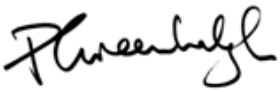
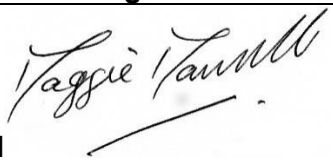
Croydon Better Care Fund Plan 2016-17

1 Authorisation and sign off

Signed on behalf of	Croydon Clinical Commissioning Group
By	 Mrs Paula Swann
Position	Chief Officer
Date	15th June 2016

Signed on behalf of	Croydon Council
By	 Mr Paul Greenhalgh
Position	Executive Director - People
Date	15th June 2016

Signed on behalf of	Croydon Health & Wellbeing Board
By	 Cllr Maggie Mansell
Position	Chair of Health and Wellbeing Board
Date	15th June 2016

2 Introduction

2.1 About this document

This document sets out the essentials of Croydon's Better Care Fund (BCF) plan for 2016/17.

This year no plan template was defined by NHSE, but the document headings and content are structured in line with the NHSE assurance key lines of enquiry headings

The content of this plan is focussed on new requirements for 2016/17 and incremental change since Dec 2014. As such, extensive references are made to previous (Dec 2014) BCF plan and other supporting documents, but content from these other documents is not reproduced here.

2.2 Croydon BCF context

Croydon have a very real commitment to integration of health and social care. However, Croydon's BCF plan must be considered in the wider context of integrated service delivery: Croydon's Outcomes Based Commissioning (OBC) programme for over-65s service

provision will be an integrated programme covering spend of approximately £212m per annum across health and social care, compared with approximately £24m invested via BCF.

Croydon's very significant and demonstrable commitment to integrated care via OBC supports our aspiration to "graduate" from BCF at the earliest opportunity.

2.3 Key references

Key documents referred to in this plan are:

a) Croydon Better Care Fund Planning Template Part 1 signed 12 Dec 2014 http://www.croydonccg.nhs.uk/get-involved/Documents/Croydon%20BCF%20Template%20(Part%20One)%20NEW%20FINAL VERSION.pdf

b) Outcomes based commissioning for over 65s – Update Report, report to Croydon Health & wellbeing Board 10th Feb 2016 https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=WEL&meet=18&href=/akscroydon/images/att7014.pdf

3 The local vision for health and social care services

3.1 Our vision

Our vision for health and social care services is set out in the Dec 2014 BCF plan (P7-16) and has not changed.

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.

The overarching principles continue to be development of integrated care services that:

- help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates;
- help to keep people with one or multiple long term conditions and complex needs stable;
- allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate;
- support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
- provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence
- support and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant
- help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

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.

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.

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 totalling approximately £212m per annum across health and social care.

OBC and BCF are foundations for integrated care in Croydon's future Sustainability & Transformation Plan, which will further extend the work already done in creating the 5 year strategy and CCG operating plan.

3.2 Outcomes based commissioning (OBC)

Croydon Clinical Commissioning Group (CCG) and Croydon Council have worked collaboratively to develop a transformation programme which will enable improvements to be achieved through a whole systems approach to health and social care.

The vision for Croydon is that people experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence into later life. With an ageing population, the focus of the programme is on services for the over 65s and the outcomes that local residents have said are important to them – those factors that make a genuine difference to their health, well-being and quality of life.

The proposal has been developed to deliver Croydon CCG's vision of "longer, healthier lives for all the people in Croydon" and meets the key national overarching aims – 'Everyone Counts: Planning for Patients 2014/15 to 2018/19. NHS England' and supports the Council's key strategic priorities with regard to promoting and sustaining independence, well-being and good health outcomes for Croydon residents.

Additionally, the programme aligns with the aims of the Better Care Fund which are that health and social care services must work together to meet individual needs, to improve outcomes for the public, provide better value of money and be more sustainable. The programme builds on a long history of joint work in Croydon, including recent developments in delivering whole person integrated care through the Transforming Adult Community Services work.

Age UK Croydon, Croydon Council Adult Social Care, Croydon GP Collaborative Ltd, Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust agreed to form an Accountable Provider Alliance (APA) in June 2015 to be able to meet the decision by NHS Croydon Clinical Commissioning Group (CCG) and Croydon Council to transform the way services for people over 65 are commissioned.

The APA aims to deliver a model of care that is people centred, with an overall vision of 'Working together to help you live the life you want'. The APA has therefore defined a model of care that is focussed on staying healthy and independent to ensure people are at the centre of their care, enabling them to achieve the outcomes that are important to them. This will include in year 1 (2016/17) delivery of 5 key initiatives:

- Development of Multidisciplinary Community Networks;
- Development of 'My Life' plan;
- Establishment of Personal Independence Coordinators
- Single Point of Access and Information
- Integrated Independent Living Service

By joining forces, the APA believe they (a) are best placed to deliver community based healthcare services in people's homes and in the communities where they are comfortable and (b) will be able to provide a more holistic, well-rounded and bespoke health and social care service to our people.

For further detail on OBC, refer to the report "Outcomes based commissioning for over-65s – update report" to Croydon Health and Wellbeing Board 10th February 2016.
https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=WEL&meet=18&href=/akscroydon/images/att7014.pdf

4 Evidence base supporting the case for change

4.1 Summary Case for change

The Dec 2014 BCF plan highlights (p 17-44) the case for change with a summary given below.

Health and social care challenges in Croydon:
Croydon is one of the most populated Boroughs in London with a highly mobile, ethnically and socially diverse population. The borough has an aging population, but it also has an increasing population of younger people with disabilities and as a result has over 29,000 people providing informal care to relatives and friends.

The number of people living with one or more long term conditions is set to increase significantly over the next 20 years, in line with this ageing population.

Key health and social care challenges arising from the changing demographic in Croydon have been highlighted as:

1. Increasing elderly population living for longer with one or more long term conditions;
2. Areas of deprivation in the borough with consequential impact on health;
3. Increasing numbers of younger people with disabilities requiring health and social care;
4. Increasing demand on mental health services
5. Increasing demand taking place at a time of financial challenge for health and social care

Integrated working is therefore a necessity if health and social care is to meet the challenge of enabling people to manage their own health and social care needs at a time of increasing demand and decreasing resources.

Our Population: Long Term Conditions
It is expected that many more people will be living with long-term health conditions such as diabetes, heart disease, respiratory problems, asthma and epilepsy in the future. Three out

of every five people aged over 60 suffer from a long term condition and as the population ages; this number is likely to rise. People with long term health conditions are the most intensive users of health services. They only make up around 31% of the population, but account for some 52% of G.P. appointments and 65% of planned hospital appointments.

Ambulatory Care Sensitive (ACS) conditions (long-term health conditions) can often be managed with timely and effective treatment in the community without hospitalisation. The King's Fund briefing in 2012, outlined the impact that tackling ACS conditions can have on emergency admissions (Kings Fund (April 2012), Emergency hospital admissions for ambulatory care- sensitive conditions Identifying the potential for reductions). The report detailed rates of emergency admission for people across the country with ambulatory care sensitive conditions and suggested that these admission rates vary from between 9 to 22 admissions per 1000 resident population

Our planned BCF changes have been planned to improve services and benefits in most of the Kings Fund priority areas through:

- Improved self-management by providing individuals the support they need to stay at home
- Improved primary and secondary prevention through better co-ordination of care for people with long term conditions through MDTs and access to a single point of assessment
- Better management for people with ambulatory care sensitive conditions with rapid response services available
- Increased integration and care co-ordination through both the single point of assessment and MDT meetings
- Reducing emergency activity by better management of care and directing patients to the best available services

4.2 New schemes in 2015/16

The Dec 2014 BCF plan refers (p23) to priority schemes to be delivered via BCF including some new schemes:

- Review of A&E Front of House
- Create a Roving GP Service
- Improving the Clinical Support and Competencies of Care Homes

These schemes have now been implemented. Progress and initial impact is described below.

4.2.1 Review of A&E Front of House

Over 2015/16 the CCG has worked closely with Croydon Health Services (CHS) to implement the proposed changes to support improvements in patient pathways at the Emergency Department (ED) at Croydon University Hospital.

This has included:

- Greater integration between the A&E Liaison and Rapid Response services with the services now operating as one service to support admission avoidance within the

community and at the CUH ED. The integrated service (operating 7days/wk 09:00-17:00 for the ED in-reach, and 24/7 for Rapid Response) enables patients to be assessed within 1hr of referral from the ED, treated if appropriate and to have a jointly developed discharge plan to enable the patient to return to place of residence with or without further intervention and support from appropriate services, including Rapid Response.

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED. The Consultant-led team treat patients that require urgent medical review without the need for a hospital stay, including conditions such as DVT, Cellulitis, Low risk GI bleed, Low risk pneumonia, and Low risk pulmonary embolism.
- Co-location of the RAMU service with the Acute Care of the Elderly service (consultant-led team supporting elderly patients 75 years and over), and the HOT Clinic provided by the Respiratory Team (to provide care for Chronic Obstructive Pulmonary Disease patients who are acutely unwell). This has enabled better integration of care with patients being quickly seen by the most appropriate clinician and a multi-disciplinary team without having to be necessarily admitted to hospital.

4.2.2 Create a Roving GP Service

A Roving GP service has been piloted in Croydon since June 2015, providing a rapid medical response to patients with urgent care needs within 1 hour of referral to avoid unnecessary admissions into hospital. The initial phase of the pilot provided access during Mon-Fri 08:30-17:00, but has subsequently been extended to Mon-Fr 08:30-01:00 and Sat-Sun 13:00-01:00 as part of a wider service delivery model being piloted across the South West London CCGs.

To date (Jun 2015-Jan 2016) the service has seen 249 people and successfully supported 89% of people to be cared for at their place of residence without the need for a hospital attendance or admission. The service is now ramping up to higher volumes of patients per day.

4.2.3 Improving the Clinical Support and Competencies of Care Homes

A number of initiatives have been implemented over 2015/16 to establish the basis for improving the clinical support to nursing care homes, and for improving competencies of care home nursing teams. This has included:

- Additional investment in nursing, and speech and language therapy staffing in the Rapid Response team to work proactively with nursing care homes to support patients, improve care planning in conjunction with the care home nursing staff, and to work collaboratively with the Croydon Council Care Support Team to identify, support and provide appropriate nursing and speech and language therapy training to improve patient care and nursing home standards. This improved capacity began in September 2015 and have been working with the top 5 Nursing Homes with the highest London Ambulance Service conveyances to assess practice and support requirements
- Consultant Geriatrician input into the top 5 care homes with weekly joint ward rounds with the GPs of the care home residents and nursing home staff
- Development of a Purple Guide clinical guidance document for the management of common problems within the care home setting to support all nursing care homes in providing improved care to care home residents

- Undertaking a comprehensive review of services supporting care homes to develop a plan for better co-ordination of care provision, including rationalising GP Practice cover of care homes to improve accessibility and accountability
- A review of non-elective (NEL) emergency admissions for Oct-Dec 2015 vs Oct-Dec 2014 shows a reduction in the number of NEL admissions in 3 of the 5 care homes (15 less). Further work is ongoing with these care homes, and in identifying the next set of homes to support over Q1 2016/17.

4.3 2015/16 scheme review

All Croydon BCF schemes have been briefly reviewed in order to inform planning for 2016/17. Individual scheme performance has been considered, alongside the totality of delivery against BCF objectives.

Key questions considered were:

- Is performance on track?
- Is there evidenced delivery against BCF metrics?
- What is the need for improvement?
- What is the potential to impact on delivery of BCF targets

Each scheme was re-mapped to the relevant 2015-16 BCF national indicators, these being:

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

In addition, schemes were mapped to:

- OBC – whether the scheme is included (fully or partially) in Croydon's outcomes based commissioning for over-65s services.
- Out of Hospital services – whether the scheme can be considered as an Out of Hospital Service (new BCF national condition).

The review findings indicated that each of the current set of BCF schemes was delivering substantially as planned though, as was expected in a culture of continuous improvement, remedial actions and opportunities for further improvement were identified. Priority actions arising from the review have been incorporated into Croydon's BCF work plan for 2016/17.

Regarding the totality of BCF schemes, the review indicated that all BCF metrics were suitably well-served, and that the new national condition for investment in out of hospital services could be comfortably met by the current set of schemes.
The table in section 6.7 of this document summarises some scheme by scheme points from the review. The review has informed priorities for 2016/17 in terms of adjustment to individual schemes and the overall portfolio.

The review also highlighted that approx. 80% of Croydon's BCF spend would become part of Croydon's over-65s OBC programme during 2016/17.

4.4 Emphasis for 2016/17

Our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery as set out in 4.2 and 4.3 above. Based on our review of 2015/16 activity, some adjustment to schemes and funding has taken place to increase investment in:

- GP roving services – extending to weekends and care and nursing homes
- End of life care – sitting service in care homes and at service user's homes
- Enhanced care co-ordination for frail and vulnerable patients – greater support to MDTs and improved sharing of care plans

5 A co-ordinated and integrated plan of action for delivering that change

Much of the plan and governance arrangements set out in the Dec 2014 BCF plan (p 45-56) is still valid. This section sets out only the areas of change.

5.1 Governance structures

From April 2016 Croydon have introduced a Joint Commissioning Board working across Council and CCG. The BCF Executive Group will continue to exercise its functions providing overall accountability for the delivery of the Better Care Fund Plan until Croydon's OBC contract for over-65s comes into effect – currently anticipated as Q3 2016. Then, recognising the large (approx 80%) overlap of BCF with Croydon's OBC for over-65s, there will be a planned transfer of governance functions to the JCB which will have oversight across BCF and OBC.

5.2 Arrangements to support joint working

Croydon's arrangements in place to support joint working are fully embedded in governance and service delivery. They are set out in the Dec 2014 BCF plan (p45056 and elsewhere) but in brief include:

- Health & Wellbeing Board with multi-agency membership
- Transforming Care Board with multi-agency membership
- Joint Commissioning Board – new from April 2016 to strengthen Council and CCG "whole system" approach to commissioning
- Co-location of CCG and Council commissioning teams
- MDTs with health and social care membership
- Embedding of social care staff in health settings e.g. A&E triage, hospital discharge team
- Strengthening of health support to social care settings e.g. nominated GPs for care homes

5.3 Delivery milestones for 2016/17

As indicated in Section 4.4 our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery with continuation of the delivery of those services in 2016/17The following table gives summary milestones for overall management of the BCF plan., and for those services that have been invested in additionally for 2016/17 to further support the delivery of 7 day services and joint care assessments.

Individual schemes also have their own supporting work plans.

Date	**Key milestones**
Apr/May 2016	Plan signed off by Health & Wellbeing Board New schemes for 2016/17 formally initiated. S75 agreement signed.
Jun/Jul 2016	Q1 DTOC priority actions complete. DTOC plan refreshed. Priority 1 remedial/improvement actions (identified in 2015/16 scheme review) completed.
Aug/Sep 2016	Deep dive review completed on out of hospital activity – new national condition. Health check completed on new governance arrangements via OBC.
Oct/Nov 2016	Full review completed across all BCF schemes. First draft integration plan for 2020 and beyond prepared (subject to DoH making plan requirements available in a timely fashion)
Dec/Jan 2017	Bid prepared for "graduation" from BCF
Feb/Mar 2017	Plan approved for transfer of BCF schemes to new governance arrangements on "graduation" from BCF
Date	**Key milestones – BCF 16/17 expanded initiatives to support 7 day services and joint care planning**
Jun 2016	Provision of expanded near patient testing service by GP Roving Service. This will enable better patient management as clinical investigations such as bladder screening, and ECG monitoring can be undertaken within the patient's home with instant access to the results, so that immediate and informed decisions can be made about the patient's care. (Supporting 7 DAY SERVICES)
Jul 2016	Full recruitment and service provision of night sitting service in care homes and service user homes This will support patients and carers in being cared for at home and to reduce unnecessary admissions over the night period (supporting 7 DAY SERVICES)
Jul 2016	Full recruitment and provision of personal independence coordination service to support expanded preventative case management as part of an integrated health, voluntary sector, social care and mental health community network multidisciplinary model of care. (supporting JOINT CARE PLANNING)
Jan 2017	Completed 6 month review of personal independence coordination service (Supporting JOINT CARE PLANNING)
Sep 2016	Full recruitment of additional health visitors for older people to provide proactive case management as part of the integrated health, voluntary sector, social care and mental health community network multidisciplinary model of care. (Supporting JOINT CARE PLANNING)

5.4 Risk log

Key risks from the BCF risk log are shown in the following table:

Ref	There is a risk that..	How likely is the risk to materialise? (L)	Potential Impact (I)	Overall risk factor (LxI)	Mitigating actions
1	Demand pressures for social care services required to support health outcomes in Better Care plan exceeds projections	2	5	10	The council are implementing a comprehensive programme of transformation and demand management. BCF funding continues in 2016/17 at stable levels. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
2	Inadequate resourcing will restrict the ability of Croydon social care to provide the social work staffing resource to support plans under BCF	2	5	10	Realignment of Croydon social work resource has taken place during 2015/16 to meet additional demand, and this will continue through 2016/17 as part of Croydon's social care transformation plans. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
3	CCG 5 year financial improvement plan could be negatively impacted by introduction of BCF.	3	4	12	BCF financial planning taken into account CCG financial position, and BCF allocations have been agreed by joint Council and Social care Executive Group. Detailed and costed CCG Operational Plan – CCG workstreams/services have been planned pre BCF and are **operational**. QIPP programme overseen by CCG Project Management Office and QIPP Operational Board governance structure. CCG have engaged external support (PWC) to support COBIC and the development and infrastructure to deliver QIPP programme. BCF Executive Group will monitor progress throughout 2014/15 and 2015/16 and agree actions to be taken in response to any issues arising and adjust plans in liaison with Health and Wellbeing Board
4	Improvements in integrated care, early intervention and reablement services fail to translate into reductions in demand for acute services and/or social care costs.	3	4	12	Funding will continue via BCF in 2016/17 for reablement and early intervention schemes. The Council's social care transformation programme will further re-emphasise early intervention and reablement.

					BCF Executive Group will monitor progress throughout 2016/17 and agree actions to be taken in response to under performance.
5	Introduction of Care Bill results in significant increase in cost of care provision from 2016 and impact on current planning	2	4	8	Strong assurance from Government that full costs of care Bill will be funded Monies earmarked under BCF as contribution to ongoing delivery of new statutory duties.
6	CHS services are enablers in the success of implementing key BCF initiatives and realising the patient outcomes, and financial efficiencies resulting from integrated working. Their failure to perform could impact on key national BCF metrics	3	4	12	Managed by Transforming Care Implementation Group with escalation to Croydon Contract Management Group and Transforming Care Board as required. Managed via Outcome Based Commissioning contract arrangements.
7	Failure to deliver data sharing between health and social care will undermine ICU and integrated service delivery (G.P MDT's, Single Point of Assessment, and Rapid Response) and the realisation of benefits of integrated working and BCF	4	3	12	Development of health and social care portal through Reablement and Hospital Discharge programme. Engagement with S.W London CSU. Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

5.5 Process for monitoring of scheme delivery and issue resolution

Each BCF scheme has a named delivery lead who is responsible for day to day implementation of the scheme, and for reporting on activity figures and key milestone delivery to the BCF Fund Manager. In the first instance, issues are managed through the usual operational channels for each scheme.

The BCF Fund Manager (CCG) and the Council BCF Lead regularly (currently monthly) review delivery across all schemes, and overall performance against BCF indicators, Where there is apparent under-performance, further enquiries area made, remedial actions initiated and/or issues escalated through the appropriate channels for that scheme.

Additionally in 2015/16 a deep-dive review across all schemes was conducted to review scheme performance and continued alignment with BCF objectives. Remedial and improvement actions arising from this review are allocated to named owners and progress is reviewed regularly with BCF Fund Manager and Council BCF lead. A similar review will be conducted in 2016/17.

The BCF Executive Group will meet quarterly during 2016/17 to provide oversight across the BCF programme. Standing items on the meeting agendas include:

- Performance and spend by scheme
- Performance against BCF indicators
- Key risks and issues

6 Compliance with National Conditions

6.1 Plans to be jointly agreed

NATIONAL CONDITION: *Plans to be jointly agreed.*

This plan has been developed jointly by colleagues across Croydon Council and CCG in close collaboration. The plan was approved firstly by Croydon's BCF Executive Group, with senior officer representation from both organisations including the Chief Officer, Croydon CCG; and Executive Director - People, Croydon Council. Secondly, it was approved by Croydon Health & Wellbeing Board, by means of delegated approval to the Croydon Health & Wellbeing Executive.

The various forums for engagement with providers were comprehensively set out in Croydon's BCF planning template dated 12/12/14 (p 86 onwards) and involved the CCG and Council engaging with the health and social care providers to define and jointly agree the range of service initiatives and expectations on supporting achievement of the out of hospital benefits. Provider engagement has continued in this way throughout 2015/16. Engagement examples are noted at section 6.6. Providers have been key participants in development and agreement of new schemes for 2015/16 and 2016/17 and sign off of individual schemes – whether new or amended – has been through the standard contract management channels.

