REPORT TO:	***Health and Social Care Sub-Committee*** ***25th September 2018***
SUBJECT:	***Croydon CCG Operating Plan 2018/19 Update and Commissioning Intentions 2019/20***
LEAD OFFICER:	***Stephen Warren, Director of Commissioning*** ***Croydon CCG***
CABINET MEMBER:	***Councillor Jane Avis – Cabinet Members for Families, Health & Social Care***
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	***Stephen Warren, Director of Commissioning*** ***Croydon CCG***

ORIGIN OF ITEM:	To update the Health, Social Care and Housing Scrutiny Sub Committee on key 2018/19 plans and commissioning intentions for 2019/20
BRIEF FOR THE COMMITTEE:	*To receive an update on progress on CCG plans for 2018/19 and to receive the draft commissioning intentions for 2019/20*

1. *Operating Plan 2018/19 Update*

1.1 Croydon CCG's Operating Plan 2018/19 sets out our plans to deliver our strategic transformation priorities as part of One Croydon as well as national, London and South West London priorities.

1.2 Appendix 1 provides progress against our key transformation programmes.

2. *Commissioning Intentions 2019/20*

2.1 CCGs are required to give service providers six months' notice of significant contractual service changes; therefore, for contractual changes to take effect from 1 April 2019, the CCG must inform providers of its commissioning intentions by the end of September 2018.

2.2 Whilst subsequently notified service changes are not precluded, the 1 October 2018 deadline is best practice in the NHS planning guidance so that changes to contracts can be negotiated by 31 March 2019.

2.3 Attached as Appendix 2 is the *draft* CCG's local commissioning intentions for 2019/20. It is informed by:

- The outcome of the CCG's continuous engagement with the public, GPs and other clinicians, including GP network meetings
- National, London, South West London and local policy and priorities

2.4 The CCG and Council's Joint Commissioning Executive have been working together to identify further joint commissioning opportunities and these are reflected in the document.

Appendices
Appendix 1 – Operating Plan 20181/9 Summary Update
Appendix 2 – DRAFT Commissioning Intentions 2019/20

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BACKGROUND DOCUMENTS: None

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Appendix 1

Operating Plan 2018/19 – Summary Update

September 2018

Longer, healthier lives for
all the people in Croydon

Our Strategic Vision

'Working together to help you live the life you want'

We want people to live longer, healthier lives. Our vision is that local people be supported to look after themselves and those they care for and have access to high quality jointed up physical and mental health and care services when they need them. We want to deliver better health outcomes within our budget.

Our Strategic Context

Croydon CCG, as well as our health and care partners, face significant health and care needs and financial challenges. We are working together, building on the success of the One Croydon Alliance, which previously focused on the over 65's, to deliver whole system transformation for the whole population.

Our Strategic Transformation Programmes

The existing models of care is disproportionately provided in the acute setting. This culminates in an unaffordable health and social care system for Croydon. The outcomes people want are to be supported to self manage, prevent admissions and have appropriate community provision that meets their needs.

Our transformation health and programmes have been focusing on addressing this shift and the delivery of **Strategic Review** recommendation to develop care models to reduce non elective care

Our Operating Plan 2018/19

Our Operating plan sets out the annual implementation plans to deliver the transformation we need to see as well as national, London, South West London and other local priorities.

Operating Plan Key Highlights (1)

- **Transformation of Out of Hospital**: Strategic aim: To increase preventative and proactive care through better delivery of integrated care across health, social care, mental health and voluntary sector services
  - Delivered the roll out of the huddles, and implemented the LIFE team.
  - On target to achieve - plans for rolling out discharge to access for complex patients; completion of the integrated Care Network implementation; implementation of enhanced end of life services and implementation of community IV antibiotics
  - Phase 2 of the out of hospital business case has been agreed; Care Homes - which includes the development of telehealth; End of Life Care - which includes proactive advanced care planning in care homes, end of life huddles, end of life care front door model and expanded end of life care community engagement; Falls Service - which includes early detection, promoting healthy living in the over 65's, expanded falls service
- **Urgent and Emergency Care**: Strategic aim: To deliver a functionally integrated 24/7 Urgent Care service for Croydon and to deliver high quality, clinical assessment, advice and treatment with all services having access to patient records.
  - Have implemented 111 electronic booked appointments for urgent care services
  - Working to – implement an improvement plan for Type 1 (Emergency Department) attendance
  - Future work needed to redirect activity from Emergency Department to the Urgent Care Centre and to GP hubs and primary care

