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Scrutiny Health & Social Care Sub-Committee Agenda

To: Councillor Carole Bonner (Chair)
Councillor Andy Stranack (Vice-Chair)
Councillors Patsy Cummings, Sean Fitzsimons, Margaret Mead, Andrew Pelling and Gary Hickey

Reserve Members: Sue Bennett, Sherwan Chowdhury, Pat Clouder, Steve Hollands, Bernadette Khan and David Wood

A meeting of the **Scrutiny Health & Social Care Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 21 November 2017** at **6.30 pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

JACQUELINE HARRIS-BAKER
Director of Law and Monitoring Officer
London Borough of Croydon
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www.croydon.gov.uk/meetings
Monday, 13 November 2017

Members of the public are welcome to attend this meeting.
If you require any assistance, please contact the person detailed above, on the righthand side.

N.B This meeting will be paperless. The agenda can be accessed online at www.croydon.gov.uk/meetings

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 10)

To approve the minutes of the meeting held on 26 September 2017 as an accurate record.

3. Disclosure of Interests

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Democratic Services representative at the start of the meeting. The Chair will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Croydon NHS Trust - A&E Services Winter 2017/18 (Pages 11 - 96)

6. OBC Alliance Review (Pages 97 - 106)

7. Joint Health and Overview Committee Update

Oral Update on SEL JHOSC and SWL JHOSC

8. Healthwatch Update

Oral Update

9. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

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Health and Social Care Scrutiny Sub-Committee

Meeting held on Tuesday 26 September 2017 at 6.30pm
in the Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES - PART A

Present: Councillor Carole Bonner (Chair)
Councillor Andy Stranack (Vice Chairman)
Councillors Sean Fitzsimons, Andrew Pelling and Margaret Mead

Dr Agnelo Fernandes, Mike Sexton, Stephen Warren
(Clinical Commissioning Group)

A47/17 Apologies for absence

Apologies were given by Non-voting Co-opted HealthWatch Croydon Member: Gary Hickey

A48/17 Minutes of the meeting held on 18 July 2017

The minutes were approved by the Sub-Committee as an accurate account of the meeting.

The Chair requested the information on how Outcome Based Commissioning (OBC) for over 65's would be financed as stated in **A46/17** of the meeting minutes.

Matters Arising :Ofsted – Inspection of services for children in need of services and protection, children looked after and care leavers

The Chair Acknowledged the recent Ofsted report and stated that the focus was now on lessons learned, with emphasis on strengthened challenge through scrutiny work

A49/17 Disclosure of Interest

There was none.

A50/17 Urgent Business

There was none.

A51/17 Exempt items

There was none.

A52/17 Croydon CCG Priorities and Commissioning Intentions 2018/19

The following officers were in attendance for this item:
- Dr Agnelo Fernandes, Assistant Clinical Chair and Clinical Lead for urgent care
- Mike Sexton, Chief Financial Officer
- Stephen Warren, Director of Commissioning

Member were given a presentation on the overview of priorities and intentions for the next year with emphasis on strategic intervention on commissioning contracts, working in partnership, service transformation and accountable care provision to ensure a sustainable future.

Officers advised that the priorities were set under the NHS recommended guidance of 2 year planning contract with further direction on this to emerge in the next few months as a more detailed operative plan is formulated.

The officers stated that different processes had fed into this plan following engagement and 'big ideas event' in collaboration with the public. These were realised through different mediums of elected and outreach activities, engagement with different steering groups.

Officers advised that they looked at the infrastructure to support these programmes, worked with the public to look at best practice with joined up services centred on the needs of the individual.

The presentation also gave an overview of the financial context of intentions which included the following:
1- To deliver savings of £45-50m over 2 years (10%)
2- £21.2m savings identified so far
3- Key Risks:£8.1m in unidentified savings
4- The CCG is required to break even by 2018/19

Officers advised that as part of the challenge to break even they will seek to address long term programmes around Mental Health and Out of Hospital Care. They stressed that whilst attainment of targets were significant challenges, they were on track to deliver £21m through rebalance into primary care, community services and transformation of engineering systems.

The presentation included a summary of strategic approach and financial recovery in areas such as:

1- Joint workshops with commissioning teams around specific areas and the improvements to be made in approaching commissioning opportunities.
2- Dedicated team to work with GP's in addressing variation in practices
3- Decommissioned Croydon Referral Support Services (CReSS) which has led to a shift with GP's now retaining their own referral system through a strong and appropriate referral process.
4- Working collaboratively with South West London Partners.

Officers advised that the transformation of the services was based on the recommendation of the Mckinsey report which was commissioned by NHS England and NHS Improvement in May 2016. The report recommended integration of services following a whole system review of all Health and Social care commissioning and providers in Croydon.

There has been changes made in areas such as:
1- Guidance to nurses and parents before resorting to prescription of medicines.
2- Closure of Foxley Lane – which is now closed.
3-IVF waiting list- now frozen with no further acceptance to the list.

There are further planned savings for medicine and decommissioning in the following areas:
1- Infant Formula
2- Vitamin D
3- Gluten Free
4- Self Care

Officers stated that no complaints had been received following the changes and stressed that the changes made in the past financial year contributed to the savings being made this year.

Officers responded to members' comments on the progress by pooling of budgets as a result of integration of services adopted by other Local Authorities by advising that pool budgets were available for a number of schemes under the Best Care Funds, although Mental Health was not currently under that umbrella.

Members made reference to increase in community provision through the voluntary sector but queried whether there was an intent to withdraw funding from Mental Health Projects. Officers indicated that the focus was to readdress the balance of provision of services through retaining some voluntary sector funded services.

Members requested specific areas of funding reduction to be highlighted to which officers responded that last year there had been many alternatives discussed but the focus was now on transformation.

The Committee members sought clarification on identified and unidentified savings. Officers explained that there was some slippage on 2017/18 savings and that the shortfall this year would increase

accumulative deficit as the gap in efficiencies is currently at 12m. The challenge was to accelerate saving, unfortunately no concrete proposals were provided. Management consultants have been appointed to identify budget reductions and plan for future years.

The presentation highlighted the recommendations of integration and transformation of services made by the McKinsey report which was commissioned by NHS England and NHS Improvement which was a whole system review of Health and Social Care commissioners and providers across Croydon. Officers explained that as a result of the recommendations made, the CCG had been looking at what else could be done aside from decommissioning as this would have serious effect on services. The decision was to transform both the Health and Social care economy.

To achieve this, key issues would be addressed through a planned care vision by:
1- Reduction in emergency admissions with a change of focus from hospital care to advice and guidance, and outpatient care where appropriate.
2- Consistent care pathways with a ‘holistic’ non-medical approach to care.
3- Addressing issues of inequality of the North-South divide
4- New delivery model for Out of Hospital care through a focus on self-care, lifestyle management and behavioural change.

Members asserted that the McKinsey report identified a lack of long term vision and questioned how this will be improved. Officers responded that the trajectory for Croydon was to develop an accountable care system to include all providers.

This would be realised through:
1- Personal Independence Coordinators currently provide streamlined services for over 65s, vision is to develop and provide the same services for the wider population.
2- Delivery groups to improve consistency in improvement in all practices.
3- The roll out of Huddles – Weekly clinics.
4- Peer review and learning for processes to be shared among practices- This has reduced referral rates.

Members expressed concerns that the CCG had been in special measures since 2016, did not reduce the deficit last year and doubted that objectives would be met this year, but acknowledged that Croydon were not alone in this position. Assurance was sought on how the CCG would rebuild confidence in its financial stability. Officers responded that NHS England has made changes to the CCG’s leadership with an expectation for the new team to deliver efficiencies. Croydon is part of the South West London Sustainability and Transformation Plan (STP), was working across different strategic areas and is advanced in outcome

based commissioning compared to other boroughs. Detailed successes of this programme would be available in months to come.

Officers were questioned on how Croydon would benefit from sharing leadership with another Local Authority. Officers stated that this had been looked at in the context of other Local Authorities who share leadership on a 20% basis whilst Croydon does on a 50% basis.

In response to members query on what had been done to engage front line staff and if they had the right staff in place to adapt to the new ways of working, officers stated that some engagement work had been done but further work needed to be done on wider engagement and developing a systematic model. It was also noted that Croydon had to work hard to attract social care staff to the borough.

Officers were thanked for their answers to member's questions.

RESOLVED that officers to provide an update for the March meeting on operating plan outcomes and dashboard following recommendations from the McKinsey report.

A53/17 **Establishing Joint Health Overview Scrutiny Committee (JHOSC)**

Councillor Carole Bonner and Councillor Andy Stranack were unanimously appointed to the South East London JHOSC.

The Terms of Reference (TOR) were unanimously agreed by the Sub-Committee.

A54/17 **JHOSC Update**

There was none

MINUTES - PART B

None

The meeting finished at 8.05pm

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For general release

REPORT TO:	**Croydon Health Scrutiny Committee** **21 November 2017**
SUBJECT:	**Croydon A&E Winter Plan 2017/18 - Main Over Arching report / presentation + 3 Papers from Croydon Health Services NHS Trust, Croydon CCG, London Ambulance Service NHS Trust and Croydon Council**
LEAD OFFICER:	**John Goulston, Chief Executive, Croydon Health Services NHS Trust and Chair of Croydon A&E Delivery Board**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Families Health and Social Care**

ORIGIN OF ITEM:	**This Item forms part of the Committee's work programme**
BRIEF FOR THE COMMITTEE:	**To review and consider the plans put in place by services to address the winter pressures 2017/2018**

1. EXECUTIVE SUMMARY

The attached presentation provides an overview of the 2017/18 Croydon A&E Delivery Plan

2. *TITLE OF REPORT* - Croydon A&E Winter Plan 2017/18

The detailed winter plans from the following organisations are attached to the presentation on the Croydon A&E Delivery Plan

2.1 Croydon Health Services

2.2 Croydon Clinical Commissioning Group

2.3 London Ambulance Service

2.4 Croydon Council

CONTACT OFFICERS: John Goulston – Chief Executive, Croydon Health Services NHS Trust and Chair of Croydon A & E Delivery Board
Stephen Warren – Director of Commissioning Croydon CCG
Clinton Beale – Stakeholder Engagement Manager LAS
Pratima Solanki - Director of All Age Disability & Social Care

APPENDICES: Appendix 1 Croydon A&E Delivery Board Overview of winter plans 2017/2018
Appendix 2 CHS Winter Resilience Plan
Appendix 3 Winter Plan CCG Update
Appendix 4 LAS Scrutiny report Croydon 2017/2018
Appendix 5 Adult Social Care and All Age Discability winter plan 2017/2018

BACKGROUND DOCUMENTS: None

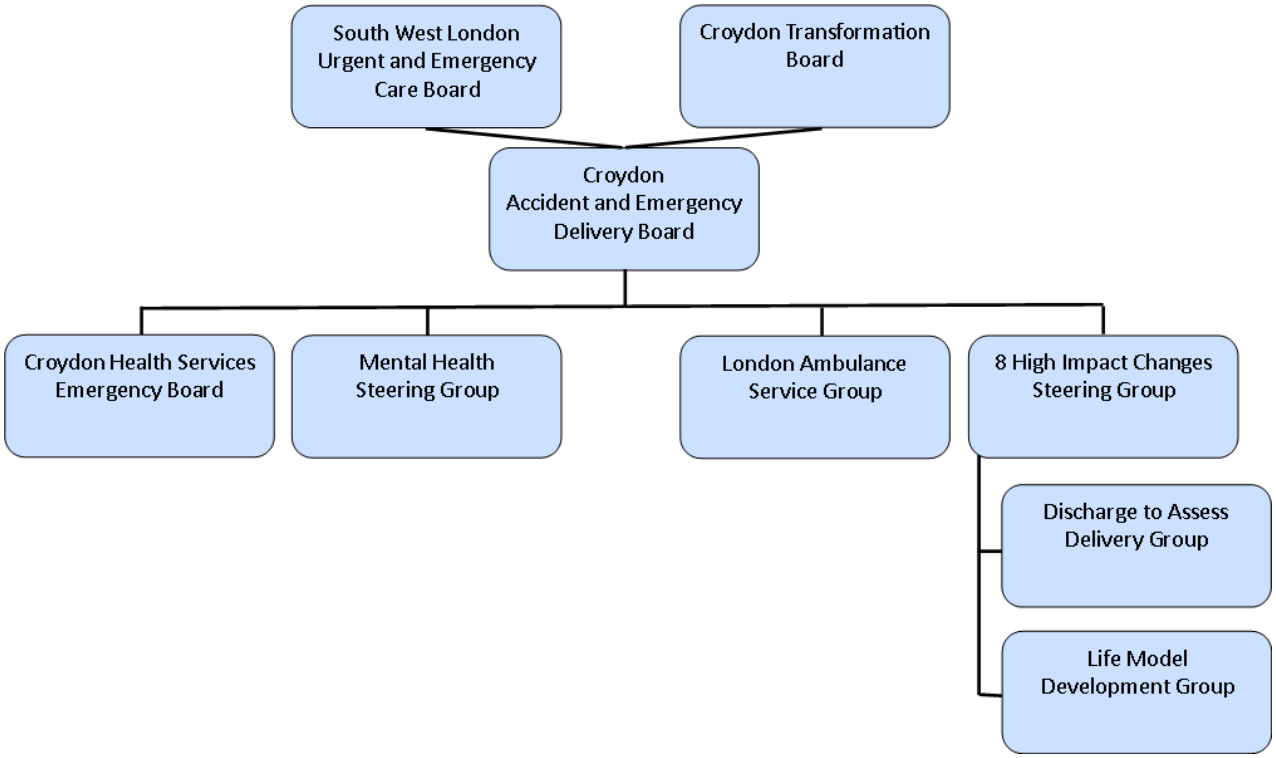
Longer, healthier lives for
all the people in Croydon

NHS
Croydon
Clinical Commissioning Group

Croydon Health Services NHS
NHS Trust

Croydon A&E Delivery Board (AEDB) -
Overview of Winter Plans for 2017/18

1. Governance Structure of the Croydon AEDB



2. Croydon AEDB Delivery Plan

- Co–produced Croydon CCG, Croydon Health Services, Croydon Council, SLaM and LAS

- Aims to address the three improvement drivers:
  - Workforce
  - Patient flow and discharge
  - Re-direction of patients

2.1 Context – Preparing in Croydon for winter 17/18

- New Urgent Care Contract April 2017
  - Urgent Treatment Centre at Croydon University Hospital - co-located with the emergency department
  - 3 GP Hubs, Roving GP and Out of Hours GP Services
- Croydon University Hospital Emergency Department (ED) remains in a temporary location for winter 17/18
- Continued workforce issues reflective of local and national challenges
- Patient flow through the ED and hospital remains a challenge
- Joint health and care commitment to deliver high quality timely care, and partnership working e.g.:
  - Local Authority – Care home and domiciliary care market challenges
  - LAS – Reducing calls and conveyances in the SWL sector
  - Primary care – Promoting (extended) access to GP primary care/GP services
- The Croydon AEDB plan has been developed to support the key issues

2.2 Challenges for winter 17/18

- Analysis of the delays across the emergency care pathways identified three improvement drivers:
  - Patient flow and discharge
  - Streaming and re-direction before / when a person arrives in ED at CUH
  - Workforce
- Patients presenting to the ED with primary Mental Health concerns has a significant impact
  - Time in the ED is a quality issue for the individual and does affect the internal ED flow (average time in the department is 6hr 30min)
  - Twi initiatives to address this for winter - Implementation of Core 24 psychiatric liaison service and reduced South London and The Maudsley bed occupancy

