Outcomes Based Commissioning

Improving the health and independence of older people in Croydon

Purpose of this meeting

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1. To review why we're looking at these services
2. To share what we've done so far and how the views of the public, patients and carers helped shape the outcomes of future health and care for people over 65
3. To discuss the outcomes framework and what is happening in this final phase

Why are we doing this?

Our vision is that people should experience **well co-ordinated care and support** which is **truly person-centred** and **helps people to maintain their independence into later life**

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Just to recap: the challenges

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- **Croydon has both a growing and ageing population:** over the next five years, the number of people over 65 living in Croydon will have grown by 10%

- **Increasing numbers of people are living with long-term conditions:** these include conditions such as diabetes, heart, and lung conditions

- **There is potential for Croydon to improve its performance in terms of care for people over 65:** this includes a higher rate of admissions, emergency admissions, and emergency readmissions to hospital

Outcomes based commissioning

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- **New approach to commissioning** where success is measured by results (the outcomes) that matter to people using the services, not by the number of people seen
- **People have more influence** over how their healthcare is delivered by helping to shape the outcomes
- **People using the services are at the centre** of how things are done
- The patient/service user's journey will be more joined up, **improving their experience of care**

Potential benefits

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- Services are designed to meet the needs of those using the services
- Services are focused on outcomes that are important to patients/service users/carers
- Greater individual and community involvement
- Greater emphasis on prevention and self care
- Improved experience through greater service integration
- Services improved through greater innovation and collaboration

Joined up care

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Watch Sam's story

https://youtu.be/3Fd-S66Nqio

Key phases of our OBC programme

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Phase 1: We looked at why we needed to change

Phase 2: We started to design what it looked like, with support from all our stakeholders

Phase 3: We're starting discussions with providers to explore the future delivery model

The journey so far

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Literature Review

- Looked at best practice care internationally
- Four themes were identified
- Themes were then used in engagement events

Events & 1:1 interviews

- Feedback, data and statements collated from events (400 patients/carers, public + clinicians, practitioners across health and social care)
- Four high level outcomes generated
- Data used to develop first draft of outcome goals

Working Groups

- Volunteers from the public events, clinicians and practitioners
- Tested and further developed the outcome goals
- Developed potential indicators

Developing the framework

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High Level Outcomes

- ‘Statements developed with local people, clinicians and the third sector

Outcome Goals

- Statements that give more definition to the high level outcomes

Outcome Indicators

- Set of indicators that clearly show whether the outcomes have been met

Incentivised Indicators

- Specific set of indicators that will form part of the contract for the services commissioned

Draft outcomes from phase 2

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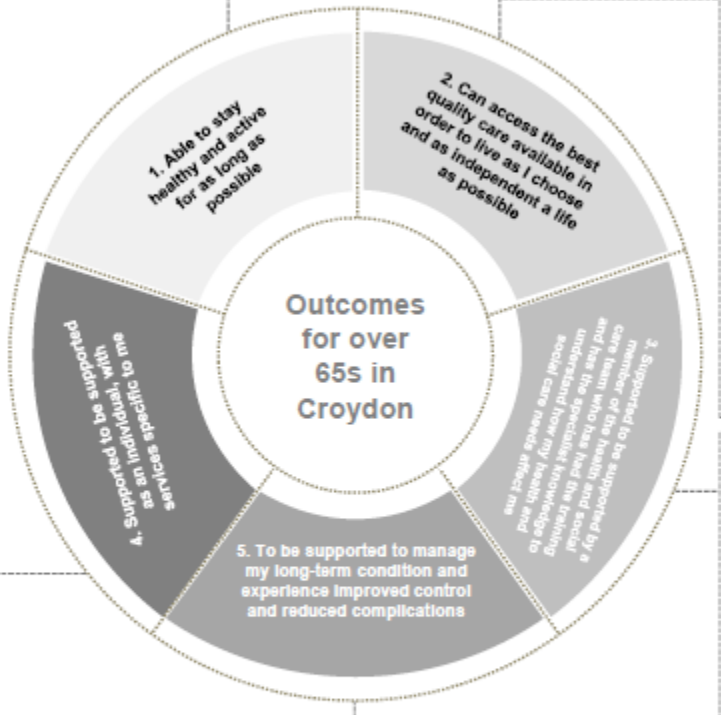
- Manage memory loss & dementia
- Eat well and keep active from a younger age
- Access information, that is consistent, in a format that is accessible and understandable to me
- Expect and access proactive and preventative care
- Feel that my wider social networks [including faith groups] are involved and supported to help me stay well
- Feel that I and my family are supported to help me stay well
- Access appropriate choices about services
- Have equality of access to services regardless of where I live and my financial status
- Live as active a life as possible
- Live as sociable a life as desired
- Plan for old age - Practically e.g. finances, personal care
- Expect and have access to proactive and preventative care

