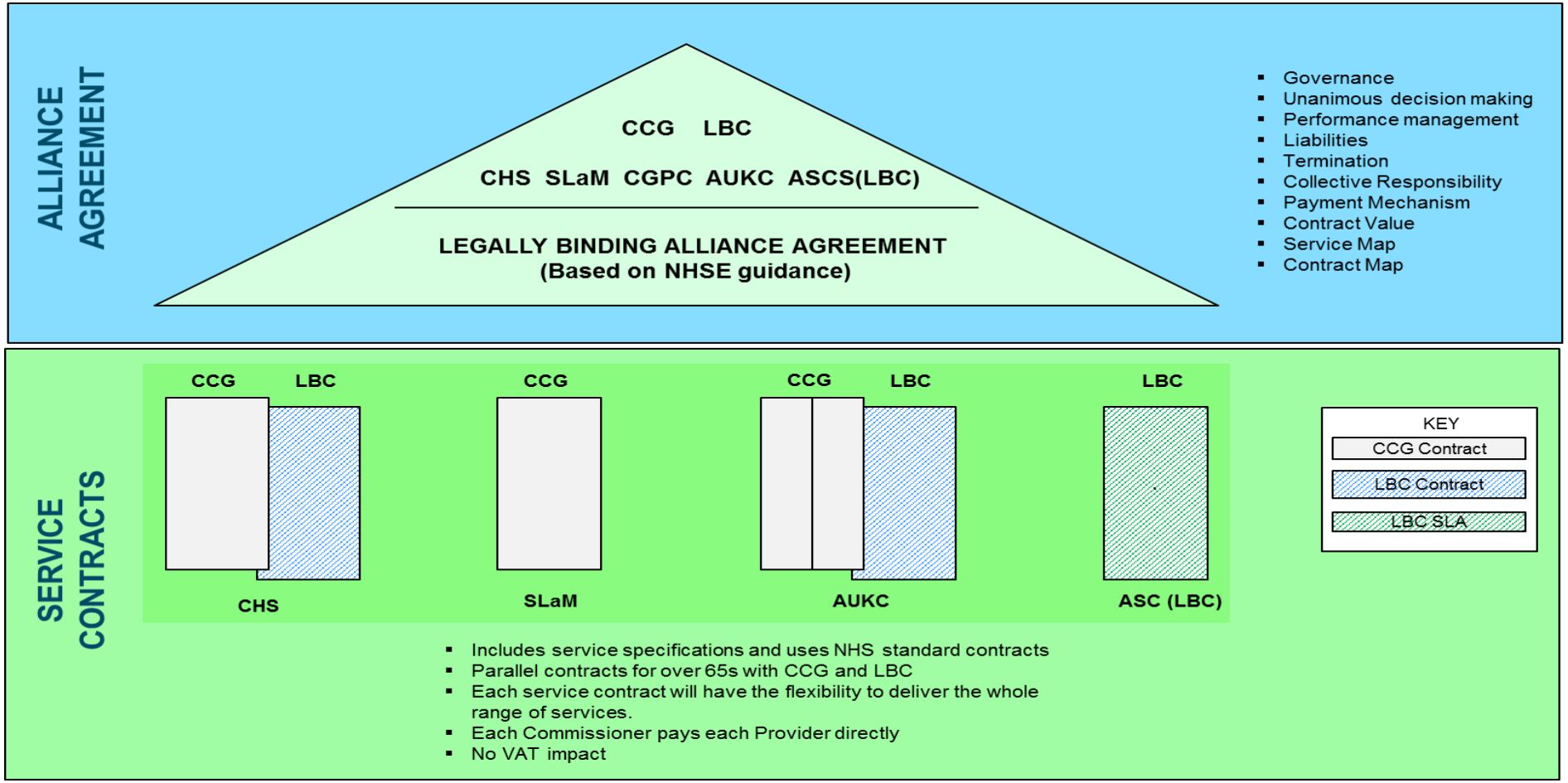
Our vision:

For people in Croydon to experience well co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence

Croydon Outcomes Based Commissioning (OBC) for over 65s:

Health and social care providers and commissioners in Croydon have come together to form the Croydon OBC Alliance to agree a contract for Outcome Based Commissioning (OBC) for over 65s. This Alliance provides a whole system transformation that will deliver the outcomes our over 65s have specified they want in Croydon:

OBC Commercial Structure



There is a 10 year (1+9) Alliance Agreement and associated in scope Service Contracts. We are currently in year 1 (Transition Year). The decision to extend to years 2-10 is planned to be taken by all partners in December 2017.