2.3 AEDB Delivery plan: Top 9 Solutions

Actions	% Impact	Improvement Driver		
		Workforce	Improve patient flow & Discharge	Re-direction & Streaming
Direct booking to GP Hubs from NHS111	0.25		✓	✓
Direct booking to GPs from NHS111	0.25			✓
Identification of frequent callers	0.5			✓
Comprehensive streaming model	0.5			✓
MH - Core 24	0.25	✓	✓	✓
Implement the 8- HICs	2.0	✓	✓	✓
Out of hospital business case	1.0	✓	✓	
Review of staffing	1.0	✓	✓	
Review roles & responsibilities, bed usage 7 capacity, & care pathways	3.0	✓ ✓	✓	✓

2.4 Croydon AEDB Delivery Plan - high impact solutions

NHS Croydon Clinical Commissioning Group

- Three high impact solutions have been identified which will deliver a 5% improvement on the 4-hour target (from 90.13% as at 30/9/17):

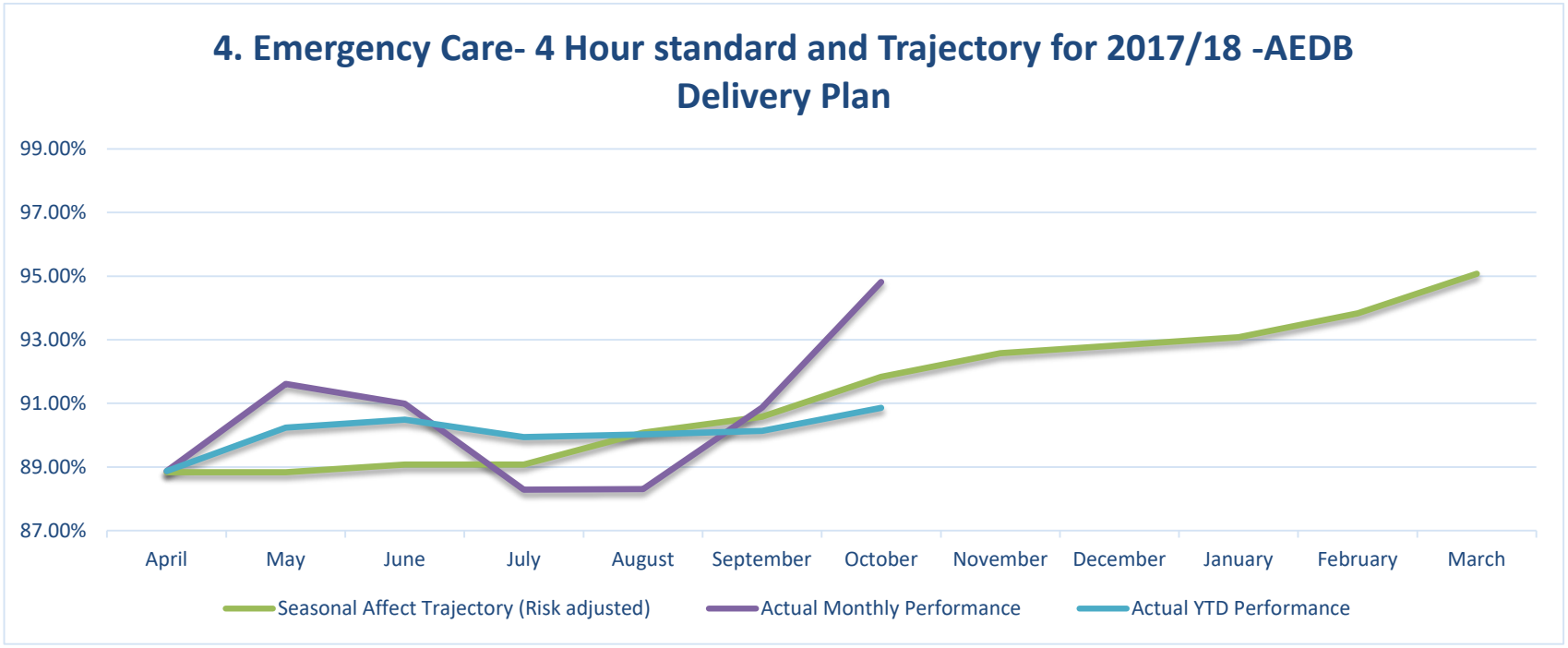
1. **Implementation of the Out of hospital business case for people aged over 65 (1% improvement)**
   - Accelerated discharge (Discharge to Assess) piloted in Sept 2017, went ive for Pathways 1 & 2 in Oct 2017, and for Pathway 3 across all wards in March 2018
   - Improved and enhanced reablement services to reduce re-admissions
   - Integrated Community Networks: Enhancing MDTs to provide one-to-one support in care planning, seamless coordination of care, and facilitation and promotion of self-care through the engagement and promotion of community groups.
2. **Review of staffing across the emergency care pathways (1% improvement)**
3. **Review roles & responsibilities, bed usage and capacity, & care pathways (3% improvement)**
   - Robust discharge policy; supporting clear pathways and patient choice
   - Ability to discharge from inpatient ward settings is imperative to promote “Right person Right ward” and to ensure safe, quality care

- The risks associated with delivering these have been identified and mitigating factors have

3. Performance Against Trajectory for 2017/18 - vs. AEDB Delivery Plan to 31 October 2017

A&E Delivery Board Plan

	April	May	June	July	August	September	October	Nov	Dec	January	February	March
Original 17/18 Monthly Trajectory	93.30%	95.64%	96.58%	97.70%	96.59%	95.16%	94.31%	95.78%	94.77%	94.83%	93.49%	95.12%
Target against AEDB Plan	88.83%	88.83%	89.08%	89.08%	90.08%	90.58%	97.33%	97.33%	97.58%	97.58%	97.58%	98.33%
Seasonal Affect Trajectory (Risk adjusted)	**88.83%**	**88.83%**	**89.08%**	**89.08%**	**90.08%**	**90.58%**	**91.83%**	**92.58%**	**92.83%**	**93.08%**	**93.83%**	***95.08%***
Actual Monthly Performance	**88.87%**	**91.61%**	**90.99%**	**88.29%**	**88.30%**	***90.87%***	**94.82%**					
Actual YTD Performance	**88.87%**	**90.24%**	**90.49%**	**89.94%**	**90.02%**	**90.13%**	**90.86%**					
Total Impact Percentage Improvement (as per plan)	0.00%	0.00%	0.25%	0.00%	1.00%	0.50%	6.75%	0.00%	0.25%	0.00%	0.00%	0.75%



4. Winter Plans from partners within the Croydon AEDB – see attached papers

1. Croydon Health Services
2. Croydon Clinical Commissioning Group
3. London Ambulance Service
4. Croydon Council

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Croydon Health Services NHS
NHS Trust

Croydon Health Services Winter Plan Summary 2017/18

1. INTRODUCTION

The purpose of this plan is to provide an overview of the Trusts programmes of work to ensure operational resilience and to maintain safe, effective services throughout the winter period of 2017/18.

Each year the Trust faces additional pressure at specific points of the year and in particular the winter months. Croydon Health Services NHS Trust plays a key role in ensuring effective winter planning, operational resilience and capacity planning is in place for all services across the health economy. Working in collaboration with commissioners and partners, this report sets out the parameters in order to meet the needs of our patients in a timely and effective manner. The Trust will continue to improve the quality of the care that it offers to the local population through learning from best practice and by continually reviewing its services on a regular basis.

In 2017/18 the Trust continues with its strategy to respond to the challenges we face and to create services that are clinically and financially sustainable, to meet the changing and growing needs of the local population and reduce health inequality in Croydon. The key challenges going ahead are:

- The continuation of the Emergency Department (ED) rebuild and associated moves and the constraints experienced in the physical environment, both in ED and bed escalation capacity
- Reliance on agency staff due to vacancies across the professional groups
- To work within the Trust's deficit financial control total
- Continued population growth with seasonal pressures and the expectation of continued high quality services

The purpose of this plan is to articulate the Trust's actions to maintain effective access to all services and in particular strengthen emergency preparedness for surges in activity, changes in estate or environment (infection control issues) which can impact on the core business of Croydon Health Services (CHS).

We are committed to continuing to provide cost efficient, safe and quality services, good patient experience, achieving both performance and Improvement trajectories for ED 4 hour performance, Referral to Treatment (RTT), Cancer and Diagnostics sustainably. With this in mind our winter planning will build on lessons learnt from 2016/17 and incorporate:

- Embedding the escalation processes and internal professional standards across ED and departments across the Trust
- Continuing the work within our Assessment Units to prevent admissions and continue to drive down length of stay (LOS)
- Increasing access and availability of Ambulatory services
- Improving our Discharge processes
- Reducing our bed base
- Elective Capacity and Demand Management
- Information Technology Stabilisation
- Revised workforce planning, recruitment and retention

The key pressures posed by winter include:

- a tendency for a more complex / dependant case mix leading to an increase in length of stay and a subsequent reduction in capacity
- reductions in timely discharge of patients due to increased demand from the hospital Trust and primary care for capacity in community / social care
- increased demand for acute services due to higher levels of infection and/or ill-health within the community
- significant peaks of bed closures due to sustained infection (e.g. Norovirus) outbreaks
- increase in medical outliers, cancelled operations and ambulance handover delays
- pressure on adult and paediatric critical capacity across the network
- unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work.

Croydon has seen significant challenges over the last two years fuelled by an increase in demand for services and a decrease in patient flow. More specifically the trust has seen:

- An increase in admissions from outside of the borough
- Increased admissions from Croydon as a result of a combination of increased acuity / complexity of patients presenting at A&E and increase in decisions to admit
- Increasing difficulties in discharging the more complex patients from hospital to suitable long-term care (home care and/or nursing or residential home placements) caused by:
    - increased complexity of long-term needs for some patients
    - Increased numbers of older people with mental health needs and/or challenging behaviours that are not always well served by current models of care
    - Increased number of adults with a mental health need requiring transfer into a mental health unit waiting for placement to be available
    - Increased number of Delayed Transfers of Care

The overarching purpose of this Winter Plan then is to provide a collective overview of those new and existing initiatives that will ensure Croydon Health Services NHS Trust experiences operational resilience throughout the winter period (1st November 2017 to 31 March 2018). Historical data, learning from past winter periods and knowledge of the Trust's current position has been used in the development of these arrangements.

The Winter Plan is written to compliment and add to the whole systems winter plan for Croydon and to build on 'business as usual'.

2. AT A GLANCE WHAT IS DIFFERENT?

2.1 Key initiatives from the Croydon A&E Delivery Board

The focus on continuous improvement of patient pathways and services (across both acute and community) and embedding the ethos of integrated services for adults and children will continue through the winter months.

Through the (AEDB), the key actions that have been defined to deliver the optimisation of patient flow, a clinically safe and sustainable service and delivery of the 4 hour performance are:

- Re-designation of Urgent Care Centre (UCC) to Urgent Treatment Centre (UTC)
- Direct booking from 111 to GP Hubs
- Direct booking from 111 to GP surgeries in hours
- Identification of frequent callers/attenders and development of care plans
- Comprehensive streaming model to alternative treatment pathways (e.g. UTC, GP Hubs, Pharmacy and RAMU)
- 7 day ambulatory care to South West London (SWL) model
- Mental Health Care – Core 24 services in place
- Implement the national 8 High Impact Changes for Discharge
- Implementation of the Out of Hospital Business care to support admission avoidance and early supported discharge
- Review, recruitment, retention and re-training of staff across UTC/ED
- Processes and Flow: Review roles and responsibilities, Emergency care pathways, bed capacity and usage

2.2 Key initiatives within the Trust

These include:

- Improved governance and monitoring of Emergency performance
- Changes in medical model within ED and across the assessment units/wards to avoid overcrowding in ED maintain safe handover from London Ambulance Service (LAS) and ensure the right placing of patients, thus reducing length of stay (LOS).
- Developments in technology to support clinical practice and patient flow
- Implementation of the new Urgent Care model through the Croydon Urgent Care Alliance.
- Revisions to processes and workforce to support patient flow.

These key actions also reflect the Trust's strategic priorities and concentrate on:

- Improving patient experience and maintaining safety
- Continuing to deliver high quality care
- Making the best use of our resources

Allowing for the Trust to:

- Maintain resilience throughout peak periods of activity and changes in environment
- Manage and improve patient flow through changes in clinical models; streaming of patients to the 'right place, at the right time'; improve discharge processes and management and ensure senior decisions makers at the 'front door' of the hospital
- Ensure alignment with arrangements with the local health economy
- Reflects work undertaken across the hospital and community based services and by partners to implement robust, effective and timely preparation for additional pressures.
- The outcome through this process is to provide uninterrupted provision of high quality, timely care

The plan then underpins the continuity of safe, resilient, high quality, integrated services and provides effective response for managing winter pressures.

This will be achieved by:

- Ensuring the directorates and service level action plans are in place for seasonal variation
- Ensuring risks are identified, monitored and appropriately managed
- Monitoring of agreed key performance indicators (KPI's) and measures for management of patient flow in and out of hospital are undertaken.
- Ensuring clinical operating standards are monitored and maintained throughout the pressure period to ensure clinical and patient safety
- Support and monitor our governance arrangements for strategic, tactical and operational level oversight, throughout peak periods
- Emergency Planning and preparedness is maintained as a priority within the Trust to support periods of severe weather, holiday periods and significant events

2.3 Winter Listening into Action (LiA)

In October 2017, the Trust held a 'Winter' LiA Big Conversation, attended by over 80 clinical and operational staff from both the acute and community. From this a number of suggestions have now been incorporated into the Trust's winter plan. These include:

- Management of workforce and annual leave planning, especially across holiday periods
- Improve communications across the organisation of 'how it is'
- Forward planning
- Agreed triggers for wards, departments and escalation processes

A follow up 'Winter' LiA is being held on the 7th December to feedback to staff and to communicate and test out new arrangements.

3. ACTIVITY AND PERFORMANCE

In 2017/18 the NHS nationally and locally have experienced significant and sustained demand resulting in considerable operational pressure resulting in a poor experience for some patients and the Trust underperforming against the 95% 4 hour Accident and Emergency standard, as well as ambulance handover delays and cancelled operations.

Historically at CHS and nationally, the period running from October through to the end of the financial year brings surges in activity, a number of these surges are predictable (Christmas, New Year and Public Holidays) but other surges that are less so (Norovirus, Influenza). In order to manage both planned and unplanned surges, the Trust requires the development and deployment of robust plans in order to manage these significant changes in demand.

Notoriously with surges in activity impact on performance and CHS are committed to delivering over 90% through September to the end of February and 95% in the month of March 2018. Performance is monitored in REATLIME and on a daily basis operationally but the required initiatives within the organisation to sustainably deliver against these targets are managed internally through the Emergency recovery Board (EDB) and through the Emergency Care Clinical Leadership Group (ECCLG) and externally via the Croydon A&E Delivery Board.

The activity levels have changed for the Trust in this financial year with the UCC and GP Hubs now being included as part of the overall performance. In essence this has enabled the trust to 'extend' the "Front Door" as an acute Trust but also as a Community Provider. Harnessing this is key to the Trust to ensure the successful management of performance, to improve flow of patients through the organisation and home to their normal place of dwelling.

In recent weeks, the Trust have seen a significant improvement in performance, consistently achieving greater than 90% despite the continued reduction in our bed base as preparation for our surge periods in the winter. The organisation must maintain this position in order to safely and sustainably manage demand through this period and deliver against the targets that have been set.