Operating Plan Key Highlights (2)

- **Transformation of Planned Care:** Strategic aim: To transform local healthcare by introducing new pathways and models of care, whilst promoting and embedding behaviour and cultural change across patients, public, and clinical workforce
    - Planned care business case signed off which will revise nine patient pathways
    - On target to commission a new primary care base MSK service and pilot an integrated community dermatology service
    - Future work is needed to progress some of the pathway changes
- **Together for Health and Care:** Strategic aim: To support people to become active citizens in managing their own health and care ensuring that individuals remain healthier for longer. People can make informed decisions about their health and social care including decisions they make around lifestyle factors that may be impacting on diseases and conditions that they may have or be at risk of developing
    - On target to - scale up social prescribing and developing the community resource through a Local Voluntary Partnership (LVP); rollout diabetes group consultations; implement an Expert Patients Programme; and further develop the Health Help Now app

Operating Plan Key Highlights (3)

- **Mental Health:** Strategic aim: To prevent mental health problems and to ensure early intervention for those with mental illness, through improved access to services , and care provided closer to home where appropriate
  - Implemented 'CATCAR' ensuring ambulances have a mental health nurse, and Core 24 to reduce unnecessary admissions to A&E
  - On target to – complete the mental health community services review; implement an enhanced primary care service to enable GPs to better manage mental health in primary care; mobilise the re procured forensics pathway; and implement the enhanced memory service pathway
  - Further work is needed to reduce delayed discharges, create bed capacity and improve system flow
- **Learning Disabilities:** Strategic aim: To support more people with a learning disability can live in the community, with the right support, and close to home by making health and care services better
  - On target to – implement Annual Health checks (of LD patients) across all GPs in Croydon; develop the market through the stimulation of new LD service providers in Croydon evidenced by the emergence of new LD providers with whom Croydon CCG can contract services
- **Children and Young People:** Strategic aim: To improve the health outcomes for children and young people through prevention and self care and improve families experience through more effective diagnosis and care of long term conditions
  - On target to - implement agreed information, advice and guidance initiatives for GPs; and develop LAC CAMHS pathway (in place during 2019/20)
  - Future work is underway to achieve the target for LAC health assessments

Operating Plan Key Highlights (4)

- **Primary Care:** Strategic aim: To develop primary care at scale to provide a consistent quality service to residents of Croydon. Working to transform primary care in line with the London Strategic Commissioning Framework, the GP forward view, and the 10 high impact actions
    - On target to – complete GP extended access; rollout of on line consultations; complete a review of locally commission services in primary care, re-procure Edridge Road GP practice
    - Implementing a programme for GPs to work at scale to manage a population health network based approach (circa 40,000 - 60,000 people)
- **Medicines Optimisation:** Strategic aim: To ensure that patients get best quality and value from the investment in medicines made by the CCG and the wider NHS.
    - On target to – launch the prescribing incentive scheme, implement national recommendations for 'over the counter' medicines

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Appendix 2

DRAFT

Commissioning Intentions

2019/20

Version 12

Longer, healthier lives for
all the people in Croydon

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CONTENTS	Slide number

Context: General

Local context

The CCG is required to give service providers six months' notice of significant contractual service changes; therefore, for changes to take effect from 1 April 2019, the CCG must inform providers of its commissioning intentions by the end of September 2018. Whilst subsequently notified service changes are not precluded, the 1 October 2018 deadline is best practice in the NHS planning guidance so that changes to contracts can be negotiated by 31 March 2019.This paper sets out the CCG's local commissioning intentions for 2019/20 (currently draft)

- Partners have been on a journey to sustainably transform health and care services in Croydon. The One Croydon Alliance, formed in April 2017, created a step change in how partners work together to achieve this. The initial focus of the One Croydon Alliance was people aged over 65; however in April 2018 the Alliance agreed to build on the approach and extend the One Croydon Alliance Agreement for a further nine years and extend its scope to the whole population. This is the foundation for an Integrated Care System for Croydon and sets a context for changes in what and how services are commissioned.
- Our local commissioning intentions for 2019/20 in the main continue the implementation of our current health and care transformation plans
- Also, over the past few months, The Croydon Transformation Board has been developing the One Croydon five year Transformation Health and Care Plan which sets out the ambition for system wide, whole population transformation of health and care. These commissioning intentions reflect the emerging plans and these will continue to develop over the next few months.
- Further work is being undertaken during September including:
    - Continued work with the Local Authority to further develop joint commissioning plans
    - The further development of the Croydon Transformation Plan
    - The development of transformation business cases

Wider context

- These local commissioning intentions support the implementation of national, London and South West London priorities
- We are awaiting national planning and contracting guidance which will further influence or commissioning intentions.