Service Contracts in scope

The contracting structure for year one is an Alliance Agreement with the following Services Contracts:

Parties	Service(S)	Value
Croydon Council and Croydon Health Services	Occupational Therapy, Hospital Discharge Support and Intermediate Care	£1,661,000
Croydon Council and Age UK Croydon	Information & Advice, Hospital Discharge Support, Healthwise	£539,300
Croydon Council Service Level Agreement: Commissioner -Provider	Adult Social Care Directly Delivered Services, Externally Commissioned Contracts that will be managed by the Council	£42,431,650 (£12m – internal) (£30m – external)
Croydon CCG – Croydon Health Services	Acute and Community Health Services	£140,000,000
Croydon CCG – Age UK Croydon	Personal Independence Coordinators (PICs)	£170,000
Croydon CCG – South London and Maudsley MHT	OP Mental Health Services	£20,000,000

Model of care, Croydon

Very high risk (0.5%)

High risk (4.5%)

Medium risk (15%)

No / Low risk (80%)

4 Points of access and information

4 Directory of services

Person/carer

Dynamic identification of risks

Person/carer

Person/carer

1 Integrated Community Networks (ICN)

GP network

GP network

GP network

GP network

GP network

GP network

2 My life plan

3 Independence coordinators

Proactive multidisciplinary management of people with complex needs and medium risk

Supporting healthy independence

Preventative services, lifestyle support and community groups

Exacerbation /event

5 Living Independently For Everyone (LIFE)

(Community based joined up intermediate care)

Integrated independent living team

Reablement / Rehab

Tele-care and equipment

Community support

Home care

Optimised Rapid Response (TACS) + MH Crisis Team

Intermediate care beds (step up / step down)

Early supported discharge (CICS)

Secondary care (CHS, SLAM)

A&E

Edgecombe Unit (ACE, RAMU)

CHS In-patient wards

Mental health In-patient ward

Long term care

Nursing home / Residential care

Personalised shared care plans
(My life plan)
Falls prevention
Staff training and development

GP & Geriatrician

Social care

Community services (therapy and nursing) and mental health

Third sector and community groups

Trusted assessment

Integrated Community Networks (ICN) Programme

Establishment of 6 Integrated Community Networks (ICNs) building on current 6 GP network model serving 52-90k population range.

Projects include:

1. Core ICN Team Multi-Agency Working, including “Huddles”
2. Complex Care Support Team
3. My Life Plan _ Shared care record
4. Personal Independence Coordinators (PICs)
5. Points of Access and Information (PoA&I)
6. Galvanising Community Networks

Integrated Community Networks (ICN)

- One dedicated core ICN team surrounding each practice; breakdown of barriers;
- Not just an MDT meeting - key worker and care coordinator role;
- Weekly or fortnightly huddles;
- Additional resources across participating network(s);
- Direct access to complex care support team;
- IT and virtual networking tools; and
- Enhanced network services – point of access and practice community.

Integrated Community Network Programme

Integrated Community Network

1 — Multi-Agency Working (MAW) and Huddles

1. Huddles held weekly for 30 minutes
2. Consist of Core ICN Team – GP, PIC, SCW, Community Nurse, pharmacist, VCS, & Network Facilitator.
3. Discusses, and case manages top 3 tiers of people in the Kaiser Triangle; v. complex, complex and medium risks

2 — Complex Care Support Team (CCST)

1. Provides advice to Huddles on management of care and where appropriate receive referrals .
2. CCST MDTs
3. Includes Community Geriatrician, Community psychiatric nurse, and specialist community nurses and Therapy staff.

3 — Personal Independence Coordinators (PICs)

1. A member of the core ICN team, bringing together the voluntary and community sector and health and care organisations to support people over 65.
2. Independent of social services and the NHS, and not part of the person's family.
3. Works intensively with people with long term conditions,

Key Dependencies

Points Of Access and Information (POA&I) – a virtual or physical POA&I solution will be developed to support each Network and be accessible to the Huddle, Core ICN Team and the general public to support self care and independence.