What the organisation has experienced recently is:

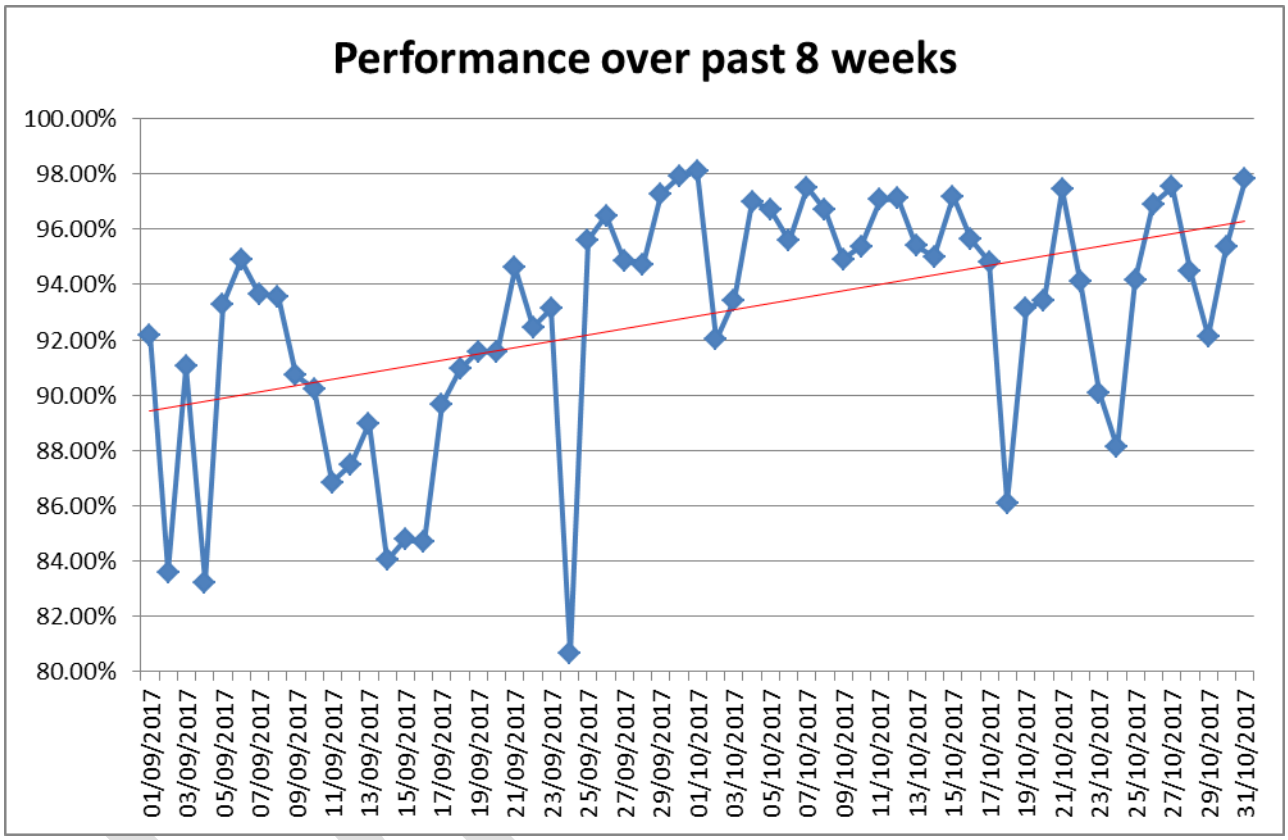
- Attendances to Emergency Care continue to rise
- The organisation continues to reduce the number of admissions on a daily basis
- Length of stay continues to decline
- The Discharge Profile of the organisation to create capacity is still too late in the day
- DTOCs (Delayed Transfers of Care) are increasing (but also nationally)
- Our conversion rate remains above the national average
- We have, until recently, seen a reduction in the use of models of care that we have implemented (e.g. RAMU, SAU and Rapid Response)
- Right Person, Right Bed and the placing of patients appropriately

With this in mind, the winter period will remain to be a challenge for the organisation, but a challenge that is being prepared for. The 2017/18 Winter Operational Resilience plan for the Trust will be released in the next week to be operationalised and the drive to deliver effective models of care that have been developed internally remain to be the priority for the Trust.

Over the summer the Trust has developed an Emergency Recovery Plan, which forms part of the Croydon Emergency Plan. This has been developed and monitored through the monthly Croydon A&E Delivery Board (AEDB). In September the Trust reorganised the internal governance of monitoring emergency performance to ensure that visibility of the plan and issues is seen from all levels and supports the NHSI requirements of demonstrating

delivery of the Emergency NHSI Undertakings . For the organisation and staff (clinical and non-clinical) this governance structure entails a greater focus on following process and actions that has been designed to optimise flow, defines roles and accountability and identifies and mitigates risks within the system. The last eight weeks of improved performance by the Trust have demonstrated how effective this can be.

Graph 1: 4 hour performance (Sept '17 to 15th Oct 2017)



Graph 1 demonstrates the impact on performance when focus is given to flow through ED and the redirection of clinical care to the most appropriate environment. In order for the Trust to continue to achieve the current performance, this is key and the visualisation and communication of flow from attendance through to discharge is paramount.

4. CAPACITY PLANNING and ESCALATION

With process being a priority for the organisation, planning to support the delivery of flow, especially during surge periods is key. To that end the Trust has modelled the required bed capacity, month by month through to the end of the financial year. The bed requirements are monitored through the 'Forward planning' group, chaired by the Director of Operations. This also takes into account staffing, discharge profiles and will ensure communication across the organisation of what is expected and any issues.

The bed capacity requirements are demonstrated in the table below:

Table 1: Winter Bed Capacity 17/18

Month	Oct	Nov	Dec	Jan	Feb	Mar
Number of beds required	420	416	455	482	447	465
Number of beds available (incl. escalation)	459	459	459	459	459	459

If no other changes were to be implemented, then the Trust would require the additional 27 bed capacity. This winter the Trust and health economy is looking to utilise resources differently and by working collaboratively with external partners, especially through the Croydon Alliance. In the first instance the Trust will endeavour to redirect patients to the most relevant resource, if the acute trust is not the appropriate setting. Hospital avoidance measures and alternative settings to the emergency Department include:

4.1 Front door streaming:

The clinical streaming model to General Practitioners (GPs), GP hubs, the Urgent Care Centre and to other alternatives such as pharmacies and other self-help initiatives is in place.
Clinical streaming has been part of the urgent care model since November 2015. This covers both adults and paediatrics. Streaming is in place to UCC and both medical and surgical assessment areas, including ambulatory care.

Since the beginning of October, there has been direct booking to GP hubs. Further redirection to Rapid Response and Pharmacy is coming online in this quarter. To compliment this, NHS 111 will also be able to book appointments direct into GP practices in core hours.

4.2 Alternative pathways

Work is underway with London Ambulance Service (LAS) to utilise alternative pathways through the increased use of patients directed admission straight to Rapid Assessment Medical Unit (RAMU), Community Rapid Response and the roaming GP – this is being monitored through the Croydon AEDB.

4.3 Implementation of the Out Of Hospital model through the joint working of the Croydon Alliance, which includes the key establishment of the 'Life' model, Discharge to Assess, Care Home initiative and the Integrated Community networks. This model has commenced in October and will roll out over the winter period. The implementation and success of these initiatives is monitored through the Out of Hospital Delivery Board and the Croydon AEDB.

4.4 Optimising internal Trust pathways

Through the introduction of the national initiative 'SAFER', the Trust has developed a collaborative way of ensuring patients are placed in the most appropriate place for their needs.

Initially at the beginning of the year a 'SAFER' week was run across the whole Trust through which SORT was developed as the preferred methodology. This meets all the principles of SAFER.

This methodology is used by the clinical teams on a daily basis to assess the following:

- **S**ick patients
- **O**ut today or tomorrow?
- **R**est of the patients
- **T**o come in

SORT is in place across all adult wards. There is a strong emphasis on setting estimated discharge dates (EDDs), Golden patients before 10.00am and discharge before 1pm. Multidisciplinary Board and Ward Rounds are in place and all use SORT as an aide memoire.

Two years ago the Trust commenced review of all patients over 28 days, down to over 7 days. Now, over the past 6 months **every patient** is reviewed by the MDT group once a week. This determines the delayed transfers of care (DTOCs) and medically fit for discharge (MFFD).

Additional work will also be in place as follows:

- Criteria led discharge in being developed for roll out in November
- The Trust is reviewing the policy for monitored patients
- The Trust is trialling 'Patienteer' which monitors appropriateness of processes/ tests ordered. This is being rolled out for 10 hypothesis in November and a 'live' initiative in ED

4.5 Right person, right bed

The Trust has instigated a programme of work to improve the patient journey to provide an improved patient experience ensuring patients who arrive at Croydon University Hospital remain only while necessary, understand and plan their discharge and when our patient has received an intervention that supports their journey through to discharge, all that is planned or requested happens on the day it is requested. This programme consists of a number of work streams which are medically, nurse and operations led creating a collaborative, professionally diverse team to support:

a. Patient Flow

The review and improvement of our Hospital at night, Site Practitioners and discharge services optimising our opportunity to reduce LOS and improve the patient journey; revised workforce alignment and supervision structure which is consistent with the current nursing structures within the Trust providing equity to those within these services and to improve patient flow and care. A new Head of Operations has been appointed to lead the work in patient flow and managerially responsible for the site team and complex discharge. This role will link with the initiatives and teams in the new Out of Hospital model implementation.

The Trust has 'tested' out a number of initiatives that have had significant benefit in improving patient experience, patient flow and emergency performance. In particular the introduction of:

- An acute physician working in and alongside ED. This has supported 'streaming patients to the right beds and utilising alternative pathways, such as ambulatory, rapid response, more effectively

- Specific dedicated medical/nursing cover for escalation areas and MDT reviews have had the greatest impact. The trust is currently working through how these can be sustainable throughout winter.

b. Inpatient Review

The review and submission of Internal Professional Standards for inpatient reviews on all wards (Surgical and Medical) supporting a consistent and standardised approach to inpatient management. Implementation of a standardized Estimated Date of Discharge (EDD) process and Ward/Board rounds which will continue the roll out of the Perfect Ward process which was piloted on 2 wards in 2015-16 and as part of SORT.

c. Discharge /Transfer Process

The review and clarification of the roles and responsibilities has been carried out of all those who interact with a patient as they begin their journey within Croydon University Hospital, enabling discharge planning to begin on admission. Review and submission of Discharge policy and supporting documentation enabling a consistent and standardised approach to Discharge which aligns clinically and complies with all mandatory requirements of our partner organisations who enable supported discharges. Therefore, this provides assurance for our Delayed Transfer of Discharge process, with consistent and accurate data to support the Health and Social Care system to identify any unmet need within the system. Monitoring of 'stranded' patients is also in place. In addition, as part of the Out of Hospital model implementation, Discharge to Assess has commenced and will be rolled out across the Trust for completion by January 2018.

4.6 Escalation Process (Emergency Department)

For the Winter period of 2017/18, the Trust are adopting a new escalation process "The Bristol Shine Toolkit" which will go LIVE on Monday 6th November. The toolkit is an Emergency Department (ED) Safety Checklist developed in order to standardise and improve the delivery of basic care in EDs, to improve resilience in EDs during periods of crowding, to improve the safety and clinical outcomes for patients accessing the emergency care system, and to improve ED performance against Best Practice Tariffs.

4.6.1 What is the ED Safety Checklist?

An ED Safety Checklist is a time based framework of tasks that is completed for every patient, other than those with minor complaints. The ED Safety Checklist can be completed by any member of clinical staff in any area. It is prescriptive and contains all basic elements of care. Best Practice Tariffs and early triggers to specific care pathways such as sepsis are included.

4.6.2 What is the problem we are trying to address?

Crowding has a profound impact on the ED's ability to deliver safe care. Delays in recognition and treatment of severe illness are common, with associated poor outcomes. This is particularly problematic for patients suffering from stroke, heart attack and sepsis. A scarcity of staff in the ED workforce has resulted in a reliance on agency and non ED-trained staff. Human factors - as staff become overwhelmed by the tasks they need to complete in a timely fashion and with constant interruption.

4.6.3 What is the evidence base for the intervention?

At University Hospitals Bristol NHS Foundation Trust (UH Bristol) the mean proportions in Key performance Indicators (KPI) taken before and after the introduction of the ED Safety Checklist improved in 5%-25% in most cases.

The tool will be used by ED to assess trigger points in crowding and clinical care to be communicated to the Site and Operational teams.
Quality improvements we hope to achieve:

- Improved baseline clinical care
- Less clinical incidents
- More efficient handover
- More efficient documentation
- Improved performance against best practice tariff
- Decrease avoidable harm by recognising deterioration
- Enhanced safety region-wide
- Improved communication
- Improved team morale
- Improved patient and staff feedback

The ED Safety Checklist is structured into two parts:

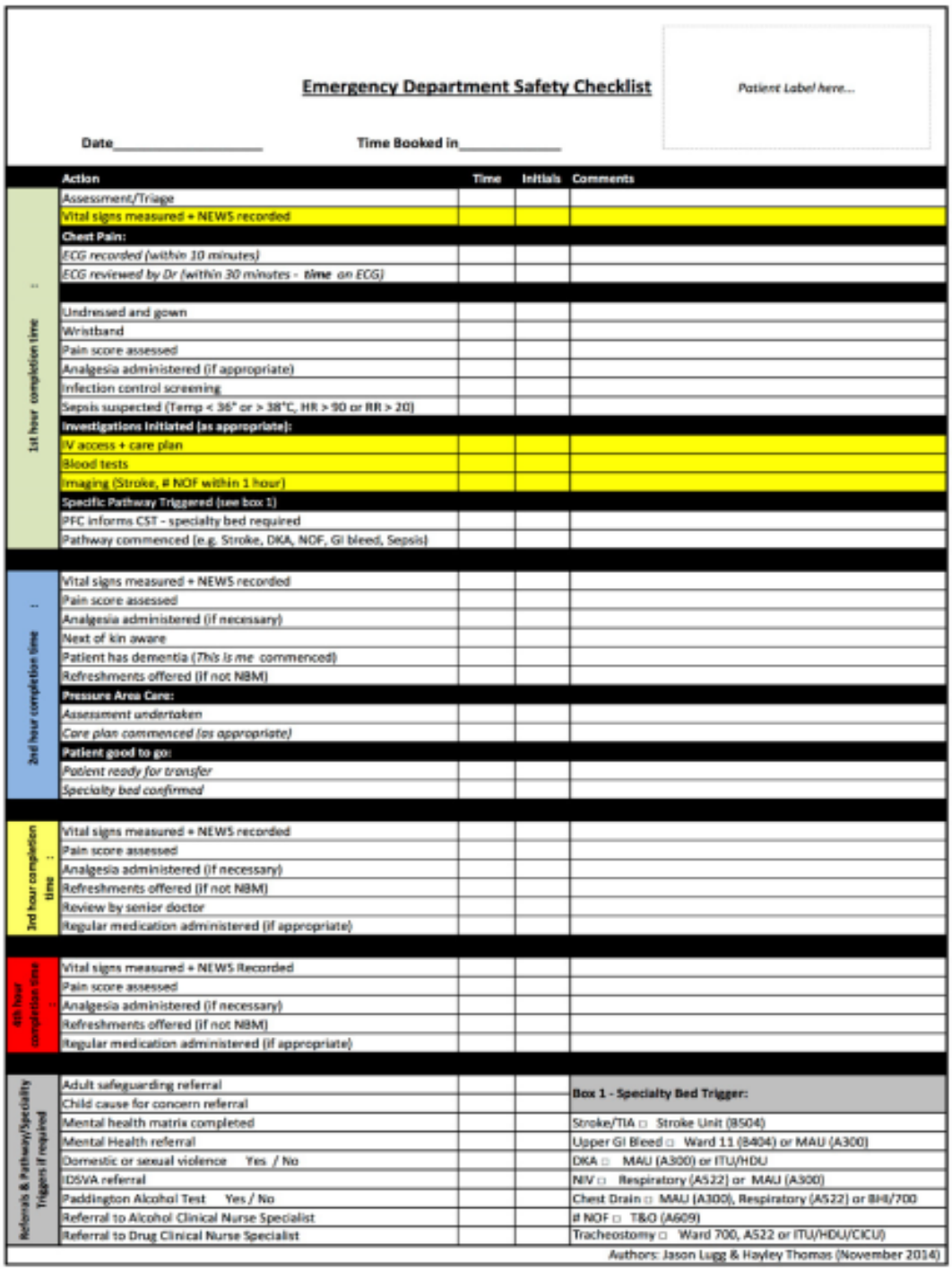
Part 1 - Provision of basic safe clinical care

A time-based framework for vital sign measurement and calculation of the National Early Warning Score (NEWS), pain scoring, administration of drugs and front-loading investigations.

Part 2 - Value added tasks

Include referrals to drug and alcohol services, liaison psychiatry and occupational therapy. Commencement of pathways that demonstrably improve outcomes (e.g. fractured neck of femur, stroke and diabetic ketoacidosis).

Diagram 1: ED Safety Checklist



Emergency Department Safety Checklist

Patient Label here...

Date_____ Time Booked in_____

	Action	Time	Initials	Comments
1st hour completion time :	Assessment/Triage			
	Vital signs measured + NEWS recorded			
	Chest Pain:			
	ECG recorded (within 10 minutes)			
	*ECG reviewed by Dr (within 30 minutes - **time** on ECG)*			
	Undressed and gown			
	Wristband			
	Pain score assessed			
	Analgesia administered (if appropriate)			
	Infection control screening			
	Sepsis suspected (Temp < 36° or > 38°C, HR > 90 or RR > 20)			
	Investigations initiated (as appropriate):			
	IV access + care plan			
	Blood tests			
	Imaging (Stroke, # NOF within 1 hour)			
	Specific Pathway Triggered (see box 1)			
	PFC informs CST - specialty bed required			
	Pathway commenced (e.g. Stroke, DKA, NOF, GI bleed, Sepsis)			
2nd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Next of kin aware			
	Patient has dementia (*This is me* commenced)			
	Refreshments offered (if not NBM)			
	Pressure Area Care:			
	Assessment undertaken			
	Care plan commenced (as appropriate)			
	Patient good to go:			
	Patient ready for transfer			
	Specialty bed confirmed			
3rd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Review by senior doctor			
	Regular medication administered (if appropriate)			
4th hour completion time :	Vital signs measured + NEWS Recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Regular medication administered (if appropriate)			
Referrals & Pathway/Speciality Triggers if required	Adult safeguarding referral			**Box 1 - Specialty Bed Trigger:**
	Child cause for concern referral			
	Mental health matrix completed			Stroke/TIA □ Stroke Unit (B504)
	Mental Health referral			Upper GI Bleed □ Ward 11 (B404) or MAU (A300)
	Domestic or sexual violence Yes / No			DKA □ MAU (A300) or ITU/HDU
	IDSVA referral			NIV □ Respiratory (A522) or MAU (A300)
	Paddington Alcohol Test Yes / No			Chest Drain □ MAU (A300), Respiratory (A522) or BHI/700
	Referral to Alcohol Clinical Nurse Specialist			# NOF □ T&O (A609)
	Referral to Drug Clinical Nurse Specialist			Tracheostomy □ Ward 700, A522 or ITU/HDU/CICU)

Authors: Jason Lugg & Hayley Thomas (November 2014)

4.7 Escalation Process

The current Trust escalation policy is being reviewed following the winter LiA in October and will be completed for the 1st December. This is being based on the triggers identified across a number of areas into one policy. To support this a revised policy for monitored beds has been designed (appendix 1) .

4.8 Additional Escalation Capacity

In the event of requiring additional capacity, plans and provisions for both adult and paediatric beds has been made. The escalation for using additional bed capacity is currently being revised and to be signed off in November Executive Management Board and clinical cabinet. This will include triggers for opening and closing escalation capacity. This will cover both adult and paediatrics.

Adult Escalation

In order to be able to manage the increased demand in admissions and the beds required to do so, the Trust have define additional (escalation) capacity for this period and the triggers required to unlock this capacity, thus giving the Trust access to an additional 54 beds if required. The use of escalation beds will be opened by defined triggers and signed off by the Director of Nursing and the Medical Director to ensure patient safety.

Paediatric Escalation Capacity

Additional paediatric inpatient capacity has been identified for a defined cohort of children. As with adults, this escalation capacity will be opened as defined by a set of specific triggers and signed off by the Director of Nursing and Medical Director. The escalation area will be managed by the Paediatric Matron, and the patients will be managed by the Paediatricians.

5 RESOURCE, WORKFORCE AND MANAGEMENT OF FLOW

The Trust has focused on a number of initiatives pertaining to the management of flow within the organisation from admission through to discharge.

In conjunction with these initiatives, the Trust is looking to align its workforce requirements to the pressures in both ED and at ward level in order to mitigate our expected “pinch points” and manage capacity more effectively over the winter period.

Workforce analysis requirements therefore have been completed to support the continued ED decant period and additional requirements for Winter Resilience. The Emergency Care Intensive Support Team (ECIP) have carried out a workforce analysis alongside the ED Consultants and the Trust will complete a ‘heat map’ of the ED activity and nursing workforce.

It has also been agreed that to ensure continuity that NHSP bank staff can be booked in advance on ‘lines’ for agreed areas.

In addition to the above for Winter 2017/18 with regard to the workforce analysis, the Trust are committed to the review of annual leave over the pressure periods in order to ensure ourselves that leave has not been over committed thus preventing service areas being understaffed unnecessarily. The Trust have also committed to clarifying what meetings are essential to attend over this period to prevent staff being pulled from clinical duties and adding additional pressure to the service areas.

In times of surge, alternative workforce options are being explored, following suggestions from the ‘Winter LiA’ to support the ward areas and departments. This will be added to the revised surge escalation plan.

6 STRANDED PATIENTS

It is nationally recognised and supported by ECIP (Emergency Care Improvement Programme) led by NHSI that “stranded patients” have a direct impact on flow within any acute hospital environment. During the course of the winter months, the number of stranded patients in acute hospital beds will increase due the acuity of illness and additional pressure on capacity externally.

CHS currently hold a weekly meeting to discuss all patients and this will continue throughout the winter period with representation from the wards, site team, discharge co-ordinators, social services and therapies. The purpose of this meeting is to discuss and ensure discharge arrangements are put in place as soon as possible.

In addition, CHS will hold separate meetings to discuss those patients on a CHC pathway with the CHC team, those patients who have no recourse to public funding and those who have a length of stay over 100days.

Any concerns regarding discharge delay that cannot be resolved locally will be escalated to the Director of Operations who escalates accordingly and supports the system to resolve the situation.

7 ASSESSMENT UNITS

CHS have established assessment areas through the Edgecombe Unit (RAMU, Ambulatory Care and ACE), a Surgical assessment unit (SAU) and a Gynaecological Assessment Unit (GAU), which are all fundamental to effective flow through and out of the organisation.

The key benefits of this model streamline patients to the right place for assessment; reduce length of stay and avoid hospital admission by redirecting patients to community support services. Further development of the ambulatory care pathways will reduce the admission of patients further and increase the access to immediate medical intervention via a GP for those in our community

Additional work is being done in partnership with the CCG to review the model for the 'front end' of the hospital, but also to enable access to these services to expedite and support discharges. Our ambulatory care service through the implementation of fast-track pathways, pulls suitable patients at the point of triage and signposts them to Ambulatory care, thus bypassing the Emergency Department. The Trust will also be continuing the placing of Acute Physicians in ED, to support flow and pull patients through the system, as well as provide another strand, to avoiding hospital admissions and placing patients in alternative care settings. Surgical Consultants are currently trialling an alternative model in providing 'senior surgical decision makers' at the 'front door'.

For the winter period, CHS are driving the utilisation of these pathways from the moment our patients are greeted by the Clinical Streamer at the front door and significant work is underway via our clinical and non clinical staff to drive these pathways and rejuvenate this flow through the organisation.

The assessment units will enhance the patient experience through a defined pathway, focusing specifically on their healthcare needs in order to provide optimal care. Short stay patient flow will therefore be realigned by managing cohorts of patients in one location. This will in turn reduce average length of stay on the short stay wards and avoid ED breaches.

The reduction in LOS will support the reduction in our bed base therefore contributing to the associated capacity planning in previous sections.

8 INFORMATION TECHNOLOGY

For Winter 2017/18, IT is currently in the process of implementing new software via IMPRAVATA to give additional stability to CERNER mPage technology (Whiteboards/ Worklists/ Maternity and Theatres). This will allow for prolonged and sustained utilisation of these systems to further support visualisation of patient flow across the hospital. There is currently a rollout programme in place within IT to deliver this to all ward areas.
All desktop PCs and laptops continue to be upgraded to Windows 7 or Windows 10 this year (replacing the obsolete windows XP), and remote access systems will be implemented to allow a more flexible approach to working.

The '835' system has now been fully implemented to the Trust giving greater access to REALTIME data for the organisation and accessibility to data queries need to run our services. The Trust is in the process of developing a specific Patient Tracking List for ED in order to monitor flow through the department more effectively. This coupled with the PATIENTEER clinical system will allow for enhanced clinical and operational management of flow at the front end.

The Trust has implemented 'Tap & Go' into ED and will commence over the coming months electronic prescribing and depart processes.

In relation to Community, there has been an increased focus on improving IT support, and work will commence shortly on delivery of EMISWeb to replace EPEX. This will support improved business processes such as mobile working, and, eventually, information sharing with acute and primary care services across Croydon

9. TRUST RESILLIENCE AND MITIGATION IN ADVERSE SITUATIONS

9.1 Infection Control

It is widely acknowledged that outbreaks of infections may result in the closure of a number of ward areas throughout the winter period, the Trust will build on the success of previous winters by the close monitoring and tight infection control measures to minimise the closures and disruption.

In the event of the development of an infection control outbreak daily meetings will be led by the Infection Control Team to ensure that there is appropriate management of the outbreak. These meetings will be attended by a member of the respective site team in order that the impact on ward/bed closures can be discussed and an action plan for managing inpatient capacity can be agreed.

Infection control policies relating to the outbreak of infections are documented in the Trust Infection Control Manual and are available on the Trust Intranet.

As part of the winter planning, alternative capacity and provision has been identified and will only be activated by the Director of Nursing, Medical Director and Chief Operating Officer.

9.2 Influenza

The Trust is currently carrying out a flu vaccination programme to achieve 75% of staff by the end of December.

10. Adverse Weather

The Trust has an Adverse Weather Plan which will be implemented in the event of adverse weather during the winter period. The Trust receives regular weather updates from the Met Office which will be circulated to all key staff and used to ensure robust plans are in place to maintain business continuity.

The Adult Community Nursing Team and Children's Hospital at Home Team have robust Business Continuity Plans (BCP) in order to triage and maintain community care for all vulnerable adults and children on their case loads. There are plans in place to have the availability of 4X4 vehicles if required to ensure that the difficult parts of the borough can be reached and staff have suitable winter clothing to ensure that essential visits are made on foot where required. The use of 4X4s is also available in order to maintain business continuity.

11. Single Sex Accommodation

The Trust remains committed to ensure that all patients are nursed in single sex accommodation, and is building on the successes of winter 13/14 to mitigate any challenges associated with meeting this standard over the winter period.

An escalation process has been agreed for delays in transferring patients from critical care to a suitable inpatient ward.

Any requirement to mix male and female patients in any ward area will be escalated to the Deputy Chief Executive/Chief Operating Officer (in hours) and the Director on call (out of hours).

12. RISK MANAGEMENT

Measures are being taken to identify and manage risks associated with key elements of the plan and to ensure mitigation strategies are robust. These will be reviewed as part of the report to the Trust's monthly Executive Management Board.

Eight keys areas have been identified as being vital to ensuring all services and planning arrangements are well coordinated. These are:

- Handover of patient care from London Ambulance Service (LAS)
- Operational readiness (bed management, capacity, staffing, escalation and de-escalation areas and forward planning for events such as downtime of IT systems – CRS Millennium)
- Out of Hours arrangements
- NHS/Social Services joint arrangements and work with Croydon Council to prevent/avoid admissions and speed discharge
- Links between LAS, Croydon CCG and Trust
- Preventative measures, including flu vaccinations, infection control measures
- Development of improved pathways supported by both the Paediatric and Gynaecological Assessment Units
- Communication with all stakeholders developing a collaborative approach to support our community

Preparations for this winter included identification and development of mitigation measures to ensure all services are well coordinated, responsive and resilient.

Risk	Mitigation Actions
Lack of bed and workforce capacity to cope with increased demand	- Proactive management of patient length of stay - Reduced tolerance of patients delays due to diagnostic, specialty review, intervention - Review of current and potential escalation capacity - Implementation of Discharge to Assess in October 2017 - Implementation of 'in reach' to AMU by Cardiology, Gastro and Diabetes by October 2017 - Review of specific job plans to support increased workload - Recruitment to middle grade vacancies in ED - Implement ECIP recommendations

Risk	Mitigation Actions

Patients remaining in hospital who no longer require acute care	- Weekly escalation of individual cases by Discharge Co-ordinator to system leads - Restructure of Complex discharge team at CHS - Provision of in-reach from community service teams, escalated by Discharge Co-ordinator

Risk	Mitigation Actions
Emergency Department attendances exceed plan	- Implement revised Croydon Health Services Escalation policy - Escalation to CCG - Increasing capacity for admission alternatives through Ambulatory Care, Rapid Access Clinics, Hot Clinics and or assessment units. - Escalation to the system via AEDB membership - Fully implement AEDG actions for streaming to alternatives in primary care and community.

Risk	Mitigation Actions
Loss of Elective capacity	- Increase day case capacity - Exploration of assistance from local NHS and independent sector providers

Risk	Mitigation Actions
Loss of capacity for prolonged periods due to adverse weather, staff absence, infectious outbreak	- Implement Croydon Health Services Escalation Policy - Implement local business continuity arrangements - Activate enhanced Infection Control actions and measures - Implement communications strategy

Risk	Mitigation Actions
Lack of uptake	- Proactive management of data and responsive increase in

for seasonal flu vaccination	communication with support from senior leadership

13. TRUST COMMAND AND CONTROL ARRANGEMENTS

The Executive lead for operational resilience and capacity planning at the Trust is the Deputy Chief Executive**/**Chief Operating Officer.

The operational lead for operational resilience is the Director of Operations

The 'in hours' co-ordination and response for managing emergency pressures is led by the Director of Operations and Head of Clinical Operations. The 'out of hours' response will be led by the Clinical Site Practitioner Team with support from the General Manager on call. The General Manager on call will escalate any issues to the Director on call.

To support this process, the Trust has completed a further review of the roles and responsibilities of the General Managers on Call, and Director on Call during the out of hour's period.

14. COMMUNICATION

CHS are committed to ensuring staff are kept updated with how the Trust is performing, capacity issues that the organisation faces, initiatives that have been implemented and the current state of play. Such communication is led by the Communication department linking closely with the Operational and Clinical teams to update our staff via the website, LiA events and ALL USER emails.

On more local level it is paramount that the MDT keep wards updated as to where patients are on their journey, tasks that are outstanding, issues that need to be addressed and actions that have been agreed and by whom.

The first port of call for this is during the daily Board Rounds, utilising the Nursing Whiteboard to drive the operational monitoring of flow and Consultant Led Ward rounds. Key communication must be disseminated at bed meetings, to ward managers and consultant teams in order to understand the "Current State of Play" and any outstanding actions. At these points of communication, if issues are raised, these must be escalated at the appropriate point, to the appropriate person as defined in the Triggers and Escalation points defined in Section 4.

Our recent Winter LiA event picked up on a number of key themes to ensure the Trust work towards being ready for winter but the key theme being Communication across the board as imperative to effective delivery. As of the 1st November, a 'How are we doing today', daily update will be emailed to all users from the Deputy Chief executive/Chief Operating Officer.