Context: One Croydon

Our plans focus on keeping people well, and ensuring people are supported in the home and in the community rather than hospital wherever appropriate. We aim to improve health outcomes and ensure an affordable system.

Take a whole system, whole population approach
We have shown we can make a difference by working in an alliance partnership to support people in the borough who are over 65. Over the next five years we will build on this approach extending the scope of the Alliance to the whole population.

Change needs to start with our local experts. Our health and care professionals working differently together, and led by the Croydon Professional Cabinet, will define our priorities, encourage new and innovative approaches amongst the borough's wealth of professionals and make the difference for local people. From consultants to health care assistants, social workers to public health experts, GPs to practice nurses our professionals will transform local care.

Address the wider determinants of health
The greatest impact on health comes from the wider determinants of health, from housing to education, income to employment. As a partnership, we need to tackle these challenges together. This is supported by the Council looking to take a more preventative and proactive approach – working with residents and communities to stop issues becoming problems; working with partners to make sure services are meeting the needs of residents in a joined up way; and delivering the right services closer to where people live, in their neighbourhoods.

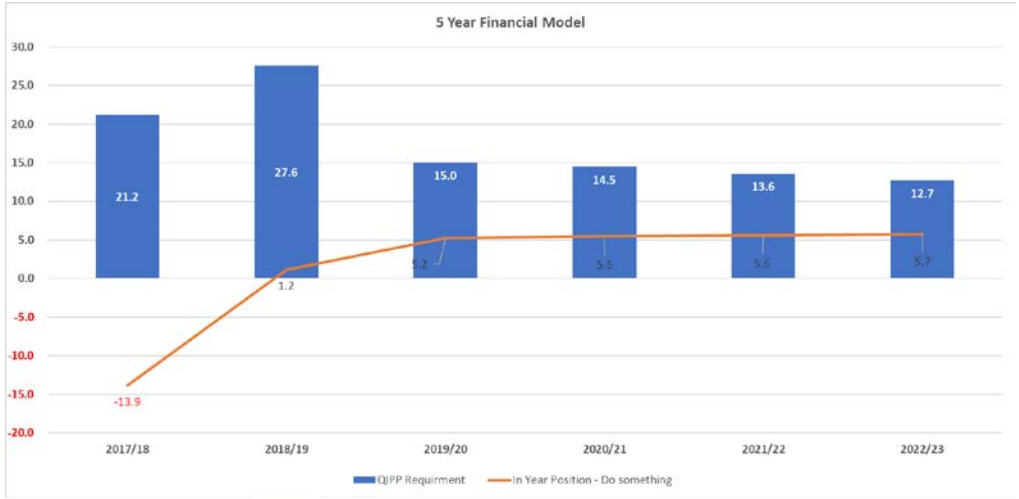
Prevent issues becoming problems
We will help people stay fit and healthy. We will help them stay in control and to live the lives they want. If people do need support we will help them access that support whether it's a group in their community or health and care services. We will help people manage their health and well being as best they can. We will aim to design services to identify issues early on and target support on promoting independence and delivering long-term sustainable solutions.

Take a locality approach
We want to keep people well and out of hospital. Making sure local people have access to services, closer to home, wherever they live in the borough. Services must be accessible and responsive to their individual needs.

Unlock the power of communities
The key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities. Social prescribing is a way of supporting people to use all of the resources within their community. Working with the strong voluntary sector in our borough to connect local people to be part of broader support networks so that local people can take back control of their own well-being.

Context: CCG Finance

- For 2019/20, the CCG intends to be in compliance with NHS Business Rules of a 1% recurrent surplus; as a step towards this goal we will deliver a £1.2m surplus in 2018/19 after delivering £27.6m (5%) QIPP savings. As at M4 of 2018/19, whilst the CCG is forecasting delivery there is risk to the delivery of the QIPP programme.
- The planned surplus in 2019/20 is £5.2m underpinned by a £15m QIPP programme. Any slippage to the planned delivery of recurrent savings in 2018/19 will impact on the exit run rate into 2019/20 and put additional pressure on the QIPP challenge.
- The key areas of risk are around:
  - Slippage on planned care transformation
  - Slippage on Mental Health care transformation – slippage into 2019/20
  - Slippage on Out of Hospital Phase 2 transformation – slippage into 2019/20
- By 2022/23 (five years), the Croydon system will have repaid £23.2m of the historic deficit.