Implications for providers overall were set out in Croydon's Dec 2014 BCF plan (p88 onwards). Croydon's 2016/17 BCF plan shows a high level of stability from 2015/16, and implications for providers are therefore minimal in terms of any changes from those set out

previously. Since Dec 2014, any changes to schemes have been discussed with providers to ensure that implications for providers are well understood. Implications for providers were highlighted to the Health & Wellbeing Board in April 2016 (which has provider representation) in the paper requesting approval of Croydon's 2016/17 BCF plan.

Future workforce and capacity requirements were comprehensively considered as input to the Dec 2014 BCF plan. For 2016/17, there are minimal changes to the majority of the BCF schemes, keeping stable workforce and capacity requirements. Providers have worked with Council and CCG to develop new schemes for 2015/16 and 2016/17, ensuring that capacity continues to be matched to demand.

Review of workforce and capacity requirements is ongoing alongside all service development, for example the SWL stock take of out of hospital services, and Croydon's OBC development.

As the Disabled Facilities Grant is again allocated through the BCF, the local housing authority within Croydon Council have been fully engaged in planning for the use of DFG monies within the BCF context. Given that, at time of writing, the grant conditions for DFG have not yet been published, DFG plans have not yet been finalised. However, the housing team are putting in place the capacity to ramp up the number of adaptations, and are working closely with commissioners to identify the optimum balance of adaptations and other capital projects to best meet local needs.

Commissioner and providers in Croydon have been working closely together to develop an Outcomes Based Commissioning delivery model, initially (from April 2016) for over-65s' services. OBC forms a core component of Croydon's strategic plans for integrated health and social care delivery. During 2016/17 it is expected, by commissioners and by providers, that the majority of Croydon's BCF delivery will be incorporated into OBC (while maintaining mandated BCF oversight and reporting).

6.2 Maintain provision of social care services

NATIONAL CONDITION: *Maintain provision of social care services.*

Our local definition for "maintain provision of social care services" is unchanged from the Dec 2014 BCF plan. The definition is:

that under BCF, the Council has sufficient resource to help meet current and any future increased demand in social care support in order to continue to manage demands on acute services and enable people to receive care at home.

This definition was originally agreed for the Dec 2014 BCF plan and has been reconfirmed for the 2016/17 BCF plan.

All BCF social care schemes funded in 2015/16 are planned to continue in 2016/17, with funding uplifted for inflation and for demographic growth. Figures for both years are given in the BCF planning return.

Funding for "protection of social care" (social care schemes funded by the CCG minimum contribution to BCF) in 2015/16 was set at £9,323,000 in Croydon's BCF submission dated December 2014. Over the following few months, further work was carried out to define the BCF schemes in more detail, and this resulted in some adjustment to funding allocations across schemes, and a new figure for protection of social care of £8,455,000, as reflected in the section 75 agreement for the BCF pooled budget signed in May 2015.

BCF delivery during 2015/16 saw a strong emphasis on reduction in non-elective admissions, and further in-year adjustments to the BCF plan resulted in increased

investment in schemes to tackle the root causes of non-elective admissions, notably ACE/RAMU, roving GP and so on. There was also a small underspend on some of the BCF social care schemes, resulting in a total 2015/16 spend of £8,304,000 on protection of social care. Taking into account adjustments for demographic and non-demographic growth, the planned BCF spend on protection of social care in 2016/17 is £8,207,000. There is also an amount of £415,000 to be allocated in year, some of which is potentially to be allocated to protection of social care, so that the total spend for 2016/17 is expected to equal or exceed that for 2015/16.

So we have maintained level of funding for protection of social care at broadly the same level as 2015/16. Development of the BCF plan for 2016/17, including proposed funding allocations, has been carried out jointly by partners. Plan and funding allocations have been approved by the Croydon Health & Wellbeing Board.

This approach has been chosen to ensure that any change does not destabilise the local health and social care economy. Management of the pressure on its budgets resulting from the support it gives in enabling timely and safe hospital discharge remains a key on-going issue for social care and the Council are therefore implementing a programme of demand management to mitigate this impact.

Further measures to maintain the provision of social care services include:

- Allocation of £1.1m to social care from BCF specifically to address non-demographic growth (i.e. growth due to inflation, or shifts in activity, rather than growth in population)
- Work towards joint CCG/Council protocols
- Ongoing review of all council-funded schemes

Schemes and figures for both years are given in Croydon's BCF planning return template. As in 2015/16, this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from NHS to social care in 2013-14. It has been agreed by Council and CCG that this approach and the funding allocated provide the same level of protection to social care as in 2015/16.

Croydon's 2016-17 BCF allocation to Care Act duties is £806,000, as per the LGA ready reckoner.

Our assessment of changes to services, and approach to managing interdependencies between Care Act and BCF are set out in our Dec 2014 BCF plan, pages 68-75.

6.2.1 Carer support

A reflection on the effectiveness of services commissioned in 2015-16

In 2015/16 Croydon have commissioned:

- 2 full time assessing & case work officers
- 2 part time assessing & case work officers

They have provided 337 assessments and 158 follow up case work on issues such as housing, benefits, social care, direct payments, employment advice, legal advice

The service offers assessments and follow ups in the carers home in addition to support in the Carers Support Centre on George Street, Croydon. As well as the additional support provided to carers as a result of the assessment, in some instances the carer assessment has identified a need to reassess the cared for person, thus increasing their package of support. This therefore has a positive impact on the carer and the cared for person.

The service is working well and is seeing an increasing number of referrals. The third sector is well placed to provide these assessments and have a long history of providing support to carers in Croydon.

Confirmation of services being commissioned in 2016-17 and how these will impact on the experience of carers.

Service for young adult carers: typically NEETs (not in education, employment or training), this cohort of individuals require peer support, one to one support, support with housing, benefits, CV building, education and employment. Without support this cohort of carers can become reliant on the state and even become patients themselves, due to the impact on their wellbeing (Burstow, 2016). 45% of young adult carers report a negative impact on their mental health (Carers Trust, 2014)

Service for working age adults: typical age of a carer is 45 – 64, this age range is also the age a person reaches their peak earning capacity. When people begin a caring role they are typically in work and continue to work for a number of years, either full or part time. Leaving work can cause financial issues for carers, and negatively impacts the local economy. £5bn nationally is wiped from the economy by carers leaving work to care (Carers Trust, 2012). To help support carers to stay in work for as long as possible, this service would encourage organisations to become 'Carer Friendly', allowing flexible working where suitable, educating management about the valuable role a carer can have in the workforce and provide carers with an early intervention that enables them to get information when they need it, thus reducing the chance of reaching a crisis point (RCGP, 2013).

Evidence-based consideration of how carer support will impact on patient-level outcomes.

Providing support to unpaid carers is the best way to help prevent a care breakdown, which can result in an emergency admission for the cared for person and/or the carer (RCGP, 2013). Moreover, new research indications that for every £1 spend on carers, creates £4 of long-term cost savings for a CCG (RCGP, 2015).

References:

Burstow, Rt Hon P. (2016) *Invisible and in distress: prioritising the mental health of England's young carers.* Carers Trust, London

Carers Trust (2012) *Carers & Employment.* Carers Trust [Online], available from: <https://www.carers.org/help-directory/carers-and-employment> [accessed 11.03.16].

Carers Trust (2014) *Who are young adult carers.* Carers Trust [online], Available from: <https://professionals.carers.org/who-are-young-adult-carers> [accessed 11.03.16].

RCGP (2013) *Supporting Carers in General Practice.* London, Royal College of General Practitioners.

Royal College of General Practitioners (2015) *Cost savings of supporting carers to Clinical Commissioning Groups.* Unpublished Data.

6.3 7 days services

NATIONAL CONDITION: *Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;*

Our Dec 2014 BCF plan sets out the comprehensive range of 7-day services which were already in operation relating to physical and mental health, and social care, and their focus in terms of admission avoidance and smooth patient flow.

To ensure suitable visibility of progress on 7-day working, we have chosen for our locally-proposed BCF metric (see section 9.5):

'20% of discharges over the weekend for Croydon Healthcare Service'.

The percentage of discharges over the weekend at Croydon Healthcare Service (from Friday midnight to Sunday midnight) for patients aged 18years plus after an inpatient (excluding day cases, obstetrics and regular day attenders).

As part of Croydon's joint plan for 7-day services, during 2015/16 we have implemented the following enhancements to our 7-day services:

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED.
- Started the procurement of an integrated Urgent Care service comprising a co-located Urgent Care Centre at Croydon University Hospital, GP Out of Hours, and 3 GP Hubs offering a 365 days service. The integrated service model will be commissioned to start from 1st April 2017.

Section 9.5 of this report sets out further work under way to enhance 7-day services. This is being delivered as part of a joint plan agreed by CCG, Council and providers.

6.4 Data sharing

NATIONAL CONDITION: Better data sharing between health and social care, based on the NHS number;

Croydon Council have made excellent progress in the use of NHS number: data matching of service user records has taken place to identify NHS number, NHS number is now available in the social care systems, a process is in place to capture NHS number at an early point of contact, and work is progressing to update standard letters and reports where appropriate to show NHS number.

Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

Croydon CCG are progressing the use of the updated national Coordinate my Care (CMC) care planning tool to support the development and electronic sharing of care plans for frail/vulnerable people between health, social care and mental health providers based on the patients NHS number. Implementation is dependent on the providers of CMC but it is currently projected that development and sharing of care plans within GP Practices with the EMIS clinical system will start in July 2016. This will significantly improve the delivery of integrated care in Croydon with access by key services such as GP Practices, Emergency Departments, London Ambulance Service, Community Services, Palliative Care, Social Care, and Mental Health services being able to access key information about patients.

Croydon are continuing to pursue open APIs as per the approach set out in the Dec 2014 BCF plan p78-81.

Croydon CCG 2015/20 Digital Healthcare Strategy recognises the importance of streamlining the range of clinical systems within Croydon to improve IM&T integration and to support greater information sharing and access to for effective patient care. The Croydon CCG Out of Hospital Strategy and our Sustainability and Transformation plans recognise that a priority IM&T enabler in achieving our out of hospital ambitions is the achievement of interoperability between physical health, social and mental care, and voluntary sector providers. This is also a key enabler for the development of the integrated health, voluntary sector, social care and mental health community network multidisciplinary model of care that is to be implemented by our Outcome Based Commissioning Accountable Provider Alliance (APA) provider over the next year. API's and shared access to records based on NHS numbers is therefore being jointly pursued by both the CCG and the APA for 2016/17, by looking to build on existing portals such as Medical Information Gateway (MIG) to deliver shared records.

Croydon is therefore planning on bidding against a national Primary Care Transformation fund that will be available in 2016/17 to support the migration of a number of GP Practices on the VISION electronic patient record system to the EMIS Web system used by the majority of GP Practices in Croydon. Further confirmation of timelines for the Primary Care Transformation fund is to be provided by NHS England.

Croydon Health Services are also currently assessing the migration of their community services from EPEX onto the EMIS Web platform. A single system platform for both the GP Practices and community services will significantly improve the delivery of API development in Croydon by reducing the complexity in range of electronic systems. It is not possible to give robust timeframes at this stage, however updates will be provided as soon as funding and assessments have been completed.

Lack of N3 connectivity from Croydon Council remains an obstacle to easy data sharing. This is expected to be resolved during 2016/17, enabled by means of a refresh of the Council's ICT estate.

Close collaboration is in place between Council and CCG on all relevant aspects of Information Governance.

In relation to Caldicott principles, a dedicated group including the Caldicott Guardians for Council and CCG are working to ensure effective implementation, in particular to support the shared record being developed by the Accountable Provider Alliance for OBC.

Information governance training is in place across Council and CCG. In 2015/16 Croydon achieved 95% information governance training for all Croydon CCG staff. Having information governance compliant staff working to the Croydon CCG values and behaviour framework (for all levels of staff, GPs, managers, clinical leaders, senior managers, Governing Body),and similarly for the Council, is integral to the delivery of the integrated model of care that is central to our BCF plans.

We have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights through various means for example:
http://www.croydonccg.nhs.uk/about-us/YI/Pages/default.aspx

6.5 Joint approach to assessments and care planning

NATIONAL CONDITION: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

The Dec 2014 BCF plan (p 81-84) sets out Croydon's approach to risk stratification, and the proportion of the population who are identified as "high risk"(2.4%) or "very high risk" (0.7%). The risk stratification multi-disciplinary teams are now fully active across all 6 of Croydon's GP networks, with approximately 2865 patients being case-managed through this process.

Over 2015/16 further work has been undertaken to improve the identification of frail/vulnerable patients who are not on the at-risk registers, by providing GP Practices with for example information on the types of patients who would benefit from a coordinated multi-disciplinary planning approach. This model of care has formed the basis of the multi-disciplinary community network model of care that is being developed by the Accountable Provider Alliance (APA) for implementation across 2016/17.

In 2016/17 BCF funding is allocated for continued support to the two existing key schemes which underpin this approach: MDT delivery and the Practice Development and Delivery Scheme.

Dementia services have been identified as a particularly important priority for better integrated health and social care services. Since October 2015, four dementia advisors and a dementia support manager have been in post. Their remit is to provide 1-2-1 support to people recently diagnosed with dementia, and their carers. This is recognised as vital post diagnosis support where often the medical side steps back, particularly where there is no medication that can be offered. The dementia advisors provide support to dementia sufferers and their carers with: understanding diagnosis, coping strategies, prevent isolation, accessing peer support and community resources, obtaining social resources to live at home as long as possible / appropriate and ensuring people are supported to make choices and plan for the future. BCF funding for the dementia advisors continues via BCF in 2016/17.

6.6 Consequential impact of the changes on the providers

NATIONAL CONDITION: *Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;*

The Dec 2014 BCF plan (p 85-89) sets out the engagement with service users, patients, public and providers that was undertaken in development of Croydon's BCF plan. Similar engagement has continued through 2015/16.

Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this, the Local Authority and Croydon CCG has had a long record of working with our key acute providers particularly Croydon Healthcare Services (CHS). All key defined Projects that have activity assumptions related to Non-elective Admission Reduction have been shared and agreed with the provider including our in-depth Project Initiation Documents. Plans for financial and activity shifts have also been shared and agreed. This sharing and agreement of plans from an early stage has ensured that Council/CCG and provider plans have remained well-aligned.

BCF is aligned with and 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 which have also informed BCF 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 closed 16th 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.

To ensure continuing visibility and political buy in, BCF has been reported through the year to a range of groups which are wholly or partly formed of elected members. These groups include:
- Health and Wellbeing board
- Health, Social Care and Housing Scrutiny committee
- Adult social services review panel

In addition, periodic BCF briefings are given to the Chair of Croydon Health & Wellbeing Board, and the Cabinet member for Families, Health and Social Care.

Mental and physical health are considered equal in Croydon's plans. Croydon's Vision for integrated services anticipates that integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'. Croydon's BCF includes provisions for mental health alongside physical health through e.g
- mental health professionals as a part of MDTs
- mental health reablement (in additional to physical reablement services)
- recognition of the links between poor physical and mental health through aspects of the IAPT provision targeted at older adults with long term conditions.

BCF is fully aligned with other CCG and Council initiatives and plans, as set out in the Dec 2014 BCF plan (p 60 – 65). Of particular note during 2015/16 has been the development of Croydon's plans for outcomes based commissioning for over-65s' services, with OBC contracts due to be put in place during 2016/17. Planning for BCF in 2016/17 has included close collaboration with the OBC programme team to ensure alignment of objectives and metrics, phased handover of scheme delivery as OBC contracts come on line, agreed reporting between OBC and BCF, and adjustment to Croydon BCF governance as BCF is gradually subsumed by OBC.

Croydon CCG is currently updating our Out of Hospital Strategy for 2016/2021. This will include a review of progress against our original strategy initiatives, and further planned initiatives. We are currently also working as part of the South West London (SWL) strategic planning group to develop the 5 year sustainability and transformation plan (STP). This will detail the health economy's ambition to improve services over the next 5 years, including out of hospital.

To support the creation and delivery of this out of hospital strategy, the SWL Clinical Board have commissioned a bed audit across all SWL acute trusts with the aim of providing a strong, systematic evidence base of the opportunity in SWL to move patients out of hospital. A stock take of current services across the SWL CCGs is also currently underway, looking at the range of health and social care services in each of the 6 boroughs to understand what's in place, the scale of impact, and workforce delivering it, any gaps that could support pan SWL developments or local developments to achieve the activity shift

The results of this audit and our review of our Out of Hospital Strategy will be shared with and discussed with all key stakeholders in Croydon to ensure that there is full engagement in defining the level of ambition for out of hospital activity and initiatives that need to be implemented to support the shift. The approach is being developed from the outset in alignment with Croydon's BCF plans.

6.7 Out-of-hospital services

NATIONAL CONDITION: *Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;*

In 2016/15, Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £12.5m, this being well in excess of the mandated minimum of £6.4m. Individual schemes and expenditure plans are listed in the BCF planning template return.

During 2015/16, Croydon has not achieved the planned improvement on non-elective admissions. However, performance has shown an improvement during Q3 which is expected to continue. This is attributed to the impact of new schemes such as Roving GP service, rapid response and ACE RAMU which have now started to become effective. This improved performance is expected to continue as the services bed in. To maintain this upward trajectory of performance, all 2015/16 out-of-hospital schemes will continue to be funded in 2016/17, at similar funding levels to 2015/16 but suitably uplifted for inflation and demographic growth. In 2015/16, the non-elective admissions target was not reached and the pay for performance risk share funding was not payable into the BCF fund. However, Croydon CCG chose to contribute the full equivalent funding to the BCF, on the basis that investment in out-of-hospital services directed at admission avoidance was the best mitigation of future risk on non-elective admissions performance.

In considering the need for a local risk-sharing arrangement, performance trends and attitude to risk mitigation have been reviewed. Bearing in mind:

- The improving trajectory of non-elective admissions performance
- The preference for investment in admission-avoidance activity

it has been decided not to put in place a pay-for-performance fund linked to non-elective admission performance.
Non-elective admissions performance data is given at section 9.1 of this report.

Croydon is part of the South West London CCG's Out of Hospital Group who are working on the development of the 5 year SWL plan for Out of Hospital provision. This would provide at a strategic level what SWL CCG's are looking to move out of hospital, and how that is envisaged to happen.

A stock take of current services is currently underway, looking at the range of health and social care services in each of the 6 boroughs to understand: what's in place, the scale of impact, and workforce delivering it, any gaps that could support pan SWL developments or local developments to achieve the activity shift.

As indicated in section 6.6 Croydon is developing our 2016/21 Out of Hospital Strategy in addition to the SWL STP, which will further inform opportunities for developing/expanding out of hospital services. The results of the SWL stocktake of Out of Hospital services mentioned in section 6.6 are not yet ready for circulation. Croydon CCG and Croydon Council have however undertaken an internal review of the current BCF initiatives and impact against the BCF metrics, and an overview of some the schemes are shown in the below table.

Scheme name	Performance on track? (RAG plus comments)	Evidenced delivery against BCF metrics?
Intermediate Care Beds	Green	**NEL Admissions** Intermediate Care Beds (mth9 177 step down admissions, and 77 step up admissions - potential cost saving of reduced admissions from step up usage of £165k)
Transforming Adult Community Services (TACS)	Green	**NEL Admissions** 1) Rapid Response (mth9 1,066 referrals successfully treated in community - potential NEL saving of £2,277k) 2)Enhanced Case Management (mth9 1,220 patients case managed by Community Matrons and Health Visitor for Older People) 3) Single Point of Assessment (mth9 22,855 referrals managed by service) 4) Use of all above services will have contributed to the overall reduction at mth8 of 8.7% in NEL Admissions (979 spells, £2,621k cost reduction) for HRGs monitored for TACS impact
TACS – GP Roving Service	Amber	**NEL Admissions** 223 patients successfully managed in their home or community setting and not admitted to hospital (potential NEL saving of £234k - £351k if 50-75% of these were avoided admissions).
TACS – Social Work Input	Green	**Non-elective admissions & Permanent admissions to care homes.** MDTs a core part of national good practice. Over a 10 week period Nov 15 - Jan16, the team attended 118 MDT meetings, carried out 530 social work checks, and received 84 referrals for assessment.
End of Life – St Christopher's	Amber	**NEL Admissions** 23% reduction of hospital deaths from Care Homes and own homes over three years (3% 2015/16, 10% 2016/17 and 10% 2017/18) as originally agreed by the Better Care Fund. As of Nov 2015 there is a slight under-performance of 2.4% (equating to 4 patients). Working with St Christopher's and Marie Curie within the community to meet targets and improve patient experience at end of life.