15. MONITORING AND REPORTING ARRANGEMENTS

- **External**

For this Winter as part of an NHSI initiative, an automated daily SITREP will be generated for submission to the Department of Health and Trust Development Authority by 11:00 hours. This will be automatically prepared within informatics and approved by either the Director of Operations or the Associate Director of Operations for Integrated Adults Directorate .

The Trust Deputy Chief Executive/Chief Operating Officer (or nominated deputy) will participate in sector wide conference calls on behalf of CHS two weekly or more frequently as required.

For the Winter of 2017/18 there will also be a National Winter Room (Skipton House for London) in order to avoid an abundance of daily phone calls. The Winter Room will go LIVE on the 6th November 2017.

- **Internal**

A SITREP report is circulated by the Clinical Site Practitioner sharing the day's previous position. The SITREP provides an update on the position in A&E, available and upcoming inpatient bed capacity, infection control, critical care CRITCON level, Nurse staffing levels and repatriations and identifies any immediate operational issues and the mitigations, and contingency plans required, as well as the SPEWS and CMS status.

In addition, the Trust has access to the Operational Control Centre (OCC), a mobile application that provides REALTIME key information of the state of ED and our ward areas with agreed thresholds in place and RAG status. OCC will be developed over the coming weeks with 835 in order to provide richer detail, increase and enhance the level of key data that is being passed onto our staff.

16. WORKING AND EXTERNAL PARTNERSHIPS

NHS South West London has a sector wide escalation plan that will be operationalised during the winter period.

The Director of Operations will be responsible for identifying the internal escalation level as per the SPEWS policy and ensuring all actions in the plan are implemented and that escalation occurs as per policy to the Deputy Chief Executive/Chief Operating Officer (in hours) or the Director on call (out of hours) who will determine the need for a sector wide conference call.

APPENDIX 1

Monitored Bed Policy- DRAFT 1

This brief policy is to enable the site practitioners to ensure that the right patients are placed in the right place.
Monitored beds are limited in the trust. These beds are mainly on CCU and in the monitored sections C & D in AMU.

Telemetry is also available on AMU and Duppas wards.

The request for monitored beds normally come from the admitting medical team or on call teams.

Clinical situations:

There are various clinical situations where patients will be required to be monitored. These are detailed below:

1. Patients with ACS
2. Patients with unstable cardiac rhythms
3. Patients on NIV
4. Patients who are haemo-dynamically unstable due to organ failure – eg sepsis
5. Patients requiring monitoring due to medical intervention – ie amiodarone infusion, phosphate infusion.

Patients with ACS and unstable cardiac rhythms should primarily be admitted to CCU.

All other patients should be on the monitored sections in AMU.

De-escalating patients

Ward rounds:

- On duty AMU consultants will highlight patients who can be de-escalated during the twice daily ward rounds.
- On duty CCU consultants will highlight patients who can be de-escalated during the daily ward rounds.

If no beds available,
Medical SpR to call on call consultants (medical for patients < 80, Elderly care for patients > 80) to discuss need for monitored bed and also to discuss any suitable patients for de-escalation.

KKOct2017

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A&E WINTER PLAN: CROYDON CCG UPDATE

INTRODUCTION

The attached checklist document provides information on the state of readiness that the Croydon system is currently at, in preparation for the coming winter. This document was originally submitted in September 2017 via the CCG to NHSE but produced in collaboration with key partners. The checklist continues to be updated as we approach the winter period so that all ambers are converted to green. The checklist by its nature contains a large number of technical terms and therefore a glossary is provided at Appendix One.

SURGE ARRANGEMENTS

Additionally "surge" processes exist to ensure that peaks in activity are managed across the system as follows:

1. Daily surge calls take place which include representation from the Trust, the CCG and its Commissioning Support Unit and over winter will include SLaM, LAS and the Local Authority.

2. There is also a Director on call during OOHs that can be contacted either by the Trust, NHSE or other agencies that can deal with any surge issues that occur during that time.

3. Any surge issues identified at the morning calls or requests from the Trust at any other time, can be dealt with as follows:

    a. Reducing Pressure at the Front Door: A media and marketing programme has been in place encouraging patients to "phone before you go" and contact 111. The CCG (as part of SWL) has funded a GP based at 111 who can give clinical advice to callers. In addition, 111 can direct patients who do not need to go to A&E to more appropriate services such as the GP Hubs, Rapid Response (RRT) team and the Roving GP service. LAS also operate a "see & treat service", a Croydon dedicated Motor Cycle (MRU) unit, and have an ACP to direct refer into the GP Hubs.

    b. Notification of Support to Surgeries: At times of surge, GPs are notified of the Alternative Care Pathways and services. In addition, services in the "LIFE" programme are notified to do additional support which will include Rapid Response Team, Roving GP and reablement teams.

    c. Reducing Pressure at the Back Door: Discharge to Assess pathways in place. Continuing Healthcare Care, social care and voluntary sector support to help reduce the level of issues that can prevent or delay discharges especially for complex care patients. Liaison through the Commissioning Support Unit surge hub if required, to help with out of borough Delayed Transfers of Care and patients needing Repatriation.

TRAINING

1. There will also be a whole system training session for key personnel, on the winter plans and preparation to ensure that all departments are fully prepared going into this period

A&E Delivery Board 217/18 Winter Readiness Checklist

A&E Delivery Board (AEDB) name: Croydon AEDB

Name and contact details to where initial queries regarding this return should be directed: Rachael Colley Rachael.colley@croydonccg.nhs.uk

Please confirm that this submission has been agreed jointly (electronically is acceptable) by the membership of the AEDB…Yes……..

Individual/s signing off the return on behalf of the AEDB…Stephen Warren & Jayne Black……

This checklist is intended to support AEDBs with winter readiness and planning for 2017/18 winter period - 1 October 2017 to Easter 2018 - as outlined in the winter planning letter. Please return this checklist by 8 September 2017, to england.london-winterhub@nhs.net

	Readiness Checklist Area	A&E Delivery Board commentary to support readiness assessment	RAG rating based on current status	RAG rating based on status by 1 Nov
1	**Wider System Preparation**			
1.1	• Please assess your current compliance with the embedding of good practice on patient flow across the organisations within your AEDB – provide an update on current plan to improve this where necessary, and your expected status by winter	Trajectory in the AEDB demonstrates how the top 11 solutions will help achieve the 4 hour target and maintain good patient flow. Further pages demonstrate the collaboration between all providers. The governance for the AEDB is included in the AEDB plan.		

	2017/18			
1.2	• Please outline the processes in place to receive weather related warning information (Met Office alerts / NHS England daily winter briefings) and the actions taken as a result to consider the likely impact on activity levels and mitigating activities (e.g. hot clinics, reduced electives, increased speciality staffing etc)	CHS plan for adverse weather conditions and include these within the Operational Resilience plans attached. CCG get updates on Monday and Friday from the Met Office. Croydon Resilience and EPR Team also provide local intelligence around weather. On a Friday the CCG receive the London Resilience briefing for the coming week including weather updates. All these documents are received by CHS.		
1.3	• Please confirm you have updated the Directory of Services and MiDoS are up to date with the most appropriate services especially those services providing alternative care pathways to support the London Ambulance Service crews	NEL CSU London DoS Team working on South London liaise closely with the CCGs to ensure appropriate services are profiled for NHS 111/ IUC referrals. HLP has funded a full time person to work on the Directory of Services in relation to healthcare professional access (via MIDOS) Services are added for HCP access. We also contact services periodically to ensure service/referral details are correct. All services are contacted before every public holiday and we liaise directly with NHS England for independent contractors (pharmacies opticians and dentist). An audit trail is kept to ensure all services are validated. CCGs across SWL are kept informed of the validation process through the monthly DoS reports. Services in addition, third party applications such as the patient website My Health London. We also carry out scenario testing to ensure that all pathways mapped within the DoS are returning appropriately for IUC/NHS111. This testing is carried out following every NHS Pathways upgrade (which usually occurs in June and December each year) The NEL London DoS Team has been based at the LAS Clinical Hub (CHUB) in Bow and Waterloo every Thursday since January 2017 to increase usage of MiDoS. The use of MiDoS allows the LAS CHUB to locate suitable services that can accept a referral from LAS, rather than sending the patient to A&E. The usage has increased rapidly over the past few months, on average 900 hits a month. Going into winter this will increase as MiDoS is rolled out to crews to support reduction in conveyances to A&E.		

1.4	• Please assess your ability across organisations within the AEDB to access Mental Health crisis Plans, GP Care Plans, End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services across the Emergency Department (ED) and Urgent Care Centre (UCC)	The LA currently has limited access to any of the Health systems recording databases. Social Services staff currently uses a separate case recording system of their own. The issue of information sharing across the whole system is being reviewed as part of the Croydon Alliance arrangements. In the interim local communication and processes are well embedded, ensuring information is shared in a timely and responsive manner. MH patient records cannot be accessed but there is a 24/7 PLN team that can be contacted for information, advice and support. CMC for those patients that a record has been uploaded for is available.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
2	**NHS 111 / primary care**			
2.1	• Is the AEDB assured that there are robust plans for GP OOH providers to deal with known activity peaks in demand across the winter period?	Workforce is reviewed weekly and adjusted according to demand. OOH - Assurance is through the contractual meetings, Integrated Urgent Care (IUC) Clinical Quality Review Group, IUC Contract meetings and submissions to HLP. These meetings provide assurance in managing capacity and demand activity peaks. Monthly contract and CQRG meetings assure performance of the provider and the clinical quality of the service and contribute to the on-going redesign of the service to meet the new IUC specification.		
2.2	• **Primary Care Access (100% coverage 7 day 8am-8pm)** • What is the current and projected coverage of extended access to primary care in evenings and weekends? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if	Currently we have three GP Hubs providing same day appointments for urgent primary care problems. This service is open between the hours of 08:00 and 20:00 pm, 7 day a week which meets national specifications. These hubs are located at: • Central Croydon • Purley • Parkway (New Addington) In addition, we have under development three further top-up hubs which will be located at:		

	planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	• Shirley area, Croydon • Thornton Heath • Mayday They will provide extended access to routine GP appointments with pre-bookable access, extending the time of availability or routine primary care services to 8-8pm Monday – Friday. In the first phase of the pilot there will be Saturday morning opening too. Additional weekend opening will be trialled as the pilot develops to determine demand/need around existing services. The hub in the Shirley area will be based at Shirley Medical Centre and will be open by early December 2017. The Thornton Heath Hub is still in development and the start date for this site is still to be confirmed but there is an expectation that this will open before the end of this year. The proposed hub in Mayday is under discussion and at a similar stage as Thornton Heath. All three top-up hubs will provide 8-8pm Monday-Friday and some provision will be made for Saturdays. At present Sunday opening is being discussed and will implemented as soon as possible.		
2.3	• **111 Capacity (51% threshold)** • What is the current and projected percentage of 111 calls with clinical contact? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall*	We currently meet 30% of 111 calls with clinical contact. We have piloted a GP in the contact centre to manage "star lines" along with the rest of London since Jan17. This has now been agreed as Business as Usual and will be funded for a further year. This additional clinical capacity alongside our enhanced pathways for young, elderly and vulnerable patients, and Low-Acuity Ambulance and A&E re-triage will ensure that patients requiring contact with a clinician will have access to the right clinical skillset to meet their needs. We will reach the 51% target by the end of 17/18 by continuing to support care homes and ambulance crews through the star lines into the GP in the CAS and by moving from c.65% re-triage of Low-Acuity ambulances to 85%. As at Oct, this is now at 77.7%. We plan to run a GP in the Clinical Assessment Service (CAS) and Mental Health Warm Transfers for the rest of the year and we will focus the additional senior clinician capacity on callers from care homes, complex and elderly patients and children, particularly where there		

	below the threshold	is a suspicion of sepsis.		
2.4	• Does NHS 111 have access to Mental Health crisis Plans, GP Care Plans and End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services?	NHS 111 has access to summary care records via adastra and EoLC plans via Coordinate my Care and SPNs. Plans are underway but at this stage there are still technical, operational and governance barriers. We will continue to work with software vendors and HLP to deliver this functionality when it becomes widely available. NHS111 will be able to send patients to the UCC but it is unlikely that booking fully operational		
2.5	• Can NHS 111 book into UCCs?	NHS 111 cannot book into UCCs. They can send via DoS – the receiving UCC will usually receive an nhs.net email from 111. There is an expectation that once the IT issues have been resolved then the ability to book directly into the UCCs will be available – HLP are currently working on this issue		
2.6	• Can NHS 111 book into primary care?	NHS 111 can book into OOH services across SWL but not into extended access hubs or primary care in hours. Plans are underway with pilot practices in a number of areas supported by the continuation of GP in the CAS. Practices will come online as and when a software vendor and HLP expertise become available to support us. A pilot for booking is expected to go live in Dec 17 in some practices with roll out following.		
2.7	• What are the AEDB's plans to seamlessly route electronic prescriptions from NHS 111 and GP out of hours to pharmacies via the Electronic Prescription Service (EPS)?	We are developing a SWL approach and the expectation is that EPS will be in place in place by Nov 2017.		
2.8	• What are the AEDB's plans to develop and test new specialist modules of clinical triage through NHS 111 for paediatrics, mental health and frailty?	We run modified pathways for paediatrics, mental health crisis, patients over the age of 85 and any patient with an end of life or care plan.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			

3	**Care home support:**			
3.1	• Please assess your AEDB's compliance against the British Geriatrics Society Guide on Care Home Medicine	A Joint policy was ratified in July 2017 between LA and CCG around medication management and administration in domicillary care settings.		
3.2	• Please outline the AEDB's risks around care home capacity this winter e.g. closures, plans to open or commission new care home beds	Current capacity will be reviewed. New block contract arrangements reablement and CICs beds are being commissioned and the added resilience is the OBC alliance programme No plans for any homes to be closed or to close in the borough.		
3.3	• Are there any CQC issues affecting care homes in the AEDB's geography e.g. self-embargos, local authority embargos?	There are around 18 care homes in Croydon who are rated as requires improvement. However at present there is no suspension on new services/placements with any care home in Croydon.		
3.4	• How many care homes in the AEDB's geography are receiving support from your quality and safety team?	We have around 150 care homes in Croydon. At any one time we are speaking to around 20-30 of them in quality discussions between quality monitoring, commissioning and safeguarding as well as the CCG. At present 6 are in a Provider Concerns process. The Care Support Team works with 15-20 care homes at any time.		
3.5	• Is there sufficient therapy and specialist nursing capacity in the community to offer in reach support to care homes in AEDB's geography?	There are specialist nursing and therapies available to visit care homes including CICS & Rapid Response. The care homes are able to make direct referrals to the Rapid Response Service 24hrs per day 7 days per week. Currently there is sufficient capacity to meet the demands on this service.		
3.6	• Please confirm you are providing the *567 access to a GP through NHS 111 for care homes and crews. Please confirm what marketing you have provided to care homes on the service offer available	The CCG provides regular notification to the care homes via emails regarding the *567 access. The next one will be sent on Friday, 24th November. From the data supplied on the monthly Care Home LAS activity reports generated by LAS, we are able to target those care homes and the managers to discuss reasons behind their high usage. This helps to ensure that the issues are dealt with quickly. Care Home managers are also encouraged to attend the Care Home steering group to discuss issues with a view to solving problems. The purple guide which is a training guide for care home staff is being updated to reflect the		