Context: QIPP schemes

QIPP Strategy

- The 2018/19 QIPP target of £27.6m is fully identified against specific scheme
- The QIPP efficiency challenge has been assessed for the next 5 years (circa £15m / 2.4% pa)
- Service level financial targets for 2019/20 have been finalised; planning of quality improvements to obtain these is ongoing
- Detailed benchmarking of acute service expenditure will be completed in September 2018, which will inform our plans further

Governance

Programme Boards provide oversight, advice and guidance to QIPP projects as well as their own project level steering groups (where they exist). QOB scrutinises performance of the projects.

- QIPP delivery is robustly governed by the QIPP Operational Board (QOB) chaired by Medical Director. Each programme reports monthly
- Deloitte audited 'QIPP readiness' for 2018/19 in Dec 2017 as GREEN
- 2018/19 financial plan, including QIPP, has been assured and signed off by NHS England
- Internal audit review currently underway

Joint Commissioning opportunities: CCG and Croydon Council

The CCG and Croydon Council both commission services that provide important support, treatment and care to people when they are unwell, but also help to prevent challenges and enable people to understand and manage their condition. Joint Commissioning is about the NHS and the Council more effectively planning and commissioning service provision and using the money we spend on these services in a more co-ordinated way.

We jointly commission a number of services. We are reviewing how we can improve on some of this including:

- Children's Services and early help
- Mental Health, Substance misuse and Domestic Violence
- Learning Disabilities
- Better Care Fund
- Market management

Future joint commissioning opportunities are detailed under each programme area. Financial mapping will also be developed to show spend across each programme area

Procurement

Recently published NHS plans enable organisations to work together through STPs to develop system wide plans that reconcile and explain how providers and commissioners will collaborate to improve services and manage their collective budgets.

Croydon has a 10 year alliance agreement across both health and social care which is intended to support the system wide working and the establishment of an integrated care system (ICS).

The CCG will consider its procurement plan in the future that supports and accelerates the NHS policy shift and aligns where possible with council plans for interrelated services.

Planned Care

Aim: To transform local healthcare by introducing new pathways and models of care, whilst promoting and embedding behaviour and cultural change across patients, public, and clinical workforce.

The CCG's are committed to work with local partners and SWL to deliver effective elective care pathways that deliver system efficiencies. Specifically, to transform the way in which out-patients are delivered embracing innovative modalities and reducing unnecessary face-to-face contacts in secondary care. We will commission end to end integrated pathways across different care settings.

- **Constitutional Requirements** - Manage and support delivery of Planned Care/LTC CCG constitution requirements and operating plan targets; e.g., RTT, Cancer.
- **Rightcare/IAF** - Explore and prioritise Rightcare/IAF opportunities that support improvements in quality outcomes and efficiencies.
- **Demand Management** - Support demand management initiatives across Primary and secondary care.
- **New models of Care** - Develop new models of care across a range of planned care and long term conditions, namely; Cardiology, Respiratory, Ophthalmology and T&O. This will including reviewing benchmarking data, demand management and quality outcomes information to inform priorities and future models of care.
- **Repatriation** - We will work with partners to explore Repatriation opportunities across a range of specialities thereby providing more care in Croydon
- **Commissioning/Contracting** - New models of care will inform future commissioning and contracting arrangements across a range of services.
- **New Pathways** - Implement new models of care/pathways agreed in 2018-19 for ENT, Gastro, Gynaecology, MSK, Dermatology, Anticoagulation and Diabetes and weight management.
- **Self Care/ self management** - Develop self care and self management initiatives across planned care/LTC for Croydon people.

The impact of these intentions is as follows:

- Reduction in hospital based Outpatient first and follow-up attendances and procedures through a different delivery model
- Repatriation of outpatient activity to primary care and community care
- Reduction in elective and non-elective activity

Joint commissioning opportunities

- Repatriation – council also wishes to provide more services locally
- Self care / self management

Out of Hospital

Aim: To increase preventative and proactive care through better delivery of integrated care across health (acute and community services), social care, mental health and voluntary sector services.