Integrated Stroke Service	Green	**NEL Admissions** Referrals in - 146, Discharged - 142, Case load - 151 94 Support Groups (Swimming pool Exercise Class, Aphasia café, Communication group, Carers support) 500 Attendances 123 hours of one-to-one contact time setting personal goals and identifying support needs for onward referral
Chronic Obstructive Pulmonary Disease (COPD) Community Service	Amber	**NEL Admissions** At mth9 ytd 2015/16 the service has achieved the following savings: 1) £60k NEL Admissions 2) £32k 1st Appointments 30 £70k Follow Up appointments
Practice delivery and development Scheme (PDDS)	Green	**NEL Admissions** Reduction of 8% in A&E Attendances during core hours. Focus on MDTs has also acted as an enabler for overall 8.7% reduction in NEL admissions. In addition there has been a reduction in 1st Outpatient appointments from GP referrals
Mental Health – Liaison Psychiatry	Green	**NEL Admissions** Reductions achieved in breaches of A&E 4hr wait due to to reduction in waits for psychiatric assessments
Mental Health – Packages of Care	Green	**Non-elective admissions and DTOC The** funding is used for packages of care to facilitate discharge from mental health in-patient settings, and to support complex cases with severe mental illness to prevent admission to hospital.
Hospital Discharge	Green	**DTOC & At home 91 days after discharge.** Core part of process. Received 1960 referrals (196/month) and facilitated 1168 discharges to a care package (117/month) over the period Jan - Oct 2015
ACE/RAMU	Green	**NEL Admissions** 1,700 patients seen in RAMU at mth9 ytd

The improved performance against the non-elective admissions is expected to continue as the services bed in further in 2016/17. To maintain this upward trajectory of performance, all 2015/16 out-of-hospital schemes will continue to be funded in 2016/17, at similar funding levels to 2015/16 but suitably uplifted for inflation and demographic growth.

6.8 Delayed transfers of care

NATIONAL CONDITION: *Agreement on local action plan to reduce delayed transfers of care.*

Croydon's performance on delayed transfers of care is better than London and England averages, but falls short of our own target. 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. The first priority actions in our local action plan therefore relate to reducing mental health DTOC. Detailed analysis of patient flow and reasons for delay has been carried out by the provider. The plan for DTOC reduction has been co-produced by Council, CCG and 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.

This plan is owned by the BCF Executive group. The CCG pooled fund manager and the Council BCF lead manage delivery on behalf of the BCF Executive Group. This is via matrix-management making use of existing contract management arrangements and co-ordinating with other initiatives where appropriate. Organisations most strongly involved at the current stage of work are: Croydon Council, Croydon CCG, South London & Maudsley NHS Trust, Croydon University Hospital.

Across the broader spectrum of discharge planning and patient flow, a range of initiatives are underway:

- Discharge planning sub-group at Croydon University Hospital is assessing barriers to discharge.
- A CQUIN target has been set relating to discharges before 1 p.m.
- Croydon Healthwatch have carried out a survey of patient experience of the discharge process.
- The Continuing Health Care action plan includes training for staff re. referrals so that awaiting CHC arrangements does not increase delay.
- SRG planning for discharge.
- Agreement on how to manage DTOC-reduction targets via OBC performance management process

These actions, and the overall DTOC plan, are within the context of the overall System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community.

The CCG does not have a separate DTOC target : -the BCF DTOC target is the area's shared target, and the DTOC plan is a shared plan. The DTOC reduction plan has been produced with providers – primarily SLAM for the initial priority actions re. mental health discharges, but wider actions are in collaboration with other providers such as CUH. Engagement with independent and voluntary sector providers has been primarily via discussion with providers of services which aid discharge, e.g. home from hospital services, but also via the Health and Wellbeing Board.

In preparing the DTOC plan we have examined national guidance and carried out an initial self-assessment against the 8 high impact interventions.

Given the wide range of work underway, priorities for Q1 2016/17 i.e. by end June 2016 and lead roles are as follows:

DTOC Action	Lead person (role)
Progress with the mental health DTOC-reduction actions noted above.	Head of social care (Mental Health), Croydon Council
Ensure DTOCs are being correctly recorded across all settings.	Deputy Director of Commissioning, Croydon CCG
Complete the mapping of current discharge/patient flow work-in-progress	Deputy Director of Commissioning, Croydon CCG
Identify any need for greater co-ordination across the patient flow/discharge activity	Deputy Director of Commissioning, Croydon CCG
Self-assess against the eight 'high impact interventions' that were agreed by ECIP (informal self-assessment done so far)	BCF Lead, Croydon Council
Agree priority actions for Q2 and beyond.	Deputy Director of Commissioning, Croydon CCG

The DTOC target for 2016/17 is given at section 9.4, and has been set by recognising a) the poor performance against the 2015/16 target and also b) the improvement actions in Croydon's DTOC plan (section 6.8) which are targeted to improve performance.

Croydon have considered use of a risk-share agreement relating to DTOC. Taking a consistent approach to that applied to non-elective admissions (see section 6.7above), we have chosen not to put in place a pay-for-performance fund as part of our risk share agreement, choosing instead to invest in schemes to reduce DTOC. Our overall approach to risk share is given at section 7 and DTOC performance data is at section 9.4.

7 Approach to financial risk-sharing and contingency

7.1 Summary of approach

The general approach to risk-sharing and contingency is set out in the Dec 2014 BCF plan (p57-59).

In brief: Croydon CCG and Croydon Council have agreed that the principle underpinning the risk sharing agreement will be based on an "invest to save" policy, as opposed to holding a performance fund in contingency.

Specifically, for 2016/17 it has been agreed not to use a pay-for-performance risk share agreement for either non-elective admissions or DTOC.

The BCF section 75 agreement specifies details of financial risk-sharing with regard to over-spends and under-spends.

7.2 Rationale for decision in relation to contingency and risk

In 2015/16, the non-elective admissions target was not reached and the pay for performance risk share funding was not payable into the BCF fund. However, Croydon CCG chose to contribute the full equivalent funding to the BCF, on the basis that investment in NHS-commissioned out-of-hospital services directed at admission avoidance was the best mitigation of future risk on non-elective admissions performance.

Croydon is part of the South West London (SWL) strategic planning group which is currently developing the 5 year sustainability and transformation plan (STP) to detail the health economy's ambition to improve services over the next 5 years, including out of hospital. To support the creation and delivery of this out of hospital strategy, the SWL Clinical Board have commissioned a bed audit across all SWL acute trusts with the aim of providing a strong, systematic evidence base of the opportunity in SWL to move patients out of hospital.

A stock take of current services is also currently underway, looking at the range of health and social care services in each of the 6 boroughs to understand what's in place, the scale of impact, workforce delivering it, and any gaps that could support pan SWL developments or local developments to achieve the activity shift.

The STP will therefore further inform what SWL CCG's will be looking to move out of hospital, and how that is envisaged to happen.

In considering the need for a local risk-sharing arrangement, the non-elective admissions performance trend, and Croydon's attitude to risk mitigation have been reviewed. As a result of (a) the improving trajectory of non-elective admissions performance, and (b) Croydon CCG's preference for investment in NHS-commissioned admission-avoidance activity, it has been decided not to put in place a pay-for-performance fund linked to non-elective admission performance. Funding for 2015/16 BCF schemes directed at non-elective admissions performance continues into 2016/17, with some additional schemes funded.

7.3 Data behind rationale

Performance against the non-elective admissions performance target is shown below.

Table : BCF1 - Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population

Period	Planned	Actual
Jan 15 - Mar 15	8,935	9,291
Apr 15 - Jun 15	9,168	9,462
Jul 15 - Sep 15	8,948	9,440
Oct 15 - Dec 15	9,863	9,497

The improvement to performance in Oct-Dec 2015 is attributed to the investment in BCF schemes such as Roving GP service, rapid response and ACE RAMU which have now started to become effective.

7.4 Mitigation of cost pressure of under-delivery of any aspect of the BCF plan.

Croydon Council and CCG will mitigate cost pressures through the established financial management processes in place including:

1) CCG monthly monitoring of acute contract performance, including:
    a. Review of and challenges on data quality
    b. Issuing of notice requests to understand over performance
    c. Implementing and monitoring financial control plans

2) Council monthly monitoring of financial performance, backed up by robust efficiencies plan.
3) Monthly review by CCG of performance and mitigating actions for BCF commissioned services supporting non-elective admission reductions
4) Quarterly review by the Croydon Better Care Fund Executive Group.
5) The BCF s75 agreement which sets out risk share arrangements relating to under-spends and over-spends.

7.5 Council self-assessment of risk

Local authorities have been asked to self-assess themselves on level of risk related to financial and service based pressures, with references to key questions set out in this section. Croydon Council self-assess as LOW RISK on the basis of the 2016/17 budget which has been signed off with forecast for 2016/17 break even, makes reasonable provision for demographic pressure, allows national living wage implementation, and incorporates a stretching but achievable efficiencies programme.

Key questions and Croydon Council responses are given in the following table.

Ref	Question	Croydon response
1	Extent of financial pressure from demography on the 2016-17 net adult social care budget. And to what extent will the identified demographic pressure be funded	The Adults Social Care Budgets have been given growth of £3m to address demographic pressures in 2016/17.
2	Spend on prevention services that can be accessed by people that did not cross your councils FACs Eligibility threshold in 2014/15, 2015-16 and 2016-17	The Gateway service was established in 2015/16. The budget is as follows: 2015/16: £1.8m 2016/17: £2.3m It is not possible to split out the prevention budgets from the total ASC budget in 2014/15 as these were amalgamated.
3	Percentage of ASC savings in comparison to overall council savings	ASC savings of £3.111m are 19% of the total savings of £16.276m
4	Level of savings planned from the council's expected total net budget and net adult social care budget in 2016-17, and source (ie efficiency / increased income from charges / service reductions)	Net ASC budget in 16/17 is £104.148m which includes savings of £3.111m This is made up of: 0.07m income 0.225m cuts 2.816m efficiencies
5	Has the 16/17 budget been signed off / set - with a current forecast for 16/17 of break-even?	Yes
6	Have demographic and other growth projections been built into the budget for 16/17?	Yes
7	Have the implications of the national living wage implementation been factored into council budgets?	Yes - £1.9m growth was included in the budget

8 Funding and spend

8.1 Funding contributions

Funding contributions to Croydon BCF 2016-17 are shown in the following table, with comparison to 2015/16 figures.

Description	2016-17 £000	2015-16 £000	Difference £000
Mandated CCG contribution to BCF	22,454	21,498	956
Disabled Facilities Grant	2,046	1110	936
Adults social care capital grant		780	-780
Total - minimum mandated	24,500	23,388	1,112
Additional contribution s256 carry forward		754	-754
Total Croydon BCF fund	**24,500**	**24,142**	**358**

In setting the funding contributions and subsequent schemes allocations, the CCG and Council have considered:

- Actual spend during 2015/16
- The desire for stability of delivery on existing schemes, and assessment of impact of funding changes
- Demographic and inflationary growth, alongside savings plans
- Priorities for additional investment

In addition, Croydon anticipate making a substantial commitment to integration of health and social care via OBC contracts of approximately £212m during 2016/17. Taking all these factors into account, the BCF Executive agreed that only the mandated minimum is planned for investment via BCF in 2016-17, and this has been approved by Croydon Health & Wellbeing Board.

8.2 Scheme level spending plan

The BCF schemes and the allocated funding to each is given in the following table:

Scheme name	Patient benefits	2016/17 allocation	Lead commissioner

St Christophers End of Life - Core Contract	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£286,000	CCG
Marie Curie End of Life - Core Contract	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£65,000	CCG
St Christopers End of Life - QIPP Scheme	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£114,000	CCG
Marie Curie End of Life - QIPP Scheme	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£145,000	CCG
End of Life Training - QIPP Scheme	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£27,000	CCG
St Christophers Palliative Care	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£1,354,000	CCG
Crossroads - Palliative Care	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£121,000	CCG
End of Life - social care	helping people requiring end of their life care to be supported to receive their care and to die in their preferred place	£253,000	Local Auth ority
SLaM - Community Investment (HTT)	supporting people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home	£1,591,000	CCG
SLaM - Older Adults Community Investment	helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£307,000	CCG
MHOA - Dementia - Altzheimers Society	helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£200,000	CCG
Care UK Amberley Lodge	helping to keep people with one or multiple long term conditions and complex needs stable	£260,000	CCG
Mental Health - Reablement	supporting and providing education to both family and carers to ensure their health and well- being	£202,000	Local Auth

	needs are met, including support to maintain finances and staying in work, where relevant		ority
Mental Health - Packages of Care	helping to keep people with one or multiple long term conditions and complex needs stable	£303,000	Local Auth ority
IAPT - Long Term Conditions Pilot	helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£177,000	Local Auth ority
Transforming Adult Community Services	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£2,459,000	CCG
Transforming Adult Community Services - Nursing Homes	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate	£204,000	CCG
TACS - Social Work Input	supporting and providing education to both family and carers to ensure their health and well- being needs are met, including support to maintain finances and staying in work, where relevant help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates	£455,000	Local Auth ority
Enhanced Care Management	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£317,000	CCG
ACE/RAMU	allowing people to get timely and high quality access to care when they are ill, delivered at the front end of acute care where appropriate without the need for admission	£1,025,000	CCG
GP Roving	allowing people to get timely and high quality	£401,000	CCG

Service	access to care when they are ill, delivered in the community where appropriate		
COPD	helping to keep people with one or multiple long term conditions and complex needs stable	£521,000	CCG
Extended Staying Put	providing people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence	£121,000	Local Authority
Specialist Equipment eg Telehealth / Telecare	helping to keep people with one or multiple long term conditions and complex needs stable helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£187,000	Local Authority
Disabled Facilities Grant	helping to keep people with one or multiple long term conditions and complex needs stable providing people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence	£2,046,194	Local Authority
Early Intervention & Reablement	providing people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence	£1,023,000	Local Authority
Demographic pressures - package of care	helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£2,043,000	Local Authority
Social Care Pressures	helping to keep people with one or multiple long term conditions and complex needs stable providing people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence	£1,111,000	Local Authority
Prevent return to acute / care home	helping to keep people with one or multiple long term conditions and complex needs stable	£480,000	Local Authority
Falls Service	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate	£220,000	CCG
Age UK - Integrated Falls Service	helping to keep people with one or multiple long term conditions and complex needs stable	£30,000	CCG

Falls & Bone Health Communications	helping to keep people with one or multiple long term conditions and complex needs stable	£10,000	CCG
Intermediate Care Beds	supporting people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home helping to keep people with one or multiple long term conditions and complex needs stable	£480,000	CCG
Integrated Stroke Service	helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£64,000	CCG
Medicines Optimisation	helping to keep people with one or multiple long term conditions and complex needs stable	£100,000	CCG
Diabetes Service	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£1,000,000	CCG
Diabetes LES	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£96,000	CCG
Basket LES	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates	£414,000	CCG
Practice Delivery & Development Schemes	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the	£2,020,000	CCG

	community where appropriate helping people to self-manage their condition and to understand how, when and who to access care from when their condition deteriorates		
Step Down & Convalescence Beds	helping to keep people with one or multiple long term conditions and complex needs stable allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate	£505,000	LA
A&e Triage	supporting people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home	£177,000	LA
Hospital Discharge	supporting people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home	£177,000	LA
Care Support Team nurses	supporting and providing education to both family and carers to ensure their health and well- being needs are met, including support to maintain finances and staying in work, where relevant	£126,000	LA
Alcohol Diversion	allowing people to get timely and high quality access to care when they are ill, delivered in the community where appropriate	£61,000	LA
Care Act	Implementation of new statutory duties to the Council arising from the Care Act	£806,000	LA
To be allocated during 2016/17		£415,598	Joint
TOTAL		£24,499,792	

The BCF Planning Template return provides further detail.

For each scheme, the BCF section 75 agreement includes a brief summary of: funding allocation, scope of what is to be delivered, agreed reporting and activity or other metrics.

In addition, each scheme has a service delivery plan and/or project implementation plan suitable to the scheme size, complexity and maturity. The process for monitoring scheme delivery and management of issues is outlined in section 5.4 above.

These schemes are integral parts of other plans including CCG operating plan, and Sustainability and Transformation Plan (under development).

9 National metrics

The Council target-setting process for 2016/17 is currently (April 2016) underway. Therefore the information provided in this section is **PROVISIONAL** and may be amended for sections 9.2, 9.3, 9.4 and 9.6.

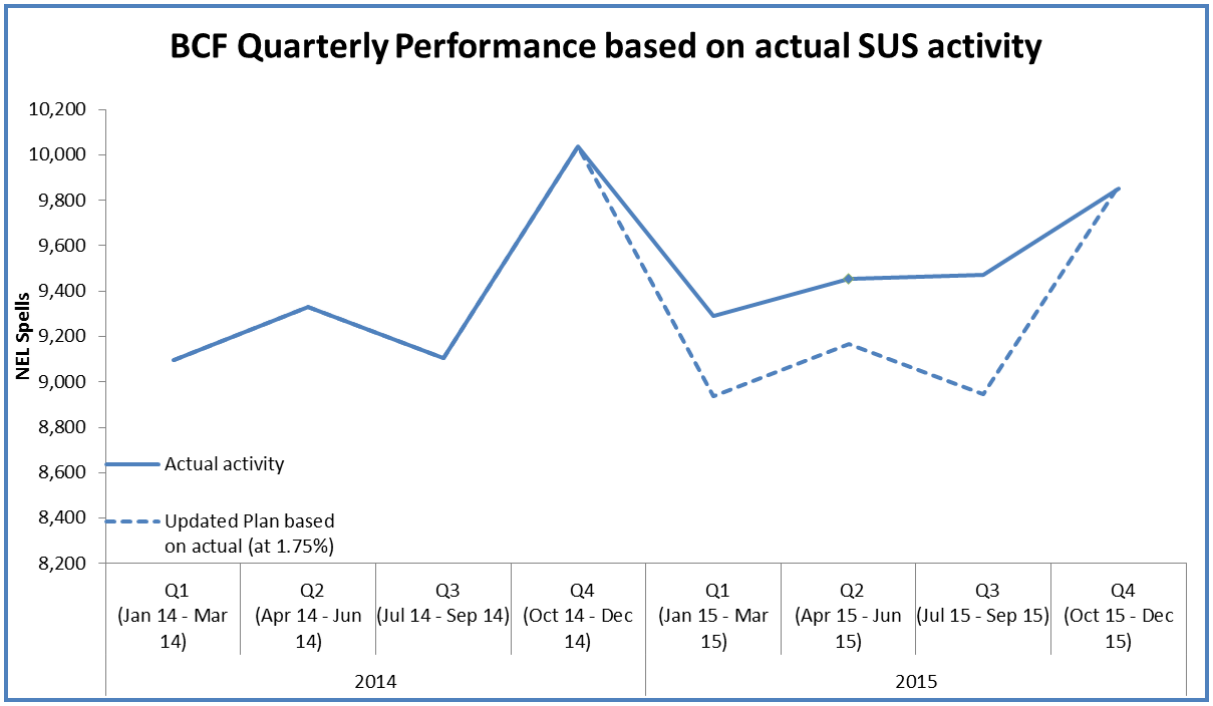
The target-setting process encompasses a robust analysis of current performance and trends in performance over the last few years, alongside consideration of relative performance to England average, London average and other comparators. Expected Impact of planned service changes, whether delivered through BCF or other initiatives, is also taken into account.

9.1 Non-elective admissions

Croydon CCG have continued to work collaboratively with our providers in 2015/16 to assess how further improvements in patient quality can be achieved in 2016/17. This has involved different approaches including use of national guidance and best practice, bench marking against local and London peers to identify areas for investigation, and working together with providers to identify areas where providers have highlighted could be provided in a different way to improve patient care. Discussions in the various clinically-led steering groups (including both CCG and providers) have enabled the CCG to define the QIPP initiatives we have stated in our 2016/17 Operating Plan, using specific HRGs to build and define the cohort of non-elective activity that is expected to be impacted upon as a result of the pathway improvement.

In 2015/16 performance against the year to date target at month 10 was 3% higher than planned (38,067 vs 36,914), however there was improvement over the previous 2 months (see Graphxx: Total Year to Date Non-Elective Admissions as at November 2015 forecasted to Full Year).Mitigating actions were implemented to improve performance across the year including validation of HRGs mapping following introduction of the new ETO tariff in 2015/16 and agreement with NHSE to measure activity based on SUS (HSCIC's Secondary Use Service) to improved accuracy of reporting, and expansion of admission avoidance service provision by the Rapid Response and GP Roving Services.