		*567 access numbers and latest developments around care homes. There is an expectation that the updated version will be circulated prior to the end of the year.		
3.7	• Is there a tele-health service to reduce 999 calls and ED attendance? Please provide explanatory commentary	There is currently limited provision of telehealth on a case managed basis for individual patients with Chronic disease (COPD, HF). Limited provision within some selected care homes. However this is set to expand within the ICN and the LIFE initiatives. In respect of Adult Social Care, the Council operates a Tele Care and care Line system which helps reduce unnecessary ED attendance and maximise people's independence and their ability to remain in their own homes.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
4	**Front Door**			
4.1	• Is the AEDB assured that the acute provider has a rapid assessment service in place? If so, is the rapid assessment service aligned with social care? • How has the AEDB ensured that there is a clear process for primary care referrals (including OOH) to acute specialities to bypass ED? • What alternatives to immediate referrals are available, including 'hot' clinics?	CHS have a variety of Rapid Assessment Areas: • ACE • RAMU • SAU • GAU • PAU Ambulatory clinics run alongside a variety of specialty hot clinics. GP referral directly to AMU, ACE and RAMU are well established, including LAS referrals directly to RAMU which came on line May 2017. In the community, Rapid Response provides an admission avoidance service with access to the Consultant Geriatrician, the Roving GP and Step-Up beds.		
4.2	• How is the AEDB ensuring that EDs have sufficient clinical input from surgical and clinical specialties? • Does the ED have access to Records (EOL/GP Care Plans / Mental Health)	CHS have produced an updated Streaming and Re—Direction policy that will support patients being re-directed to other services within the CUCA system. Going forward being able to book directly to Primary Care services will be dependent on IT intra-operability. The IT issues are being looked into by HLP and there are no timings available when this will be resolved. MH patient records cannot be accessed but there is a 24/7 PLN team that can be contacted		

	• Are there plans in place for winter for UCCs and EDs to book into primary care?	for information, advice and support. CMC for those patients that a record has been uploaded for is available.		
4.3	• What actions are in hand or planned to ensure that LAS handover delays are reduced to a minimum?	We use an escalation process to avoid delays in handovers, this alongside direct referral to RAMU for those appropriate patients reduces hand over delays. Some LAS delays are due to the temporary location of the ED which results in delay from arrival of LAS into the hospital grounds to arrival in the department. This is being reviewed as part of the LAS AEDB Sub Group.		
4.4	**Streaming (50% threshold)** • What is the current and projected trajectory for percentage of patients streamed at the front door? • What plans are in place to ensure that streaming performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	All patients are streamed on arrival. There is a KPI within the CUCA contract that stipulates % of patients' walk-in/any mode of arrival are to be streamed to UCC. This is monitored in the monthly CUCA CMG meeting. A SOP has been developed to support streaming and re-direction of patients away from the ED into UCC or GP Hubs		
4.5	**Ambulatory Care** • What proportion of patients presenting at the ED are for ambulatory care sensitive conditions? • What plans are in place to increase service provision for these patients?	We are currently achieving 24% of patients converted to an ambulatory pathway and whilst not achieving the required 33% we are on an improving trajectory. There is an expectation the new Streaming and Re-Direction policy (see 4.2) will help to deliver the trajectory. The provision is being extended from Q3 to support increasing hours of service at weekends		
	Is additional support required in this area? If so please specify the nature			

	of, and where, support is needed			
5	**Mental Health**			
5.1	• Is the AEDB assured that there is a 24/7 liaison psychiatry service available. Does the service include a consultant psychiatrist?	There is a 24 hour Liaison Psychiatry team based in CUH, Woodecote House, the team consists of 5 nurses with 4 vacancies, 1 team administrator 1 team leader, 1 consultant psychiatrist with 1 vacancy and 4 junior doctors. There is an on-call core trainee Doctor covering CUH based at the Bethlem site out of hours. The team also have access to a Specialist Registrar and Consultant on call out of hours. With increased investment as part of NHSE Core24 funding we will be recruiting into 12 month fixed term posts, to date the following posts are filled: • 0.2wte Consultant MHOA Liaison Psychiatrist Croydon University Hospital • 1.0wte b7 MHOA Specialist Psychiatric Liaison Nurse Croydon University Hospital • 0.5wte Consultant Liaison Psychiatrist King's College Hospital Pending Recruitment by the end of 2017: • 0.6wte Consultant Liaison Psychiatrist • 0.6wte Psychologist • 1.0wte Occupational Therapist • 2.0wte b6 Psychiatric Liaison Nurse		
5.2	• What training/competencies do staff, including doctors have against the Mental Health Act and the Mental Health Act Code of Practice? Have the upcoming (Autumn) MHA legislation changes been considered?	All staff are required to attend mandatory training including MHA and MCA training yearly. Doctors are required to renew their section 12 / Approved Clinician status on 5 yearly basis. The team have a dedicated MHA and MCA Lead.		
5.3	• Is the AEDB assured that the provider is compliant with NICE guidance on short-term management and prevention of recurrence of self-harm?	An initial informal audit had identified a need for consistency in this area. The team leader has met and recently reminded all staff of the NICE Guidelines for the short term management of self-harm and ensured that psychosocial assessments were in place for every attendance. We are currently re-auditing to ensure adherence to this with the		

		results presented to the SRG when complete.		
5.4	• To support the timely delivery of care for individuals detained under s136 and requiring physical health input has consideration be given to a parallel and concurrent mental health assessment and treatment by medical staff?	The team follow the key principles of the PAN London Section 136 pathway. People subject to Section 136 attending for medical treatment are discussed with the MHLT to ensure parallel working protocols are adhered to. If there is a need for prolonged medical treatment the MHAA can be completed by the MHLT both in and out of hours.		
5.5	• In line with the pan-London s136 pathway, what protocols are in place for patients arriving under s136? Are these protocols recognised by the police and ambulance service?	The team follow the PAN London sec 136 pathway – this will be added to the operational policy for CUH currently in draft for ratification and the Health Based Place of Safety operational procedures		
5.6	• What arrangements are in place between the acute and mental health trust to ensure robust clinical pathways and reduce the number of patient transfers between sites?	There is a Mental Health Act Service Level Agreement in progress for CUH. SLAM also follow the medical fitness for transfer protocol where each CUH patient is assessed as medically fit for transfer to a MH bed before transfer and this is documented in EPJs by a SLAM Doctor. There is currently no formal protocol for the transfer of patients to CUH from the Bethlem site in place. It is accepted that when a patient is admitted to CUH from the Bethlem that the SLAM transfer of patients policy be adhered to : **<u>Transfer of a Service User to Another Hospital/Unit/Service</u>** *All transfers should be well planned with the service users and carers being given adequate and timely information as to why the transfer is taking place. There also needs to be good communication between the Trust and the receiving hospital/unit, with photocopies of the relevant records being provided and a formal documented handover of care between the Trust and receiving service.*		
5.7	• What area is provided for patients to wait in until transport for admission to a psychiatric service or other follow-up action is arranged?	Assessment room in ED is available for patients waiting for admission when not in use for assessments. If this option is not available patients will wait in the general ED area.		
5.8	• What arrangements are in place	LAS are currently reviewing the monthly high callers to their service and working with GPs,		

	with the community and ambulance service to reduce the number of frequent attenders?	acute providers and MH colleagues to implement care plans where appropriate to support community support. There are ACP in place for LAS to RAMU and to GP Hubs. There are plans to develop an ACP for LAS to Rapid Response and the Roving GP service. There is a National CQUIN to reduce the number of attendances and bed days to CUH. This is jointly owned by SLAM and the acute trust. A frequent attender's forum is being facilitated and is designed to include all clinicians involved in the persons care and can include, but not exclusively, CUH, community staff, LAS and Local Authority staff. The forum is designed to ensure robust safety and recovery plans are in place alongside onward referrals if appropriate. We have achieved Q1 and are on track for Q2. Frequent callers are managed through an integrated process involving a multi-disciplinary group that meet monthly. This group includes representatives from the LAS, Croydon Hospital, Community Health Services, Social Care, MPS and Mental Health teams. It looks to review identified frequent callers and frequent attenders to ED and put in place appropriate care plans that are visible to all agencies in order to appropriately manage a reduction in attendance.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
6	**Flow**			
6.1	• What is the current status on the implementation of the SAFER Patient Flow Bundle • Implementing SAFER reduces stranded patient numbers and reduces deconditioning that results from prolonged hospital stays. If not implementation is not 100%, please describe the plans to drive full implementation,	CHS have provided a number of implementation weeks, and is currently promoting SORT to support a consistent approach to ward rounds. EDD's are being promoted by using mixed media and we are seeing an improvement across the Trust. We monitor our compliance monthly and have a programme of work to improve the application of SAFER.		

	including AEDB oversight.			
6.2	• How is the AEDB area monitoring and managing 'stranded patients'? • Are you making use of 'mini-MADE' (Multi-agency discharge events) early when stranded patient numbers rise, rather than as an urgent measure during escalation. It is essential to identify the number of stranded patient that should trigger the mini-MADE • Please describe the local arrangements which address this	Weekly reviews of all inpatients, escalation within the trust preceding system wide escalation. Weekly review of all DTOC's and shared across social and health providers to minimise length of stay. Reviewed monthly at AEDB within the Dashboard and monthly reports shared with CCG and Social services colleagues. As from the end of October, "stranded patient numbers" are being reported daily as part of the morning surge call.		
6.3	• Is the AEDB assured that the trust has a Full Capacity Protocol (FCP) in place? • If it does not, please confirm that this is either because the trust has sufficient capacity available not to require one, or, that the trust wards have been surveyed and judged unsuitable to support the use of a FCP. • If this is the case, please articulate the trusts plan to manage a crowded ED safely, without recourse to an ED redirect or closure *NB The use of FCPs is supported by the Royal College, but their use should be kept to an absolute minimum, and they must be*	CHS escalation policy and Operational Resilience shared and support de-escalation. To be reviewed at AEDB		

	introduced with suitable governance, in a planned manner.			
6.4	• If there were 12 hour trolley breaches within your AEDB geography last year, what were the causes, and what actions have been put in place to prevent them occurring this year?	Only 1 recorded, lessons learnt regarding Mental Health support and place of safety		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
7	**Capacity**			
7.1	**Bed Occupancy (92% threshold)** • What is the current and projected non-elective bed occupancy? • What plans are in place to ensure performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation*	**Please refer to Appendix 2 – Bed audit/ occupancy exercise**		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
8	**Discharge**			

8.1	• Describe the current status of implementing the Eight High Impact Changes for Managing Transfers of Care locally across your AEDB	The 8 High Impact Changes Steering Group is leading on the implementation of the 8 High impact changes. The next big milestone is the rollout of the Discharge to Assess model developed for Croydon. A detailed status report is embedded below. Discharge to Assess pilot to has been in place for 4 weeks and has had 40 patients through the D2A(2) pathway. Starting work on the D2A(3) pathway before end of December 2017		
8.2	• Has the AEDB modelled discharge capacity (workforce, beds, equipment, funding) to ensure that health and social care can meet daily demand, including variation, across the whole of winter? • Please provide supporting narrative regarding any gaps or issues which are of concern and where further work is required, including timescales for completion	Bed modelling has been completed by CHS and submitted to NHSE this alongside the winter planning to support operational resilience gives assurance plans are in place. The draft winter plan takes into account staffing, demand and capacity. Croydon Council have highlighted the risk regarding market forces and the impact on placement and care package provision within AEDB and mitigation is being prepared to support the system over the winter period		
8.3	• How many additional home-care packages have been commissioned to support 'discharge to assess'. Systems that have done this find that Continuing Health Care (CHC) delays and social care delayed transfers of care (DToCs) are reduced. This additional capacity can be realised before winter and	From September 2017, a six-week pilot will be introduced at Croydon Health Services NHS Foundation Trust to test the local Discharge to Assess (Home First) process in three hospital wards (Purley 1 & 2 and Wandle) with the expectation of a full rollout by March 2018. The Council has commissioned 38,000 hours for D2A homecare packages, which will double by the end of the year. This will reduce social care delays for care packages. Work looking at the Discharge to Assess for Pathway 3 will start October 2017. Currently 15-20% of the CHC assessments are done in CHS.		

	used for surge			
8.4	• In previous winters, acute trusts have reported difficulties in discharging patients because non acute providers cannot provide the level of care that the acuity of the patients demand. Has this been an issue for your AEDB area? If so, what action has been taken to provide additional services to non-acute care settings, in order for them to be able to support acutely unwell, but medically fit patients?	Several steps have taken place to prepare for any challenges due to reduced discharge profiles: Out of Hospital transformation with D2A and increased intermediate care provision will be implemented during September and October 2017 to prepare for increased winter demands. Integrated working with Health and Social care to support our complex patients who cross funding barriers support innovative approaches and joint care provision to support the patient pathway. Acute trust has escalation routes to partner organisations to address any key issues. Increase support for admission avoidance for those who can be cared for in the community Rapid Response, ICT, Reablement and step up/down bed provision		
8.5	• What work has been undertaken to promote maximising earlier in the day discharges? • Do you have targets for the numbers of patients to be discharged before 9/ 10am? • Are they being achieved, how is this monitored, who at board level is responsible?	This work stream is within our Right Patient, Right Bed programme of work chaired by the Medical Director and we have already seen a reduction in LOS from April to June of 0.6 days and whilst our discharges before 13:00 are still recorded at an average of 15% we acknowledge in real terms this is often the recording of the discharge on EPR rather than real time when a patient leaves the ward. We have recently implemented SORT which is impacting our discharge profile operationally and we anticipate seeing this within our data over the next month's monitoring		
8.6	• Is a 'placement without prejudice' process in place? *This ensures that when a patient has been identified as potentially requiring CHC, he/she is discharged to an appropriate environment out of hospital while the assessment and decision is made. A local agreement should exist between the CCG and Local Authority specifying which party will initially pay for the care or*	Funding without prejudice will be taken on a case by case basis as in previous years.		

	placement. If CHC is agreed, the costs should be met by the CCG backdated to the date of discharge.			
8.7	• Are plans in place to use the trusted assessor guide, designed to support hospitals, primary and community care and local councils deliver trusted assessment as a key part of the High Impact Change Model described in Chapter 2 of *the Five Year Forward View Next Steps*?	The trusted assessors used to support the discharge to assess model are compliant with the guide. Pilot Sept 2017 Roll-Out October 2017 Working with Respiratory colleagues in their Facilitated Discharge initiative also.		
8.8	• What specific trusted assessments are happening in the AEDB geography? • Does the Local Authority have trusted assessor models of working? If so, what kind? • Does your CHC team follow a trusted assessor model? • Does the AEDB have plans in place for non-prejudice funding agreements with the Local Authority for patients not eligible for CHC but do have health needs. For example: patient with grade four pressure sore	The local Authority and Croydon University Hospital have created a trusted assessor model. A single trusted assessment has been created for people going through Pathway 2 D2A. The short assessment takes place in hospital. A full functional assessment takes place in the community, which follow the trusted assessor model. Funding without prejudice will be taken on a case by case basis as in previous years.		
8.9	• What specific work is being undertaken to support capacity at the end of the festive period? • Please outline current work with internal teams around re-ablement and external teams re community support / social services etc., so that options are	The LA requires its staff to work consistently across the festive period and is currently engaging with staff in respect of extended working hours under new models of delivery (LIFE). Staff will be deployed equitably to ensure an even spread across peak times. At times of pressure, staff will be deployed to cover different parts of the service to ensure social services are fully responsive to support pressures in the whole system.		

	not exhausted straight after the return after the New Year, increasing the risk of long ED delays, ambulance handover delays and 12 hour breaches.			
8.10	**Medically Optimised (3% threshold)** • What is the current and projected MOs performance during winter? • What plans are in place to ensure that the percentage of patients that remain within the threshold level? • Do you have sufficient community therapy and domiciliary care capacity to manage the medically optimised patients who are discharged form hospital sooner? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	The trust is predicting a MO of 2% over the winter period; our current average is 1.5%. We are confident that with the implementation of D2A from October, the winter effect will not increase the MO beyond the 3% threshold The Plan is to introduce a new service called The LIFE Service (Living Independently for Everyone). The service will be an integrated community based single team of staff drawn from across reablement, rehabilitation, intermediate care, health and social care professionals, clinicians and colleagues from related community organisations within the 3rd Sector. The new service will start in October and will work on a home-first principle, but will incorporate bedded facilities for people who cannot be safely care for at home, but do not require acute hospital care. Extra investment has been given to the service to staff nurses, physiotherapists, occupational therapists, health and wellbeing assessors and reablement workers		
8.11	**Continuing Health Care (threshold 75% by end Oct-17, 85% by end Jan-18)** • What is the current and planned trajectory for CHC assessments taking place outside of an acute setting? What plans are in place to ensure performance is within	Croydon CCG has assessed their position regarding the numbers of CHC assessments outside of the acute setting. Our current trajectory is 75-80% of all CHC assessments are taking place outside of the acute setting. We are currently working with our acute colleagues to develop plans to increase this number by reviewing existing pathways and processes and to ensure that over 80% are completed during the winter months outside of the acute setting.		

	this threshold level? • What plans in place to ensure that the 80% threshold of CHC assessments taking place within 28 days during winter is met? • Please provide justification if planned trajectory is below threshold levels • How will the AEDB assist acute trusts with choice issues related to CHC placements and care offers? • How will the AEDB work with the Local Authority to ensure residential home patients are regularly reviewed to ensure cross over from residential to nursing care is seamless to avoid admissions for re-banding to Funded Nursing Care or CHC *N.B. CHC assessments will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	Within the Discharge Policy choice is included, and the brokerage team also support and enable families to make informed decisions regarding making the appropriate decision for their relative. The CCG is currently working with all stakeholders including our LA colleagues to ensure that processes are in place to ensure that there is a seamless transfer from FNC to CHC.		
8.12	**DTOCs** • What plans are in place to ensure performance is aligned with the expectations set out in London DTOC Expectations – Winter 2017/18 (Appendix 4)? • Please provide justification if planned trajectory is below threshold levels	We have reviewed our processes and implemented a weekly review of all inpatients and DTOC review with our Social Services colleagues. This has led to an increase in the % of DTOC as we have a complete picture and transparency across providers. The implementation of D2A provides the assurance we will achieve 3.5% consistently from October. DTOC are currently 4.1% and this is felt to be due to improved reporting of the process. This is part of the 8-HICs programme and is under review to ensure DTOCs are reduced to under the 3.5% national target.		