Relevant providers: Specialist palliative care services (St Christopher's Hospice), Community Intermediate Care Service (CICS) and Rapid Response – both CHS, Personal Independence Coordinators (PICs) contract with Age UK Croydon, End of Life Care outreach training and community engagement programmes, palliative night service (Marie Curie)

Impact on providers: Shift from reactive to proactive care, which will deliver a shift of activity from acute to community, primary care and self care. Reduce non-elective admissions, reduce A&E attendances, reduce acute average length of stay, reduce pressures on General Practice.

Intentions we will definitely deliver (Pathway redesign and service transformation (with investment):

- Joint commissioning strategy for care home beds between the Local Authority and the CCG
- End of Life Care pathway will be reviewed and may provide further transformation opportunities – additional palliative care capacity in a 'front door admission avoidance model' (A&E/AMU/RAMU)
- Expand and roll out social prescribing, Voluntary groups and community based groups as part of Local Voluntary Partnerships programme
- Expand Otago exercise programme offer, transform Integrated Falls Service to include community bone health nurses for community falls clinics, expand Age UK home advice and modification service
- Wheelchairs service to be part of integrated equipment service model provided by the Local Authority (in-house by CES)
- Awareness campaigns for both falls risks and end of life care community engagement
- Workforce development and education programme for care home staff to increase the skill level in the market
- Reconfigured & coordinated specialist support – the Complex Care Support Team
- Continued implementation of the Integrated Community Networks (ICNs) and the LIFE (Living Independently for Everyone) team
- Rollout of the Red bag scheme
- Inequalities: By transforming services to move activity into the community and away from the acute, we will improve access and allow services to be more responsive to the needs of their local community

Intentions we would like to deliver

- Telemedicine solution in care homes in a new commissioned service
- Scoping: Community Stroke Rehab, Occupational Therapies led Falls Rapid response pilot; Community IV Antibiotics and Fluid dedicated service – viability study being run
- Digitalisation of care planning for care homes supported by the Healthy London Partnership & SWL STP
- Transformed continence service, incorporating primary care integration, bowel & urine management
- Drugs and alcohol misuse admission avoidance team to be based in the ED
- Dementia advisors to target falls risks

Joint commissioning opportunities

- Joint commissioning strategy for care home beds between the Local Authority and the CCG should aim to provide more preventative services
- Expand and roll out social prescribing
- Wheelchairs service to be part of integrated equipment service model provided by the Local Authority (in-house by CES)
- Workforce development and education programme for care home staff to increase the skill level in the market
- Dementia work
- Joint commissioning of the voluntary sector
- Council commissioning of respite care

Urgent Care

Aim: To deliver a functionally integrated 24/7 Urgent Care service for Croydon, providing public access to the right treatment, in the right place, first time. This service will include NHS 111, GP Out of Hours, Urgent Care Centres, community services, ambulance services, social care and emergency departments. To collaborate to deliver high quality, clinical assessment, advice and treatment with all services having access to patient records.

Relevant providers: CUCA (GP OOH, UCC, GP Hubs, GP extended access); CUH (relevant services); Social services; Ambulance services; SLAM; Voluntary sector (Age UK etc.)
Impact on providers: Shift from reactive to proactive care, which will deliver a shift of activity from acute (appropriate urgent care attendances) to community, primary care (e.g., more booked GP hub appointments) and self care. Reduced demand on ambulances (as part of the alternative care pathways)

Intentions we will definitely deliver

- Integrated UTC through the implementation of the CUCA governance model, which will enable, flexibility to meet surges in demand, and a single point of access for patients
- Provision of acute frailty service to ED of 70 hours a week
- Extended AEC to 12hrs / 7 days per week by September 2019 (business case is due by end of December 2018)
- Supporting pathway redesign to facilitate delivery of outcomes aligned with the CUCA (Croydon Urgent Care Alliance) contract and the ambition to extend the contract with CUCA/CHS (e.g., GP Hub bookable appointments; improve streaming and redirection)
- Establish new AEDB governance structure (A&E Delivery Board) with five new groups (i.e., Emergency Care Board, Demand Management, System & Flow, Mental Health in ED, and Out of Hospital) to support operational delivery alongside a shift to undertaking more transformation activities to improve performance through pathway redesign at CUH
- Deliver and sustain the 95% A&E 4 hour standard
- Data analysis to understand the health inequalities across communities and to consequently develop a robust strategic plan to address them