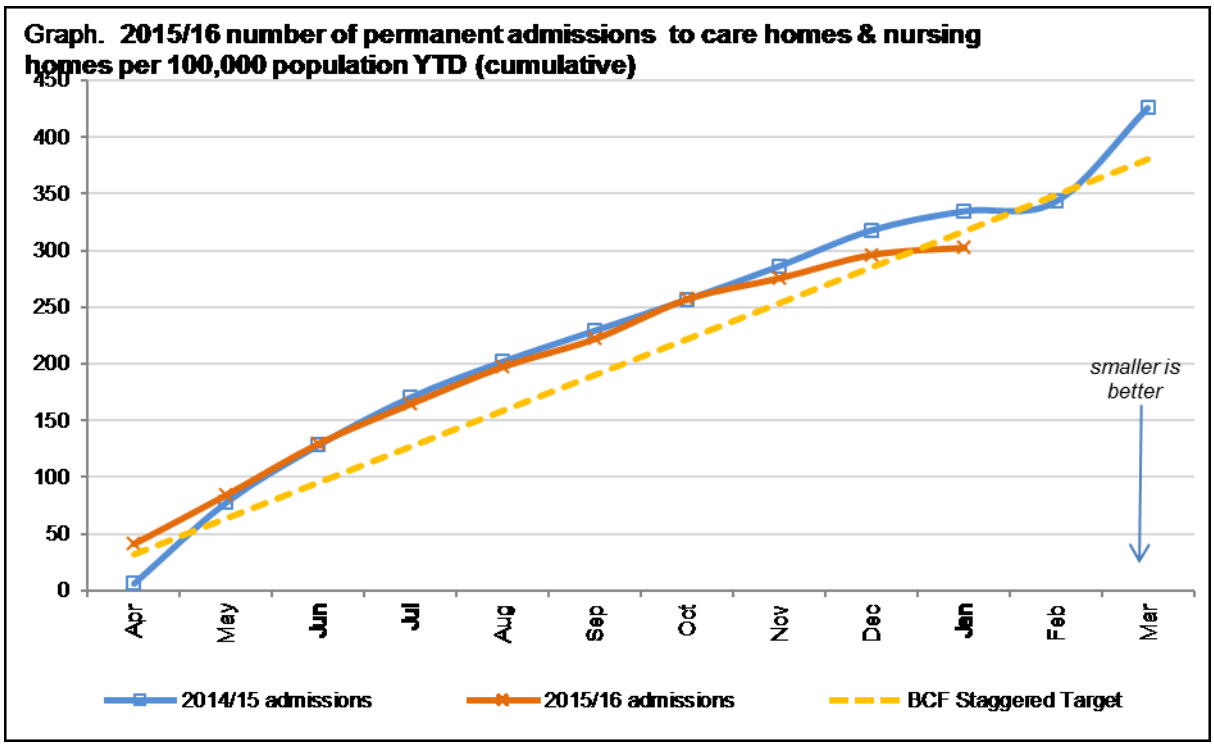
Graph: Total Year to Date Non-Elective Admissions as at December 2015 forecasted to Full Year



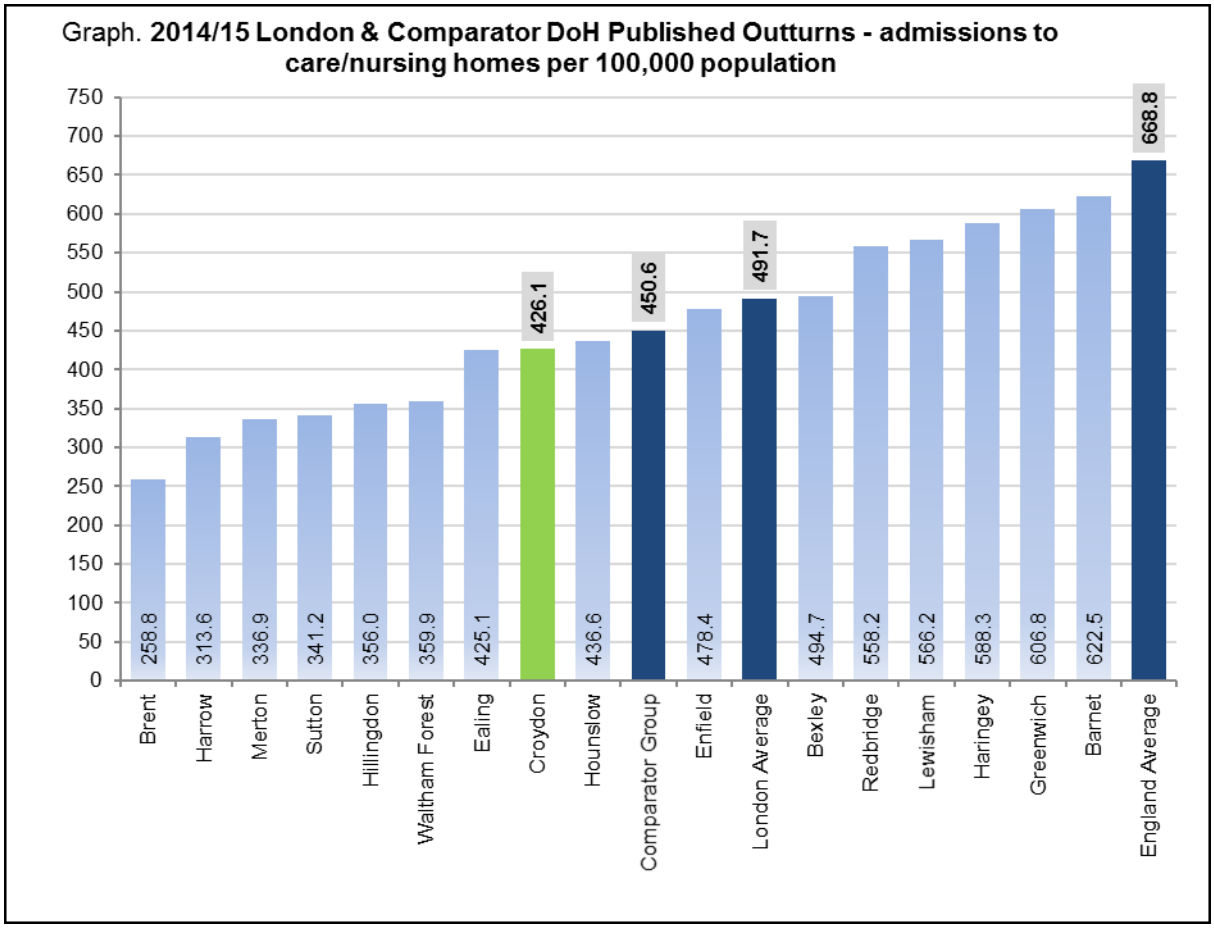
9.2 Admissions to residential and care homes

In 2014/15 Croydon did not meet its own ambitious target for admissions to residential and care homes. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on home care packages, which has been partially alleviated through BCF funding, as well as investment in a range of preventative schemes via BCF and elsewhere.

Performance is shown in the following graph.



Croydon's performance on this measure is relatively good – better than the London average and less than 2/3 of the England average, as per the following graph:



BCF investment continues during 2016/17 on schemes to protect social care (including home care), as well as preventative measures. There is an increased investment in home adaptations in 2016/17 via the Disabled Facilities Grant, however that will take some time before impacting on performance. Through OBC, a range of improvements are anticipated which will have a positive outcome on this measure. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **380 permanent admissions of older people to residential and nursing care homes, per 100,000 population.**

9.3 Effectiveness of reablement

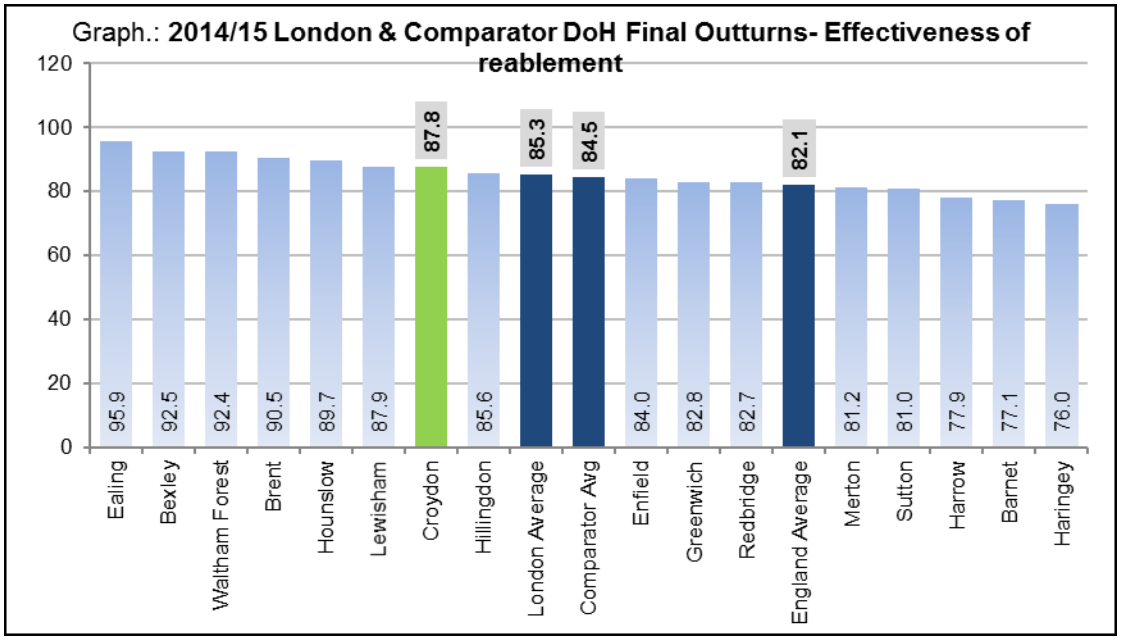
In 2014/15 Croydon did not meet its own ambitious target for effectiveness of reablement, though there was an improvement on the previous year's performance. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on reablement packages, which has been partially alleviated through BCF funding.

Performance is shown in the following table.

Table : **Performance Data - Effectiveness of reablement - 2013 - to date**

2015-16	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Target
	>>>>>>>>>>>>> Denominator Jan-Mar 2015 Numerator Apr-Jun 2015			>>>>>>>>>>>>> Denominator Apr-Jun 2015 Numerator Jul-Sep 2015			>>>>>>>>>>>>> Denominator Jul-Sep 2015 Numerator Oct-Dec 2015			>>>>>>>>>>>>> Denominator Oct-Dec 2015 Numerator Jan-Mar 2016			
Numerator			120			115			104				BCF 88%
Denominator			138			128			119				
Outturn			87.0%			89.8%			87.4%				
2014-15	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Target
Numerator	Year End 2014/15: Denominator is calculated Oct-14 to Dec-14 Numerator is calculated Jan-15 to Mar-15											122	BCF 88%
Denominator												139	
Outturn												87.8%	
2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Target
Numerator	Year End 2013/14: Denominator is calculated Oct-13 to Dec-13 Numerator is calculated Jan-14 to Mar-14											138	75%
Denominator												162	
Outturn												85.2%	

Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:



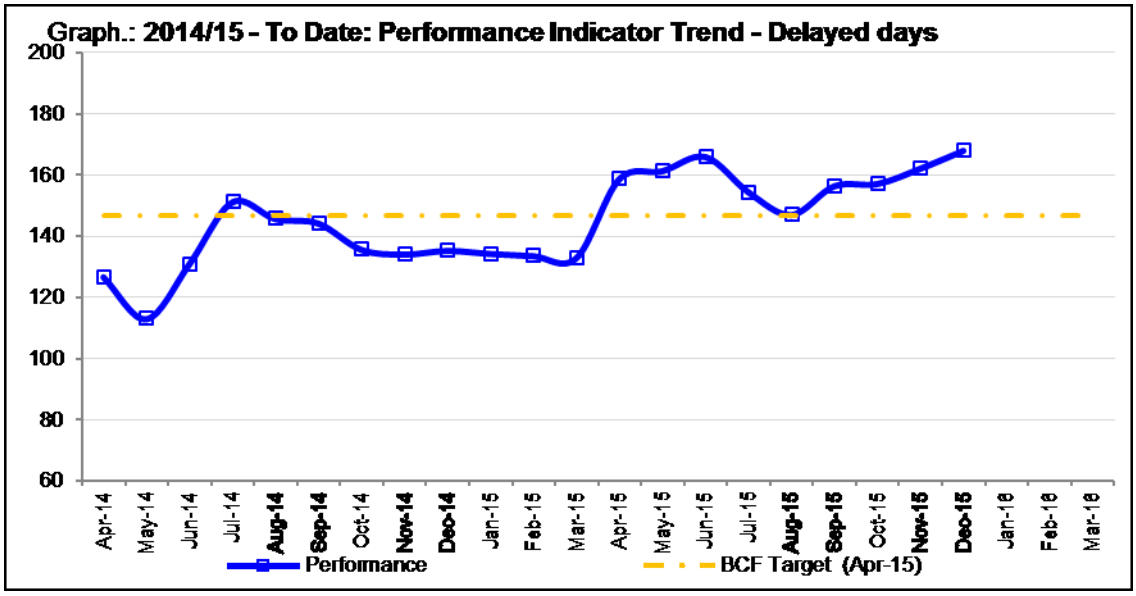
BCF investment continues during 2016/17 on reablement schemes. This is expected to be a key measure in the OBC contract, incentivising the providers to work together for a positive impact on this measure. Continued investment in BCF schemes such as reablement care packages, mental health reablement, and telecare are expected to ensure that the performance improvements over the last few years are consolidated into more consistent quarter-by-quarter performance. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (successful reablement) = 88%.**

The target has been set by recognising a) the patchy quarter-by-quarter performance against the 2015/16 target and also b) the continued investment in schemes which should consolidate performance to consistent achievement against the target.

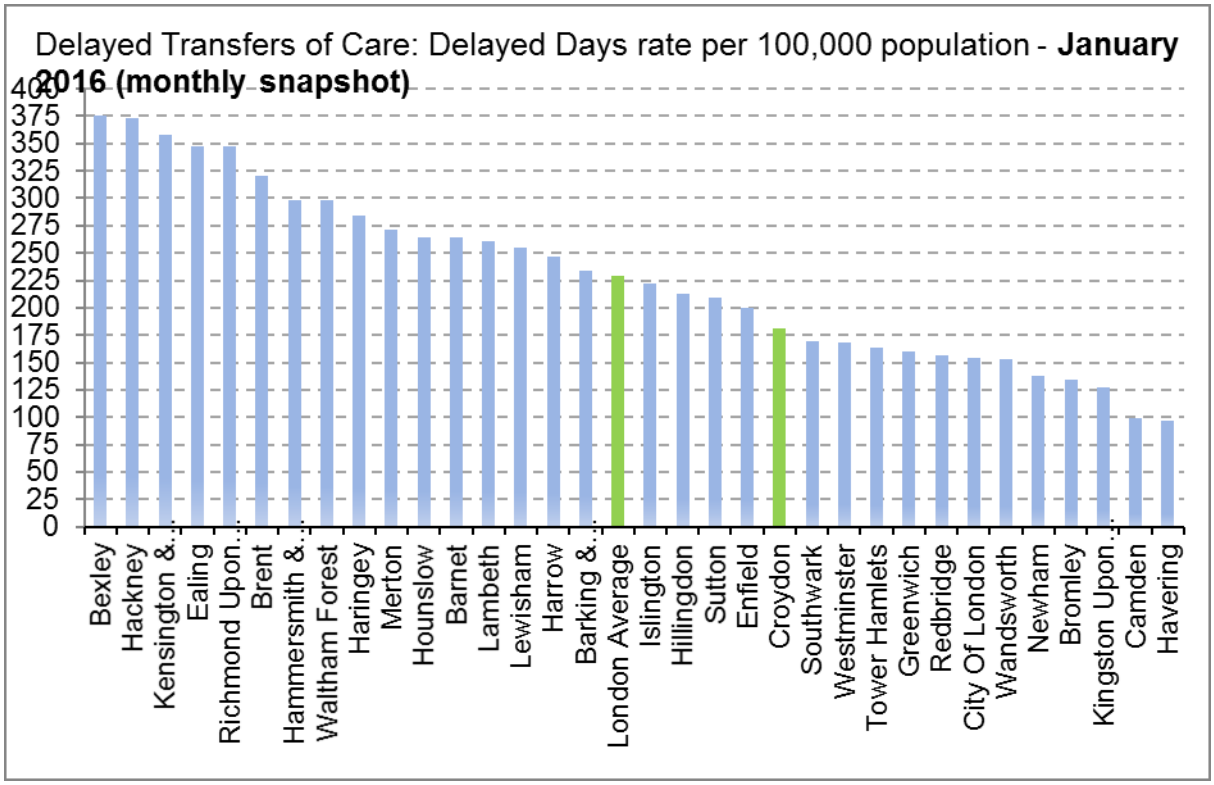
9.4 Delayed Transfers of Care

In 2014/15 Croydon met its own ambitious target for delayed transfers of care (DTOC). In 2015/16, Croydon will not meet the target.

Performance is shown in the following graph.



Performance issues and action plan for DTOC are detailed in section 6.8 above. Despite not meeting our own target for 2015/16, Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Delayed transfers of care (DELAYED DAYS) from hospital per 100,000 population = 146.7.**

The target has been set by recognising a) the poor performance against the 2015/16 target and also b) the improvement actions in Croydon's DTOC plan (section 6.8) which are targeted to improve performance.

9.5 Weekend discharges from CUH

In June 2014, the six South West London (SWL) CCGs submitted their 5 year strategy for health services across south west London, with a vision for integrated care services across SWL which included the development of services that:

support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home

Croydon's System Resilience Group as part of the development of an operational resilience strategy and plan for 2015/16 identified key initiatives that would be required to improve the operational resilience of Croydon University Hospital (CUH) and to support the achievement of the A&E 4-hour waits. These included changes that would improve patient flow through the emergency department and the hospital, including effective discharge planning, developing innovative solution tackle workforce challenges, building intermediate care capacity and flex, facilitating discharges to nursing and care homes at weekends, enhancing therapies to ensure early rehabilitation on wards and follow up on discharge at the weekends, enhanced social care support at weekends and access to emergency services e.g. housing.

A local metric for encouraging improvement in weekend discharges from CUH was therefore established based on assessment of performance over 2013/14 with a stretch target from 18.7% to 20%.

In 2015/16 performance against the year to date target at month 10 was lower than planned at 18.6% with a forecasted year end position of 18.5%. The main reasons for the underperformance were that although non-elective discharges had increased, elective discharges had reduced. Mitigating actions implemented across the year to address the situation included ongoing enforcement of the systems resilience group recovery plan and the 95% recovery plan, and the establishment in February 2016 of a discharge process working group by Croydon Health Services led by the Deputy Chief Operating Officer to develop solutions to address issues impacting on delivery.

The stretch target for 2016/17 remains at 20%.

9.6 Social care-related quality of life

In 2014/15 Croydon did not meet its own ambitious target for social care related quality of life.. For 2015/16, data is not yet available, as the base information is collected only once annually. Performance is shown in the following graph.

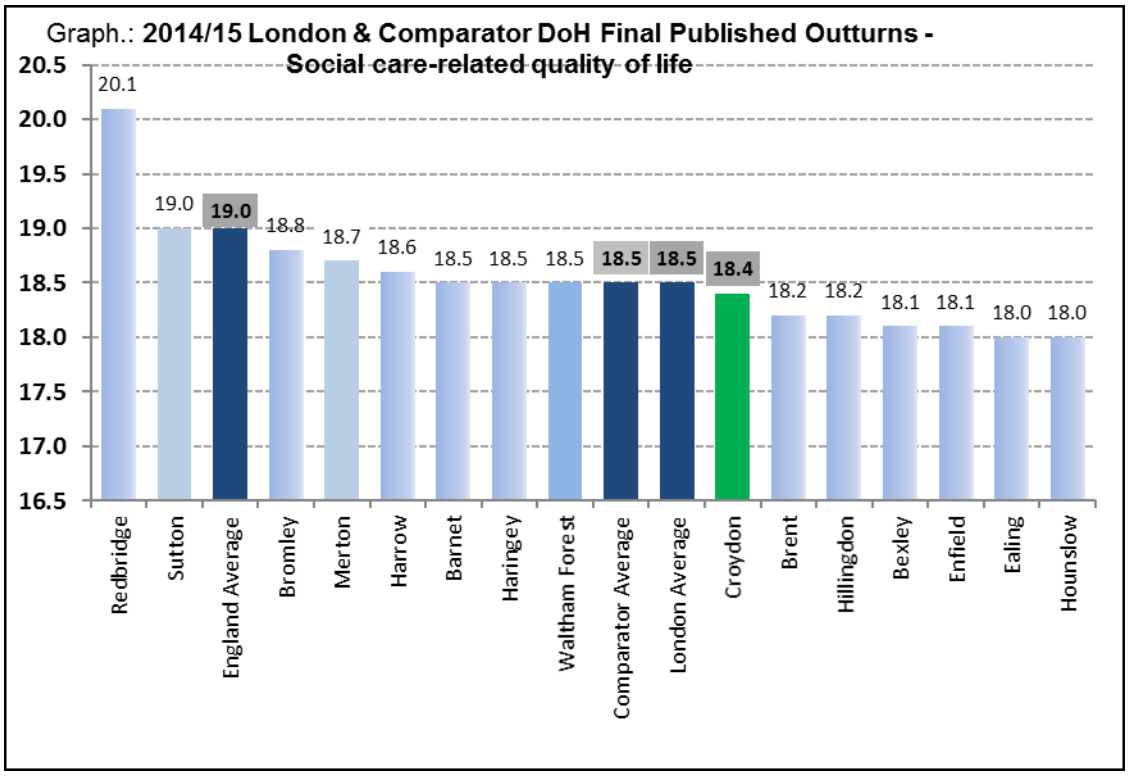
Table: **Performance Data - 2012/13 - to date – Social care-related quality of life**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
	Annual ASCOF Survey												
Numerator												78980	BCF
Denominator												4300	19.0
Outturn												**18.4**	

										14	Feb-14	Mar-14	Target
Numerator												85493.4	n/a
Denominator												4561	
Outturn												↗ **18.7**	

										13	Feb-13	Mar-13	Target
Numerator												91430	n/a
Denominator												5015	
Outturn												→ **18.2**	

Croydon's performance on this measure is close to the London average but worse than the England average as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Social care related quality of life – annual adult social care survey score =19.**