	N.B. this metric will be monitored daily/weekly depending on Delivery Board categorisation. Recovery plans will be requested should performance fall below the threshold			
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
9	**Public Health including managing flu and Infection control**			
9.1	• Is the AEDB assured that public health and prevention measures are a comprehensive part of system-wide winter resilience plans which include all providers? This should include the local plans for responding to Influenza or Influenza-like illnesses	The CCG has a flu planning task and finish group, which includes representatives from public health and other key providers that is convened during the summer months to review performance and key lessons from the preceding year and to update the system-wide plan accordingly. The group then meets regularly (at least monthly) throughout the seasonal influenza period to review progress against the system-wide plan and monitor local flu surveillance data and necessary actions that may need to be put in place if early indicators suggest an outbreak, either isolated or more widespread.		
9.2	• Is the AEDB assured that local leadership from public health commissioners and providers are involved as part of winter resilience planning? *N.B. The main commissioners are Local Authorities and NHSE for certain immunisation programmes. In partnership with Local Authorities, London Pharmacies are offering influenza vaccines to LA Care Home staff to build resilience in these care*	Croydon's system wide flu planning group includes public health commissioning representatives and plans are underway to update their flu vaccination plans for front line social workers in light of the uncertainty regarding uptake during 2016/17.		

<table>
<tr><td></td><td>homes and hopefully affect delayed discharges.
Providers include general practice and pharmacy.</td><td></td><td></td><td></td></tr>
<tr><td>9.3</td><td>• Does the AEDB have assurance around compliance with hand washing levels in trusts?
• What is the target level and what is your achievement of that to date?
• What is being done pre-winter to re-enforce the messages around good infection control?</td><td>Hand Hygiene is audited on a monthly basis and both our CCG and PHE attend our monthly ICC meetings where our compliance is monitored. Please see table below demonstrating our training compliance.

There is a rolling programme of Infection Control measures and prevention promotion and increased vigilance is supported with trust wide promotion as we plan for winter

<table>
<tr><th></th><th>Nurse/ midwife</th><th>Doctor</th><th>Therapist</th><th>HCA/ Phlebotomist</th><th>Student</th><th>Non Clinical Staff</th></tr>
<tr><td>June 2017</td><td>95%</td><td>88%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>July 2017</td><td>95%</td><td>77%</td><td>100%</td><td>100%</td><td>92%</td><td>100%</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>9.4</td><td>• Is there a comprehensive local flu strategy in place?
• Is the AEDB assured that plans are in place for the delivery of seasonal flu immunisation across all population groups and that monitoring of these plans will be part of your routine reporting?
• Do those plans include the at risk groups in your population?
• Are plans in place to routinely review and act on the PHE weekly flu surveillance reports in order to understand the indicators on flu in circulation amongst the population as well as support the</td><td>The Croydon-wide System-wide flu plan is in the process of being updated to include an enhanced focus on flu surveillance.</td><td></td><td></td></tr>
</table>

	management of the health and care system?			
9.5	• How is the AEDB using data from the sepsis CQUIN, the PHE Fingertips AMR dashboard and RX-Info to assure itself that all patients are receiving effective 3 day antibiotic reviews?			
9.6	• Is the AEDB assured that the targets for staff immunisation will be exceeded? How will this form part of your routine reporting? It is important that this includes all providers of NHS Services across acute, community, mental health and primary care. • Did organisations meet their targets for staff vaccination rates last year? • Is your staff vaccination rate target sufficiently stretching? • If targets were not met, what is the strategy to do better this year? • How will this be monitored?	CHS is our main provider of acute and community services achieved a target of 78% by January 2017. They have submitted their flu plan for 2017/18 and are on track to achieve the national target for this year. SLAM is our main Mental Health Trust (MHT) and provider of our MH services and had the lowest flu performance across all London's MHTs during 2016/17. We have requested details of their plans and are awaiting their response.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
10	**Workforce**			
10.1	• What review of workforce plans has been undertaken within the winter planning process? How has this been overlaid to fragile services, including identification of	We continually review our workforce and manage the mitigation as business as usual. Wider system workforce planning acknowledges the concerns regarding community care provision and this has been highlighted within AEDB. CHS is looking at the skill mix and other AHPs (Pharmacists, Paramedic Practitioners, ENPs		

	key operational/staffing gaps via profession/service/speciality and plans to address and the confidence levels of this within the winter timeframe?	and ANPs)		
10.2	• Has an impact assessment and risk mitigation of Brexit been undertaken and how this plays into winter and operational plans?	We have considered Brexit and will prepare this for winter 18-19 when we believe the impact will be realised		
10.3	• Is the AEDB assured that the Trust holding firm on agency use and caps across all workforce groups, in particular medics, and staying within authorised frameworks – how is this being assured over the winter period?	CHS shares its workforce overview with CCG colleagues including vacancy factors, agency usage.		
10.4	• Describe the wider links to Flu planning and exception planning in terms of workforce and impacts and risk management associated with this including outstanding risks	CHS had successful workforce vaccination plans in 2016/17 and intend to roll these forward for 2017/18. During 2016/17, the Local Authority came across different interpretations within teams as to what constitutes a front line social care worker and what was the uptake of the vaccination within this cohort. Therefore action is underway to update their plans for front line social workers in light of the above. Awaiting confirmation of actions SLAM have planned for 2017/18 for their workforce. CHS has a flu plan and includes workforce absence within its operational resilience planning		
10.5	• Have you identified any high risk workforce issues? What are these and what is the impact of not mitigating? Are they being addressed and managed within the trust or do they depend on a wider solution across STP/speciality etc?	Currently working with NHSI to review our nursing workforce requirements including risk assessments		

10.6	• Are your trust plans on workforce risk assessment and mitigations going to Trust Board for review and when is this scheduled for? Are these plans drawn together by clinical, medical and speciality managers and senior staff working in an integrated way to provide assurance across all services?	This is a continual process and these are submitted every 6 months to the Trust Board		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
11	**Escalation arrangements**			
11.1	• Is the AEDB assured that the Trust has remedied and tested escalation arrangements internally and with system partners if there were issues last year?	These have been tested a number of times over the previous 12 months both in Major alerts and due to demand management triggers		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
12	**Business continuity**			
12.1	• Have business continuity plans been reviewed recently, in particular, regarding those elements geared to coping with cold weather? • Do all parts of the organisation know what to do in the event of receiving cold weather alerts? • Does the trust have adequate	CHS reviews all BCP annually Yes CHS is prepared and plans in advance for adverse weather both in summer and winter. Yes our estates and facilities team provide Salt/Grit and maintain all exits and entrances when required		

	stocks of salt and grit, and is it assured regarding the BC arrangements of its suppliers?			
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
13	**Communications**			
13.1	• Has the AEDB reviewed the communications plans used last year, both internally with staff, but also externally with patients and partners, to ensure that it remains up to date and fit for purpose? • Does the plan focus on high risk groups and attendance avoidance best practice through self-care, pharmacy and NHS 111? • Have you made any changes as a result of learning?	Communications plan is currently under review with recognition that a system wide plan needs to be implemented and supported by all organisations within the AEDB, whilst aligning to the national comms strategy.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
14	**Summary Statement**			
14.1	Please provide a summary statement regarding your AEDB preparations for winter, demonstrating (if not clearly captured above) the lessons learned from last winter and where you have actioned these.	Please find the acute trusts draft winter plan and operational resilience report which both include the overarching AEDB winter planning		
Overall RAG status				

NB. Assurance of ambulance service planning will be undertaken once across London by the Ambulance Commissioners in NW London and results shared with Delivery Boards

Appendix One

GLOSSARY OF TERMS

ACE - Acute Care of the Elderly
ACP – Alternative/Approved Care Pathway
BCP – Business Continuity Plan
CHC – Continual Health Care
CHS – Croydon Hospital Service
COPD - Chronic Obstructive Pulmonary Disease
CQUIN – Commissioning for Quality and Innovation
CUCA – Croydon Urgent Care Alliance
CUH – Croydon University Hospital
DoC – Director on Call
DoS – Directory of Services
DTOC – Delayed transfer of care
D2A(2) – Discharge to Assess (Pathway 2)
EPR Team – Emergency Planning, Resilience
EPS - Electronic Prescription Service
GAU - Gynaecology Assessment Unit
HCP – Health Care Professional
HF – Heart Failure
HICs – High Impact Changes
HLP – Healthy London Partnership
IUC – Integrated Urgent Care
LA – Local Authority
LAS – London Ambulance Service
LIFE – Living Independently For Everyone
MCA – Mental Capacity Act
MHA – Mental Health Act
MHOA - Mental Health Older Adult
NELCSU – North East London Commissioning Support Unit
OOH – Out of Hours

PAU - Paediatric Assessment Unit
PLN - Psychiatric Liaison Nurse
RAMU - Rapid Assessment Medical Unit .
UCC – Urgent Care Centre
SAU - Surgical Assessment Unit
SLAM – South London and Maudsley
Wte - Whole time equivalent

Health Scrutiny Meeting Report – Croydon A&E Services

Winter 2017/18

1.0 Introduction

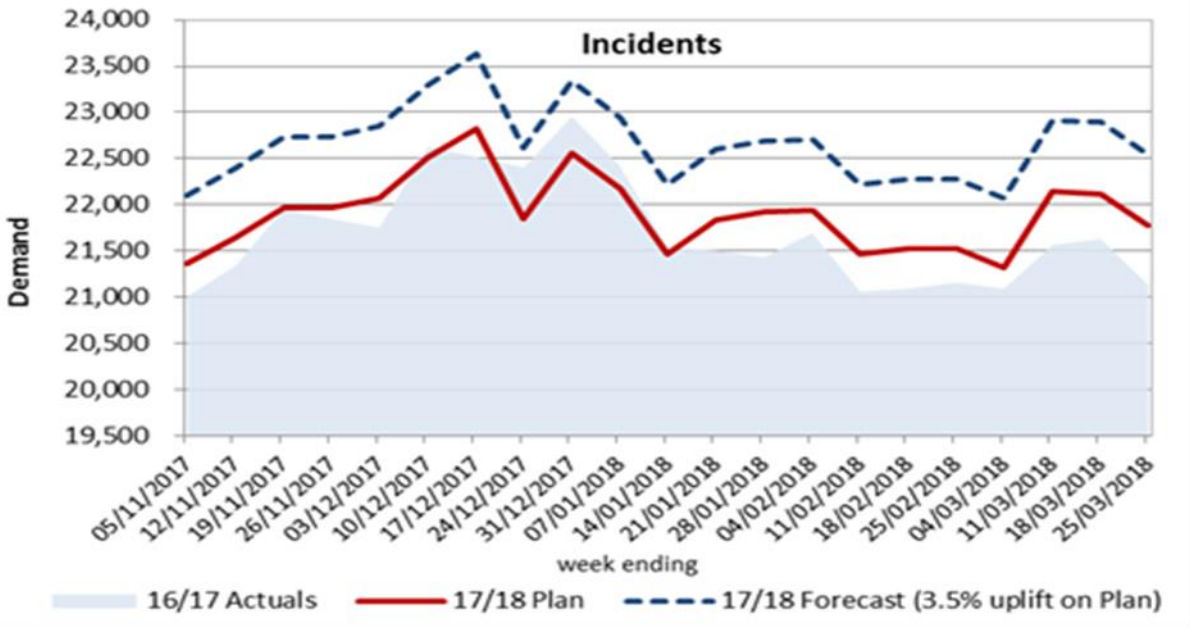
1.0.1 This paper has been written to give assurance of the winter preparedness of the London Ambulance Service working within the Croydon area and the various contingencies in place to support.

1.0.2 The winter period historically causes increased pressure within the health system for various reasons such as seasonal flu, increased falls and respiratory illnesses which lead to increased admissions to hospitals. As well as the increases in demand resulting from these factors, this period also encompasses a number of significant public and social events (such as New Year's Eve) which impact on LAS in terms of road access, large variations in population numbers and alcohol related incidents.

2.0 Performance

2.0.1 We've seen improvement in our performance this year, however this has been challenging to maintain given the unprecedented demand we have been facing.

- We are handling **200 more incidents a day** across the capital compared with 2015/16.
- We answer **5,000 calls every day**. This is a 1.4% increase on 2015/16.



2.0.2 Performance for LAS across London in September was 68.60% for Cat A (seriously ill or life threatening). In **Croydon it was 69.44**%.

2.0.3 In Croydon we reached 75% of Cat A patients in **under nine minutes**.

3.0 Staffing

3.0.1 The London Ambulance Service has recruited over 350 frontline staff within the last year.

3.0.2 Within the Croydon Area we have an establishment of 123 frontline staff, with 110 clinicians currently in post.

4.0 Ambulance Response Programme

4.0.1 Since February 2015, ambulance services in England have been engaged in an NHS England led trial of a new operating model, under an initiative known as the Ambulance Response Programme (ARP). ARP has been developed using the most comprehensive study about ambulance services completed anywhere in the world. More than 10 million patients have been studied, and there have been no adverse incidents or patient safety concerns identified with its implementation in operational practise. This work has also independently evaluated by Sheffield University's School of Health and Related Research (ScHARR).

4.0.2 The development of ARP focussed on four main areas:

- Identifying the most seriously ill patients as early as possible through processes known as Pre-Triage Sieve (PTS) and Nature of Call (NOC);
- Giving control room staff more time (up to 240 seconds) to assess incidents through a process known as Dispatch on Disposition (DOD);
- Developing new clinical code sets and response categories using the best available clinical evidence;
- Developing new targets, indicators and measures.

4.0.3 For LAS, in practical terms, the new standards will mean that the number of calls requiring a rapid response will likely fall from around 1500+ (for Red 1 and Red 2 within 8 minutes) per day to around 250 (Category 1 within a 7 minute mean) per day.