Intentions we would like to deliver

- Alignment of pathways with NHS 111 including NHS 111 Online with CUCA, which will include, supporting a phone first policy to better manage demand.
- Review, redesign and development of improved ED pathways to support effective and efficient working in the new ED due to be opened by end of November 2018.
- Rapid response to care homes
- A & E Falls out-reach

Key success criteria

- Effective alignment with Primary Care Extended Access provision, reducing use of urgent care services for primary care needs.
- Mature Care Closer to Home model and amplifying High Impact Changes, as a means to improve flow through the system, thereby reducing bed occupancy and escalation usage, and positively impacting system performance at the front door.
- Reduced attendance at, and admission to, hospital to support flow, including focus on minimising avoidable admissions.
- Patient focussed ambulance response (i.e., conveyance based on right care, right place and right time based on patient need, not just to A&E), including development of new ACPs, and improved utilisation of ACPs and improved ambulance handover to support more efficient use of LAS resources

Joint commissioning opportunities

- Street Homelessness – effective prevention to reduce Emergency admissions
- Substance misuse – reduce and prevent SM patients in ED
- DTOCS – improving discharge, releasing both acute and mental health beds
- Prevention and early help
- Care for vulnerable people

Primary Care

Aim: To develop General practice to provide a more resilient and sustainable service and to provide a consistent quality service to residents of Croydon. Working to deliver transformed general practice in line with the London Strategic Commissioning Framework, the GP Forward View, the Croydon Out of Hours strategy 2016/17 to 2020/21, and the 10 High Impact Actions.

Relevant providers: General practices; community pharmacy; 3rd sector; community services
Impact on providers: Redistribution of workload across general practice and primary care, and improve job satisfaction, staff retention and staff rates of attrition

Intentions we will definitely deliver

- Delivery of primary care initiatives to support reductions in acute activity, and improvements in quality and patient experience
- Efficiency through joint working of all key stakeholder provider organisations
- Review Enhanced access delivery (by recommissioning a streamlined service – a single provider) to improve patient access and experience
- A full review of all 14 Locally Commissioned Services (LCS), and Practice Development and Delivery Scheme (PDDS) is taking place with changes being developed:
    - Locally Commissioned Services aligned to 8 clinical strategic priorities of Planned Care (Cardiology, Respiratory, Ophtahlmology, T&O, Gynaecology, Dermatology, Diabetes, and Gastro)
    - Revised Practice Development and Delivery Scheme will streamline care planning
- Development of **Working at Scale** plans across General Practice:
    - Development of network plans 0 to 2 years – working at scale plans to deliver a population health / patient need, which will include a review and revision of the current set of CCG network groupings with the aim of basing them on population / patient need
    - Integrated Model of Care to include, for example mental health, secondary care, pharmacists, etc.
    - Workforce development to deploy skilled and specialist nurses where they are needed most to maximise high quality patient care
    - Infrastructure: ensuring the necessary infrastructure is in place including the role of the Croydon GP Collaborative.
    - MDT development to co-ordinate the planning and streamlining of the treatment of patients
- Reducing health inequalities through the implementation of working at scale and other primary care initiatives

Joint commissioning opportunities

- Focus on localities
- Enhanced primary car eservices
- Population health work
- Pharmaceutical needs
- Reducing health inequalities
- Health checks, LD checks

Mental Health

Aim: To prevent and reduce mental health problems and to ensure early intervention for those with mental illness, through improved access to services , and care provided closer to home where appropriate, in line with the Mental Health Forward View

Relevant providers: SLAM; MIND; CUH; GP Hubs; Ambulance service
Impact on providers:
Reduced number of Mental Health related attends in A&E; Reduced OBDs for MH patients; reduced ALOS for MH patients

Intentions we will definitely deliver

- Implementing the 5 year forward view through new models of care for Mental Health, starting with a review of community services:
  - Connecting communities – information, social prescribing directory of services to galvanise communities; recruitment of Personal Independent Co-ordinators to support the aims
  - Enhanced Primary care – Improved telephone advice, primary care mental health support workers (recruited by the end of March 2019); tackle stigma of mental health care; recruitment and retention
  - Community mental health hubs created and strategically located to provide a wide range of services provided at hubs, linked to Integrated Care networks, as part of the prevention and avoidance agenda