- Expect care from the right person at the right time in the right place
- Expect consistency of care between providers
- Access information, that is consistent, in a format that is accessible and understandable to me
- Expect integrated and co-ordinated healthcare, social care and voluntary sector involvement
- Expect that the care I receive will be safe
- Expect my feedback will be listened to and effect change where appropriate
- Expect to be respected as a whole person (holistically) and not a single condition including social, cultural and psychological aspects
- Experience care that is tailored to me, physically psychologically and socially, including with regard to issues around privacy
- Experience care that is timely including to prevent deterioration and promote recovery
- Experience consistency of care between carers
- Feel supported to care for myself where appropriate
- Feel I am a partner in decisions about my care, including identifying risks
- Receive information that is in line/coordinated with the care I receive



- Meet my full physical, mental and social potential
- Live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care
- Expect high quality services that are appropriate to me
- Pathway specific measures

covering:

- Long-term conditions
- End of Life
- Falls/Fragility Fractures
- Diabetes
- COPD
- Cardiovascular Disease
- Cancer
- Dementia

- Meet my full physical, mental and social potential
- Plan for a more dependent future... whilst I can
- Plan for old age - Practically e.g. finances, personal care
- Live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care
- Know how to access services
- Feel that my wider social networks [including faith groups] are involved and supported to help me stay well
- Feel safe in my home
- Feel safe in my community
- Can access opportunities to meet my desire for social activities & choose when and where I meet others and socialise
- Expect that their carers and families feel supported to help people to maintain my wellbeing
- Access transport and travel options
- Access respite care when needed
- Access appropriate housing
- Access appropriate assistive technologies to support my access to services and my independence
- Manage the process of gradual deterioration in: eyesight, hearing & mobility and mental capacity including self care
- Experience a timely recovery to maximum possible level of health

- Be assured that when something unexpected happens, my next of kin and GPs are contacted early to find out about me
- Experience appropriate translation services
- Manage the level of pain experienced
- Expect care from the right person at the right time in the right place
- Expect care that is on time and punctual
- Have appropriate help to navigate my way though the system
- Expect information that is in line/coordinated with the care I receive
- Expect integrated and co-ordinated healthcare, social care and voluntary sector involvement
- Expect to be respected and treated as individual even in a group with a similar need
- Expect and receive support to ensure appropriate treatment / feel I am a partner in decisions about my care
- Expect that the care I receive will be safe
- Expect to be respected as a whole person (holistically) and not a single condition including Social, cultural and psychological aspects
- Expect to have a plan in place that anticipates crises
- Receive information that is in line/coordinated with the care I receive
- Expect to receive good care when in a crisis

Going forward

Key outcomes and indicators

1. Able to stay healthy and active for as long as possible

- Eat well and keep active from a younger age
- Access information that is consistent and understandable to me

2. Can access the best quality care available in order to live as I choose and as independent a life as possible

- Meet my full physical, mental and social potential
- Plan for a dependent future…whilst I can

3. To be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand my health and social care needs

- Be assured that if something unexpected happens, my next of kin and GPs are contacted early to find out about me

4. To be supported as an individual, with services specific to me

- Expect consistency of care between providers
- Expect integrated and coordinated healthcare, social care and voluntary sector involvement

5. To be supported to manage my long-term condition and experience improved control and reduced complications

- Live “at home, not in a home” for as long as I can
- Expect high-quality services that are appropriate to me

Services that could be included

We need your help

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For discussion on your table:

- Has what we've 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?

Going forward: Phase 3

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Croydon CCG and Croydon Council intend to jointly commission a 10-year 'outcomes based commissioning' contract for all services for over 65s from an **alliance of health and social care providers.**

This **alliance** will work with other organisations to deliver health and social care services for local people.

The provider alliance

The following five organisations have been selected to form this new alliance:

- Age UK Croydon
- Croydon Council Adult Social Care
- Croydon GPs Group (this is GP practices in the borough)
- Croydon Health Services NHS Trust
- South London & Maudsley NHS Foundation Trust (SLAM)

Now in the final development phase

We're working with the provider alliance on how they can deliver the outcomes that we have agreed with local people.

We want to work with patients, service users, public, providers and other relevant stakeholders to inform and underpin the successful delivery of the outcomes model.

Developing a successful model

For discussion on your tables:

If we project ourselves to 2025, when the outcomes based model is well established:

- 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?

Next stage of engagement

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We want to continue to work with you throughout this final phase

- Our ambition is to improve health and social care outcomes and experiences for our patients, users and carers
- We need your ongoing support to do that
- Please leave your contact details so we can keep in touch
- Information will also be available on our websites:

http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx

https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning