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Clinical Commissioning Group

Outcomes Based Commissioning for People over 65 years in Croydon
Patient and Public Event held on 24.6.15 at The Studio, Fairfields Hall
(32 attendees)

Croydon CCG and Croydon Council hosted an event for 32 members of the public and local community organisations to share the work to date on the Outcomes Based Commissioning programme for people over the age of 65.

Tony Brzezicki, Chair for the CCG opened the meeting, welcoming people to the event. Paula Swann, CEO for Croydon CCG gave an overview of the programme to date introducing a video from the Kings Fund which set out visually the problems older people are experiencing in accessing a seamless service for health and social care.

The previous engagement work carried out in 2014 was reviewed by Brenda Scanlan, Director for Integrated Commissioning for Croydon Council and explained how feedback had been used in the development of the Outcomes Framework being used in the next phase of the programme and Stephen Warren Director of Commissioning for Croydon CCG shared with the attendees the next steps in development.

A workshop was held to obtain feedback on the work to date and a lively discussion was held to establish what a successful model of care would look like and any questions that it raised.

A summary of the themes from the event is detailed below and Appendix A shows the feedback gained from the event.

Summary of Themes - Public Event 24.6.15

The themes emerging from the public event are typically issues that are recognised as problems that need addressing when focusing on integration of services. The same issues are highlighted as elements that are missing, areas that indicate success, areas for concern and possible problems. The main themes are as follows (in no particular order):

Staffing – feedback identifies the need for more, qualified and trained staff that are also able to recognise an individual's needs across a range of areas e.g. mental health, support needs, equipment needs, care needs social needs etc. This area is identified as a possible concern that is likely to impact on the success of the project model.

Communication – this is highlighted as key to the success of the project and to ensuring the services are delivered smoothly and efficiently and covers communication with the patient as well as carers, voluntary organisations and between providers.

Service Monitoring – this is mentioned a number of times as an area that is essential for the project to ensure service delivery is consistent and meets the standards required. Feedback suggests this needs to be included within contracts with a clear description of what it will include e.g. focus groups, surveys,

mystery shopping etc.), when and who is responsible for undertaking it. Particular concerns are raised with regards who will undertake the monitoring of contracts and service delivery.

Single Point of Access – feedback suggest that a central location or site would be of value to provide centralised information and signposting whilst also potentially offering a single point of contact.

Continuity – this relates to continuity of care and of staff and is considered a possible problem with the model. This can impact on effectiveness of services, communication and integration.

Data Sharing – whilst the feedback highlights the importance of having robust data sharing systems in place, with mentions of online health records, there are also concerns about data protection and confidentiality that sit alongside this and need careful consideration.

Accountability – comments highlight this as an area in which patients and public require more information. At present the feedback seems to imply there is a lack of clarity of who (individuals/organisations) is accountable and there are concerns that this needs to be robustly addressed in contracts.

Integration – whilst not specifically mentioned frequently, many of the previous themes relate to this area. Feedback indicates that there is a real need to ensure all services including social and health care, hospital and community, voluntary and other providers understand and address the need for full and comprehensive integration.

Use of Technology – feedback is generally positive towards the benefits of increasing use of different and new technologies to ensure services work together and that patients get the care and support they need and highlight in particular the advantages of technology used for improving communications and emergency solutions. However there are concerns regarding the reduction in face-to-face experiences and the potential increase in social isolation amongst the core target group of patients, which is already an issue for many

Social and Community Activities – there are a number of comments regarding the need to ensure the model covers provision of social prescribing to address social isolation and recognise the benefits of this type of activities.

Involvement - feedback highlights the importance of involving and using the voluntary sector from the outset as they are considered key to delivering care and support to the target group of patients and carers. In addition there are mentions of the role that pharmacists play and the less publicised domiciliary service they provide.

In addition to the themes outlined above, further concerns are raised over the **proposed contract length** of ten years, with feedback indicating this is too long and what clauses will be in place if the model does not work or if there are problems. Suggestions include the possibility of shadowing the service for year 1 and also to introduce a renewal after 5 years. Feedback also highlights concerns relating to the potentially changing political landscape and how this will impact on the model in the future.

APPENDIX A

Outcomes Based Commissioning for People over 65 - Patient and Public Feedback

Public Event held on 24.6.15 at The Studio, Fairfields Hall - *32 attendees*

Has what we said explained what we've done so far	What questions does this raise	Is there anything missing from the outcomes that you would like to see
The idea is great and makes sense.	There will need to be **partnership** between patients and health care professionals to trust each other. **Confidentially** issues as sharing data between services. If people are going to stay at home, **adaptations in the home** need to be done effectively. **Good communication** as they will see £170m already spent and still patients are not getting care. **Staffing levels** – enough **qualified staff** to cover. Carers say that previously there were more appropriate places to send people which no longer exist.	**Pharmacists** – they do a domiciliary service but this is not widely known. For Self care management Needs to be **an indicator** to **ensure uniform service delivery**. This will empower both the pharmacist and patient. Pharmacists still refer back to the GP for minor ailments.
Yes	What about **private services**? Will all services be put on the **one contract**? More services now outsourced to private services – **once they have contract will they put in shortcuts?** What monitors will there be? Will there be **mystery shopper surveys** in the contracts?	Would like to see a **proper safeguarding mechanism** built in. How do you find people who have **fallen out of the system?** Older person at home, needing help- unable to contact/ask for help? **Trained people** with broader skills to recognise needs Need to ensure **mental health/dementia** taken into account. Outcomes are fine – it's how translated into delivery, how vulnerable are recognised and supported. Need a **central information hub**.