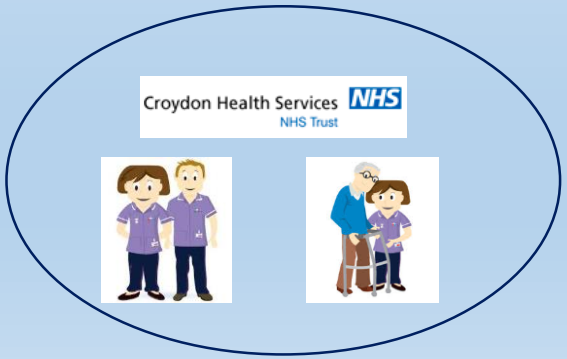
My Life Plan (MLP) – including Shared Care Plans will be developed to support advanced care planning and improved transfer of care. These will be received and generated by Huddle members to support multi agency work.

Galvanising the Community – strengthening the formal and informal social networks in each locality to work together with the wider community to find new ways of developing services and/or activities that meet the growing and changing needs of a diverse population within each of the ICNs. This includes commissioned and non commissioned services.

Multi-disciplinary Intermediate Care Service (LIFE team)

Present

- Fragmented approach by both Croydon Council and Croydon Health Services (CHS)
- Some people qualify for a CICs service and others are referred to a reablement service which is provided from one of the nine reablement home care providers, or other providers not currently on the reablement framework.



Living Independently For Everyone

Living Independently For Everyone – a name that came from a member of the CICS team. The project will review the current reablement and rehabilitation referral pathways.

LIFE will provide integrated step-up and step-down reablement to reduce the need for hospital admissions, improved and speedier hospital discharges and reduced need for Care Homes placements.

Future

- The creation of a new team made up of the existing teams should stop duplication, increase capacity, enable the sharing of resources and prevent/ reduce admissions to acute care.
- An optimum service model needs to be staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, and reablement workers.

'As Is':

- Limited referral pathways;
- High hospital admissions (non-elective);
- High use of bed days;
- Delayed discharge;
- Multiple assessment and referral points (case studies suggest up to **20**)
- Large domiciliary care packages which are not always reviewed (overall cost of £13m approx.)

- 'One Name, One Budget, One Team': A team providing intermediate care and reablement services plus other reintegration support to the over 65s of Croydon;

- One core eligibility criteria: to 'unblock' pathways and minimise assessments and referrals;

- All services working to the same key outcomes;

- **Making sure the correct services are being used most efficiently**
- **- Creating more opportunities for client outreach**

Multiple points of entry (examples below)

From Hospital

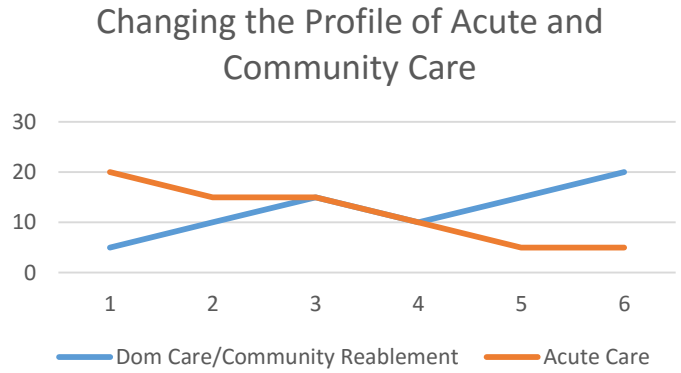
Through the Point of Access & information

From the GP

From the Community

'To Be':

- Decrease in non-elective hospital admissions;
- Decrease in bed days;
- Increase in smaller domiciliary care packages; (increase in larger) and community reablement
- Increase in wider community interventions;
- A cultural change around the need for domiciliary care;
- A sustainable single system;
- Increased range of entry pathways;
- Unblocking of community and environmental barriers