- Reducing Delayed Transfers of Care, and Long Stays through the Multi Agency Discharge event (MADE project) and ongoing review
- Improved Crisis care pathway to be designed by the CCG in partnership with the Local Authority, CUH and SLAM, to reduce MH patients in ED
- Achievement of the national access rate target for IAPT
- Compliance with the CCGs public equality duties through the rigor of the Joint Impact Assessment process for all services
- Achieve the national access rate for IAPT

Intentions we also want to deliver

- OBD Risk Share and release of cashable savings for community service re-investment
- Integrated housing - work with housing to develop housing support options e.g. The Shared Lives Scheme, develop Crisis Planning

Joint commissioning opportunities

- Connecting communities – information, social prescribing directory of services to galvanise communities
- Tackle stigma of mental health care
- Improved Crisis care pathway to be designed by the CCG in partnership with the Local Authority, CUH and SLAM, to reduce MH patients in ED
- Integrated housing - work with housing to develop housing support options e.g. The Shared Lives Scheme, develop Crisis Planning
- Development of community hubs
- Related substance misuse services
- Street Homelessness – effective prevention to reduce Emergency admissions
- Joint commissioning of the voluntary sector

Learning Disabilities

Aim: To support people with a learning disability to live in the community, with the right support, and close to home by making health and care services better, and to prevent people dying prematurely through preventable conditions

Relevant providers: CHS CTLD (Community Learning Disability Team); Specialist LD team in SLAM; Specialist inpatients (spot purchase); Continuing Healthcare (spot purchase)
Impact on providers: Increased demand (through lowering of age group of patient cohort); different models of care delivery; preventing inpatient admissions

Intentions we will definitely deliver

- Move from institutional care
- Review CTLD activity level in SLA around therapies pathway and resources for speech and language and physio for young people with learning disability and physical issues; for example, altered physiology, posture care with a view to securing additional resource – the main aim being to reduce premature death
- Proposal of an additional post in the CTLD for primary care liaison to support delivery on Annual Health checks and Health Action plans (to support GPS with LD work)
- Development of local care crisis service / building for people with complex needs, so that people stay in the community, including services for challenging behaviour
- Business case signed off by end of November 2018 (based on CYP workshop) that identifies the need for behaviour support pathway for people aged 14+ with LD and autism, leading to Community Crisis support for people with complex LD and autism in Croydon rather than being placed out of area
- Market development to stimulate new providers in Croydon regarding accommodation and support for people with complex needs / LD / Autism, in partnership with Croydon Council and SW London transforming care.
- Reduced inequalities of health through
    - the commissioning of specialist posts working alongside mainstream services
    - Annual Health checks and Health Action Plans will be a key driver in reducing health inequalities
    - MH LD specialist services

Joint commissioning opportunities

- Development of local care crisis service / crisis house for people with complex needs, so that people stay in the community
- Market development to stimulate new providers in Croydon regarding accommodation and support for people with complex needs / LD / Autism, in partnership with Croydon Council and SW London transforming care
- Planning for the Cherry Orchard hub
- SEND strategy (Special Educational Needs and Disabilities)

Children's Health

Aim: To improve the health outcomes for children and young people through prevention and self care and improve families experience through more effective diagnosis and care of long term conditions

Relevant providers: CHS (Acute and community)
Impact on providers: Reduced activity in some areas (e.g., A&E Attendance, emergency admission)

- CHS Integrated Paediatric Centre (IPC) model including short stay provision to reduce emergency admissions.
- Other interventions to reduce emergency admissions
- Transform the community services model
- Review and update community service specifications
- Quality improvements in pathways for long term conditions

Children's Mental Health

Relevant providers: SLAM (Eating disorders, Early Intervention in Psychosis community service; CAMHS); Croydon Youth information and Counselling services (Croydon Drop in); Off the Record (open access counselling)
Impact on providers: Increased activity through improving access to MH treatment

- CAMHS transformation plan refresh and developement
- Improve access to Mental Health treatment for CYP achieved through setting an activity target in each contract and a requirement for improved monthly data collection and verification process
- Eating disorders – improved access and waiting times
- To commission Joint contracts between the Council and CCG for open access counselling from April 2019
- To review and revise the SLaM contract service specification to reflect the services delivered
- To set new KPIs and targets for CYPMH with SLaM
- Review and refresh the Neurodevelopmental pathway at SLaM

Joint commissioning opportunities

- Sexual health and substance misuse (Council commissioned; however these need to form part of a joint strategy)
- Commission Joint contracts between the Council and CCG for open access counselling from April 2019
- Early help strategy
- Children's hub
- Children's workforce (e.g., health visitors, school nurses)
- Cherry Orchard disabilities hub
- Safeguarding
- Emotional health, including self harm
- Healthy eating and obesity

Maternity

Aim: To improve safety, access to continuity of carer, choice and personalisation for maternity services, in order to provide improved outcomes, including a reduction in stillbirths and neonatal deaths and improved women's experiences.