Yes, get this to the PPGs, to get them on board – lack of knowledge at this level.	**Accountability** Lead carer/**tackling inequalities** Skills	**Continuity of Care** Effective **care management** Effective **discharge planning**
	What is the whole budget? Does this include **increasing staff?** What happens if people need a series of tests? Are the **GPs on board**? Who will do the assessments?	

What would a really successful model look like?	What would people be saying about it?	What are your concerns about the new model?	What could go wrong?
Being able to connect people (carers/GPs/Staff) – **Care plans** drawn up every year, time to develop and updated regularly. **'One Stop Shop'** where people can have everything done in one place - **Single point of access** to get help and advice (care/case worker) - People knowing what is happening to them and who is dealing with them. **Voluntary Sector** involved at the outset through signposting - **Communication** between agencies. **Ease of transfer** from hospital to community based services. **Face to face service** **Integration** of old and young people The whole wellbeing of the person is covered.	Able to lead active lives **Easy access** to services I'm **listened to – respected and acknowledged**.	**Data protection** is a sensitive issue, especially for the mentally ill. Electronic mail **reducing the face to face** element. **Population growth** outstripping available resources - Service not reaching 'hard to reach' Lack of **trained staff** Lack of co-ordination - Lack of **continuity** of seeing same person Raising expectations - Pressure on the system Can all organisations work together - **Continuity of care** - 24 hour acute sector against non 24 hour community service	**Breakdown in communication** due to lack/continual change in staff. **Electronic mail** – older people not being able to cope Passing buck to other agencies and **no-one taking responsibility.** **Government changing** and bringing in new models.
More than one person providing services to the individual. Everyone trained to spot a person's difficulties, particular mental health, including eg., cleaner, meals on wheels –	Contact and support connectivity **Best possible health in place I choose**	Change in technology may be difficult for this GP of people and could decrease physical contact.	Contractor unclear about what's needed or find loopholes. Alliance could fall out.

ringing in to find out how people are – phone calls, checks. **Continuity** **Accessible – home adapted**. Services talk to each other, info shared. **Activities that keep people connected**. Community activities (to minor things they do for kids) Probus: monthly lunches, trips, look out for each other **Social isolation** is critical. Social pursuits to suit eg., sports for some, lunch, chat. **Technology** means discussions could be through TV etc. Emergency buttons/ alarms more extensive use.		**Funding could run out** – more people, more retiring. **Need same person** – not lots of different unknown people **Volunteers** – self funded but schemes could be under threat – **increased demands** on volunteers. Need the right supervision, need to be appropriately skilled. **Ethical issues, info, governance**. Technology could increase **social isolation** – reduce physical visits.	
Signposting – holistic care coordinator – personal. Working with the **voluntary sector** – befriends and thus maintaining independence/pastoral care ECG/appts – 24hrs use of **technology**, Health records on line. Shared records IT smartcards. Remote consultation Skype **Reducing isolation,** being part of community and social prescribing, flexible support. Dedicated nurse and practice. Use **pharmacists** more. Skilled carers and **continuity of personnel.** Personal and accountable		10 year contract – needs clauses to ensure **accountability** – legal advice. Piloting Size of contract an ask? **Piloting,** shadowing in the first year. Accountability – need robust contract **Checks and Balances**	Picks easy hanging fruit but not the socially isolated.

24/7 outpatients. **Good access to local care** – diagnostic services. Smaller hospitals – minor accidents **Joined care -** Convalescent care **Shorter well-managed waiting lists** Immediate care **No buck passing**	**Informed**	Too expensive and ambitious. Getting out of non-expensive contract if necessary **Politics change** Depersonalised **Lack of trained staff -** Solo working **Change of technology** **Lack of continuity** and commitment **10 year contract too long** – what are the guarantees/safety nets? **What happens if money runs out** – who is **accountable** Who reviews how well it is doing. Who inspects the alliance – is there an external audit?	Not monitored properly. Greed **– profit making**
CPNs aligned with GPs **Less unnecessary admissions to hospital.** **Voluntary Sector** and volunteers felt important in the programme. Health professionals in the community seeing where they can make improvements. **Access to care 24/7 - No buck passing** No fragmentation No waiting lists **Social and health care working together**	**Patients feel in control** - Not just pushed into services. **People have choice** in who they see **Feel informed** and empowered to care for own health - Feel **part of the conversation**	**Organisations** not incentivised to **work together** now – will **preventative measures be put in**? D/S and H/V are overstretch already – what will be put in place for this? **GPs** can cope with any **further pressures** put on them – **recruitment** of GPs **Change of government** and policy. **Will lessons be learned** from the past. Is it too top-heavy with administration?	10 year contract – **too expensive to maintain** Risk of silo working – measures not put in place Greed if providers are included that are **'not for profit'** **Lack of continuity of care**.

Comments Received from a Participant by email after the event	
10 year contracts are too long – 5 year renewal dates focus corporate minds Full range of quality tools should be employed to make sure quality is not only being given but improving and should be signed up to as part of contract – focus groups, surveys, mystery shoppers. Regular review meetings, dealing with whistle blowers	As budgets allow and by negotiation with contractors, new technology is incorporated into the existing contract.