Best case saving of 15,00 bed days (approx.) and 44 beds by year 10*

*Figures from MoC overarching document

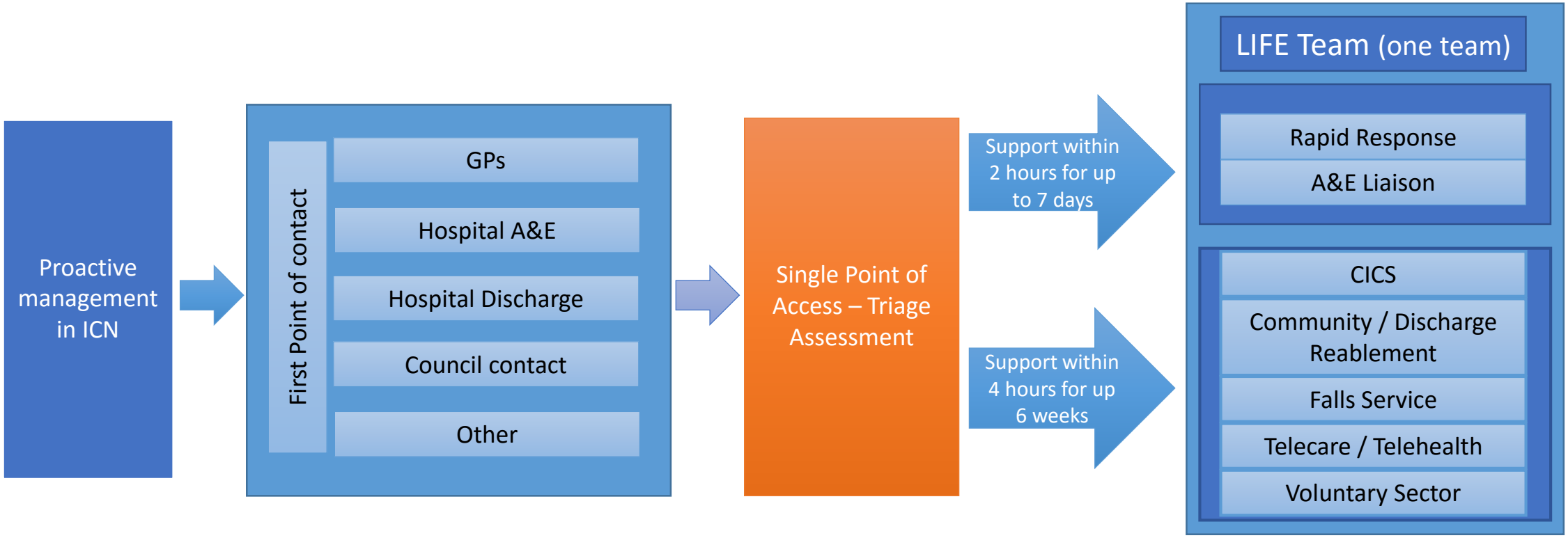
Services in scope

- Community-based Reablement (not currently provided)
- Reablement following hospital discharge
- Rapid Response
- Community Integrated Care Service
- A&E Liaison Team
- Age UK reablement service
- Falls services

- Occupational Therapy provision including the provision of equipment
- Care Line Plus
- Telecare
- Telehealth
- Step up/ Step down beds

Services in red will come together as a service in the first phases

Proposed Intermediate Care and Reablement Pathway



LIFE Implementation Programme

Phase 1

Create Community Reablement Team (1st June 2017)

Improve the Reablement offer

Procure one private reablement provider to be relocated with the Reablement Team

Outputs

- Open to Community Discharge

Phase 2

STEP 1 (Sept 2017)
Integrate CICs and Reablement Team
30% of clients discharged 3 day earlier

STEP 2 (Dec 2017)
Integrate A&E Liaison and Rapid Response with the CICs and Reablement Team
Large increase of clients accessing service to prevent hospital

STEP 3 (Dec 2017)
Review the OT and Falls Services, and Red Cross and Age UK Croydon reablement

Outputs

- Increase 20% case load
- Discharge to assess team to see assess and see client at home 2 hours from discharge

Phase 3

Telecare / Telehealth

Outputs

- Implementation of the CCG Telehealth / Telecare proposals

Challenges & Opportunities

- **Workforce**
  - Recruitment and retention
  - Training and development
  - Skill Mix
  - Governance
- **Culture and Behaviour**
  - Historical relationships
  - Matrix Working
- **IM&T & Record Sharing**
  - Connectivity
  - Consent
  - Information Governance
- **Engagement and working with the community**
  - Shift to Asset Based approach
  - Community and voluntary services as providers
- **Estates**
  - Colocation ?
  - Mobile working

Programme Structure/Governance

To support the delivery of the OBC Year 1 Transition