Relevant providers: CHS, St George's, Epsom & St Helier; King's College, Surrey & Sussex; Guy's & St Thomas' (main providers account for 98% of activity)

Impact on providers

- Significant organisational development and change management requirements to deliver continuity of carer (caseloading) model
- Increased midwifery time in delivery of the 'Choice conversation' and development of personalised care plans jointly with women.
- GPs fully and positively engaged in facilitating the 'Choice conversation' in support of 'Croydon first'.
- Increased maternity activity within Croydon maternity care service settings
- Shift of activity from obstetrics led births to midwifery led births where appropriate

Intentions we will definitely deliver

- Better Births: Commitment to deliver 'Better Births' national ambitions at SWL and local level, including:
  - Personalisation and Choice: expand information about 'My Maternity Journey' to GPs to enable the facilitation of the choice conversation – the information expansion to include web site for self-referrals and Best Start
  - Safer care: National ambition to significantly reduce stillbirths, neonatal and maternal deaths and brain injuries, with a 50% reduction by 2025
- QIPP development: Early discussions with CHS will be needed to quantify the impact of these applications alongside opportunities for QIPP development
- Reduced inequalities of health across communities achieved through increased access to continuity of carer

Intentions we also want to deliver

- Midwife led birth: Increase the number of births in midwifery-led settings (from obstetric led births) to improve personalisation and choice and to support the continuity of carer model
- Continuity of Carer: NHSE target to achieve 20% of women being booked onto a continuity of carer pathway by March 2019 (increasing to 50% by March 2021).

Joint commissioning opportunities

- Maternal Mental health
- Health visitors review
- Support to vulnerable families
- Teenage pregnancies

Medicines Optimisation

Medicines optimisation is defined as the safe and effective use of medicines, to ensure people obtain the best possible outcomes from their medicines

Aim: To ensure that patients get best quality and value from the investment in medicines made by the CCG and the wider NHS.

Relevant providers: GPs; community Pharmacists; CUH
Impact on providers: Redistribution of medicines related activity across GP, primary care, pharmacy and hospital services. Positive impact will be the development of community pharmacists, following the pharmacy review. Fewer GP attends for minor ailments; fewer unplanned hospital and UCC attendances

Intentions we will definitely deliver

- Increased integrated pharmacy services/pathway across Croydon, which will require a review of all sectors' contribution to Medicines Optimisation, and commissioning changes to current schemes as follows:
  - Following publication on NHS England's guidance on OTC items (March 2018), the current **Minor Ailments Scheme** (MAS) is under review and formal notice will be served by end of September 2018. A new national **Digital Minor Illness Referral Service** is due to be launched in 2019/20, Croydon will be part of the London-wide pilot starting in Q3/4 2018/19 that will inform the service model.
  - The **Do Not Dispense scheme** is being replaced in 18/19; the Bath and North East Somerset (BaNES) waste reduction scheme will be piloted in 18/19 and if successful this will be rolled outed in 2019/20.
  - **Domiciliary Medicines Review Service** will be retained as there is a significant number of community pharmacists that have adopted and continue to provide the service; however, we are researching a viable alternative service as an addition to the DMR for those pharmacies who have not been able to participate in the existing DMR service.
  - Current Care Homes transformation work will review service provision to support Medicines Optimisation in care homes; the business case will be completed by March 2019
  - SW London changes to the model of pharmacist support to the individual funding request process have been proposed. Croydon's Medicines Optimisation team is supporting a six month pilot of the new model in 2018/19.
  - Proposed single SWL Individual Funding Request panel will reduce variations in decision making across the SW London CCGs
  - Higher uptake of services will demonstrate that more residents across Croydon are accessing services

Joint commissioning opportunities

- Current Care Homes transformation work
- Polypharmacy: safe and efficient use of medicines for older people