4.0.4 LAS has agreed with NHS England that ARP will be implemented on the night of 31st October 2017 into 1st November 2017.

5.0 Alcohol Related Incidents

5.0.1 The number of Category A alcohol incidents which the LAS attends peak between July and August with a secondary peak in December. While the peak is not as pronounced it does demonstrate a marked increase which presents a risk to the service during the winter period.

5.0.2 LAS is developing an alcohol communications campaign for the winter period as a means of raising awareness of the impact of alcohol related incidents. Previous campaigns such as *Eat, Drink and Be Safe* (which was a joint agency public awareness campaign) are credited with helping to reduce the number of alcohol related calls during New Year's Eve/New Year's Day by up to 12.5%.

5.0.3 A proactive alcohol awareness campaign will be run in the lead up to December to support two key operational objectives during winter: demand management and staff safety. Our aim will be to encourage Christmas party-goers to take personal responsibility for their alcohol consumption, along with educating the public on what to do if they come across someone drunk and in need of help. The campaign is likely to be online, capitalising on our ever-growing social media presence and online media to reach our target audience of 18-50 year olds (with a specific audience of 21-30 year olds, who make up our most frequent alcohol related callers).

6.0 Demand Management Strategies - Daily Command and Co-ordination

6.0.1 The LAS operates with a 24 hour, 7 day a week command structure in place, with a Silver (Tactical) Officer on duty 24/7 managing core delivery for the LAS. Over the winter period, the Trust will maintain the strategic, tactical and operational command structure, in line with London Emergency Services Liaison Panel Manual / Joint Emergency Services Interoperability Principles.

6.0.2 Normal command and control procedures will apply during the winter period. A Gold (Strategic) Officer will assume the position of the Trust's Strategic Commander on call and co-ordinate the Trust's actions during a major incident. The on-duty Incident Delivery Manager (IDM) will act as the Trust Silver (Tactical) Commander.

6.0.3 Teleconferences will be held every four hours during the winter period to monitor the level of demand, resource availability and consider any mitigating actions. These conferences will be called by the on duty Incident and Delivery Manager.

6.0.4 To further enhance the capacity of the command structure to respond proactively to demand and/or capacity issues, additional support will be implemented during the December period in the form of a strategic performance cell which will actively monitor organisational performance and take all steps necessary to resolve or mitigate performance inhibitors or escalate concerns within the wider NHS. This cell will operate 06:30 – 22:30 over seven days.

6.0.5 Increased operational management support will also be implemented during the peak winter periods to assist in the management of any delayed handovers and to provide appropriate welfare monitoring for staff during what

will be a period of increased activity. These extra managers will operate across the full 24 hour period.

7.0 Promoting NHS 111 to influence call demand

7.0.1 We are working with our colleagues in fleet & logistics to promote NHS 111 on all new ambulances and cars as they are rolled out. With assistance from funding received from NHS England, new graphics have been added to ambulances which will signpost Londoners to NHS 111 when it is not an emergency. Car stickers are also being provided to all LAS staff to display in their cars to further support this initiative.

8.0 Hospital Turnaround Improvements

8.0.1 Improving patient flow is a key requirement of the NHS for winter 2017/18 and LAS recognises the importance of engaging with A&E Delivery Boards across SWL (including Croydon Health Services), to ensure that there is region-wide, joined up effective patient care, particularly over the winter period.

8.0.2 LAS managers will continue to work with acute trusts and commissioners to understand the local actions which will support the avoidance of ambulance handover delays.

8.0.3 To assist acute trusts in planning for ambulance attendance, activity and demand forecasting data will be shared with CCG commissioners in advance of the peak festive periods.

8.0.4 Although not directly part of the winter planning process, hospital handover delays are increased during the winter period and so any improvements in this area will assist in improving capacity to respond to emergency calls within the community during the LAS's busiest period.

8.0.5 The Trust does and will continue to refer to the published NHS England (London) surge management framework when dealing with divert requests from acute trusts as per NHS England (London) Emergency Department Capacity Management, Redirect and Closure Protocol (ED Policy).

9.0 Care Quality Commission Update

9.0.1 The CQC visited the London Ambulance for a second time in Feb 2017 – rated us 'requires improvement' with our patient care being rated as outstanding. Our performance has also improved.

9.0.2 The CQC noted improvements in all areas of the Service. In particular they noted:

- Significant improvements in medicines management, staffing and levels of incident reporting
- Staff went above and beyond to offer a patient-centred service
- Impressive efforts made to improve experience of patients with specific needs e.g. mental health, maternity and falls
- Good use of care pathways and guidelines
- Significantly improved Emergency Preparedness Resilience and Response function and appraisal
- Good provision for patients with complex needs and improved Hazardous Area Response Team compliance

9.0.3 They also identified areas for improvement:

- Continue to improve medicines management
- Improvements to the 999 system
- Recruitment – placing a particular focus on meeting targets to recruit more people from the community we serve
- Improve training compliance
- Leaders need to be more visible
- Limited learning from complaints and further work needed on business continuity

9.0.4 How we are responding:

- We are continuing to improve our medicines management processes, including trialling new storage facilities and changing the way staff access medicines.
- Following issues with our CAD system we had an independent external review and have implemented over half the recommendations already. Appointed a new Chief Information Officer to strengthen our leadership in this area.
- We launched a workforce strategy and we are working on a recruitment campaign to boost recruitment. We have also been focusing on improving our BME representation. We developed an action plan and have taken a number of actions to improve equality and diversity – including: employing a lead for equality and diversity, securing £500k from Health Education England to: fund outreach in schools to raise our profile as an employer; provide coaching and mentoring for our BME talent; and support and build the BME staff network
- Improved system for training and we're making it easier for frontline staff to access training
- We have just completed a series of chief executive roadshows – attended by our operational staff across London. This gave staff the opportunity to engage with the CEO, Director of Operations, Medical Director and other members of the executive leadership team.

People Department – Adult Social Care and All Age Disability Service

Title of Document

Winter Plan 2017/18

This covers the period 1 November 2017 – 31 March 2018

October 2017

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Document information	
Version	4.0
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Current version approved by	Adult Social Care and all Age Disability SMT
Next review date	August 2018
Title	People Department – Adult Social Care and All Age Disability Services Winter Plan 2016/17
Description/purpose	To give staff in Adult Social Care and All Age Disability and our colleagues and partners from other organisations, information and assurances about services (new and existing) that will ensure operational resilience of services to vulnerable people throughout the winter period.
Author(s)	Victoria Blinks
Target audience	All staff in People Department, the Emergency Duty Team and colleagues / partners
Distribution list	Staff and partners as agreed by SMT
Key related documents	Severe weather plan; Communicating in an incident plan; Croydon Health Services Winter Plan Summary, 2017/18
Responsible Director	Pratima Solanki Pratima.solanki@croydon.gov.uk

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Section 1. Introduction

Winter planning is a necessary and critical part of business planning in order to set out business continuity and managing major areas of risk during what is typically a pressured season of the year.

In order to set out the approach across Winter 2017/18 for Adult Social Care and All Age Disability Services, a winter plan has been developed. This plan comes into effect from 1st November 2017 and will run until the 31st March 2018.

The purpose of this winter plan is to give staff in Adult Social Care and All Age Disability Services and our colleagues and partners from other organisations, information and assurances about services (new and existing) that will ensure operational resilience of services to vulnerable people throughout the winter period.

An ageing population combined with increasing numbers of people with a long term health condition means that demand for both health and social care is increasing, and we know that these pressures increase during winter months, particularly across the urgent care system. As we head into winter with an already pressured position across Croydon, this winter will prove additionally challenging for Croydon for a number of reasons including the current position around delayed transfers of care, the financial position of the council, market capacity issues; increasing complexity of meeting needs of individuals increasing the intensity of support and competences of staff requirements and workforce pressures across the health and social care sector.

In 2017/18 our service continues with its strategy to respond to these challenges that we face and to create services that are operationally and financially sustainable, to meet the changing and growing needs of the local population and to create resilient communities in Croydon.

This year, we have augmented our integrated services through the OBC 'One Croydon Alliance and introduced new models of care through our integrated out of hospital business case. These new services (for example, the 'Living Independently for Everyone' – LIFE, and the Discharge to Assess models) are already having a positive impact on our delayed transfers of care and hospital and/or care home admission avoidance. It is expected therefore, that these services will provide a stronger and more coordinated approach to winter pressures across the whole health and social care system in Croydon.

Additionally, the corporate resilience team manage the overarching resilience plan for Croydon Council and in the event if a crisis will manage the Croydon response. They link with other major agencies such as London Ambulance Service (LAS) London Fire Brigade (LFB) the Police (MET and LTP) Croydon University Hospital (CUH) and the 3rd sector.

This Winter Plan additionally sets out capacity and contacts across the Christmas and New Year holiday period. Summary contact details for points of escalation are included in the appendices of this plan.

Adult social care and all age disability services will continue to work with and align our winter plan with our health partners through the A&E Delivery Board. Where possible, a pan

Croydon approach will be encouraged to maximise system resilience and the benefits of the deployment of resources. Many of our current resources to support urgent care and flow out of hospitals have been enhanced through iBCF funding, and we will ensure best use of funding to meet key performance indicators and resilience across the system.

Progress reports and recommendations concerning significant actions undertaken will be delivered through the usual channels both within the Council and externally with partners. A copy of the winter plan will be discussed at the A&E Delivery Board for inclusion in the system wide winter planning and delivery reporting.

Any significant amendments will be communicated via the issue of a new version.

Section 2. General information

2.1 Corporate resilience

Each local authority receives severe weather information via a number of sources.
The Met Office and the Environment Agency are our main source of such information. As a category 1 responder we have the responsibility to ensure that we cascade this information, and the appropriate actions are taken by the relevant service areas, to mitigate the potential risks from severe weather events.

There is a corporate plan which aims to outline the arrangements for receiving and acting upon severe weather information, including alerts and warnings, from internal and external partners.
The document :

- Outlines the different organisations which provide us with severe weather alerts/warnings;
- Enables the reader to understand different categories of severe weather warning, and their impacts;
- Outlines trigger points for action from the organisation

The link to the LBC Corporate Severe Weather Plan is below:

http://im.croydon.net/collaboration/fin-rcm/EP/default.aspx

We ensure that these office alerts are communicated to all our staff and providers (including the voluntary sector)

2.2 Local action

In the event of severe weather business continuity plans will be used, they are reviewed regularly and held by the corporate resilience team. We prepare for such events through exercises and the production of plans and guidance documents. As each incident will be different and may require a different response, the planning arrangements are designed to be flexible in their approach and provide various options from which the response can be tailored.

The need to ensure the safety and continuity of care to the vulnerable residents of Croydon is paramount. Measures to be taken within resilience and continuity plans include:

- Identification of vulnerable service users
- RAG rating and identifying which of our teams are the most critical and which could be redirected in the event of a catastrophic event
- Ensuring plans are in place to coordinate with and update partners on an operational basis when such events occur.
- Updating partners around adult social care and all age disabilities own internal escalation status, enabling full visibility of pressures and actions
- Mapping staff availability to geographical areas in the event attending work bases is compromised.
- Senior managers attendance of local pandemic flu outbreak preparation sessions with Public Health colleagues

Section 3. Service Preparation

3.1 Capacity information & pressures

- Across Croydon health and social care system, we have commissioned several intermediate care services such as Community Beds, Reablement and Crisis Support services. Information and access to these services are detailed in Appendix A). Currently for winter 2017 / 18 – we have 23 stepdown and intermediate care beds
- We have significantly improved our health and social care capacity and ability to respond better to demand pressures both in terms of hospital discharge and care home and hospital avoidance by implementing new models of care under the 'One Croydon Alliance'. The 'Living Independently for Everyone' (LIFE) service has been set-up as an integrated community based single team under one management structure, drawn from staff from the currently separate Reablement, Rapid Response, Intermediate Care, and A&E Liaison services, alongside borough Health and Social Care professionals, clinicians and colleagues from related community organisations and the 3rd Sector.

  The team use an agreed single eligibility assessment and review process, and will work collaboratively with colleagues from related services, including Assistive Technologies, Telehealth and Telecare. They provide proactive preventative interventions and support at times of great need when people require more focussed clinical and social care interventions. The focus of the service will be to enable the person to regain their optimum state of wellbeing, functioning and independence.

  This transformed model of care has required additional investment (including from the iBCF) and is staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, pharmacists and reablement workers. The team has a range of clinical skills to provide a safe and tangible alternative to a hospital admission for many conditions that delivers better outcomes for the individual. These interventions have been supported by clear pathways and protocols between the

service and acute services such as the hospital discharge team to consolidate the use of shared urgent care plans that follow the patient journey.

The new service now:

- Operates 7 days a week from 8am to 8pm significantly improving access
- Receives referrals through the Single Point of Access. The team will also accept referrals from hospital discharge teams and will start working with clients during their hospital stay to help get them ready for hospital discharge. The majority of referrals and activity will be within normal operating hours but there will be arrangements in place with out-of-hours services to ensure continuity and consistency of service for people who require a rapid response that will prevent an acute admission
- Has the capacity and capability to provide 24-hour supervision for a limited number of people in their place of residence (e.g. night sitting service)
- Implements interim domiciliary support packages of care within 2 hours of assessment / step up existing social or continuing health care packages
- Prescribes and delivers equipment within 4 hours of request for equipment
- Has access to the third sector community services
- Provides a Carers Sitting service

3.2 Discharge to Assess

The Discharge to Assess model (Home First) is a key component of the LIFE model which commenced in September 2017. At any one time there are a number of people in acute beds, whose hospital episodes are complete but are unable to manage without support at home or in a residential home. Discharge to Assess is an integrated, person-centred approach to the safe and timely transfer of medically optimised patients from an acute hospital to the individual's own home, or a community setting, for the assessment of their health and social care needs.

The benefits of implementing a Discharge to Assess process are that it reduces length of stay in hospital, improving outcomes for people and reducing the pressures on hospital beds and enables people who are at the height of vulnerability to make decisions about their long term care once they are stabilised out of the hospital environment. People often function differently in their own home than in the hospital environment. The hospital environment can disable people, limiting their opportunity to manage core activities of daily living independently. People are more comfortable in their own home: they know the environment well and the balance of power is more equal.

The core principles underpinning the Discharge to Assess (Home First) Pathway are:

- Patient identified on ward as medically optimised and safe to transfer
- Integrated Initial assessment undertaken in the ward to identify core needs to support safe discharge
- Discharge to own home supported by the new integrated LIFE services

- Comprehensive assessment undertaken by a Health and Wellbeing Assessor (Trusted Assessor) in person's own home within 24 hours

The goal will be to achieve same day discharge as long as this in the patient's best interest and can be achieved safely with the following components in place: transport, medication, care and equipment (including for example continence products).

Since the model went live, approximately 40 service users have been discharged home. A significant number have remained at home (only 3 readmissions due to acute medical needs such as palliative care), and these have avoided permanent admission into care homes.

3.3 Contract management – Independent provider business continuity

Croydon's contract management and quality assurance approach requires service providers that can deliver operationally to the full terms of their contractual agreements. This includes having the level of staff required to deliver the service provision fully and safely, that they have a plan in place for the event of significant service impact including staff illness, inclement weather where usual routes may be temporarily impassable, and to ensure that customers are not impacted by a reduction in regular service provider delivery.

All providers have business contingency/continuity plans in place, and these are reviewed through contract monitoring visits.

In the event of an impact on service delivery, Service Providers are required to contact Croydon to make them aware of the situation as soon as is practical to do so, also confirm what they are putting in place to resolve or mitigate any impact on service delivery and submit once again the most recently updated business continuity plan. Domiciliary care providers and care home providers are contactable 24 hours a day 7 days a week.

Communications will be sent out to all providers to identify key areas within the system where their support is requested, and remind providers of the pressures in particular over the holiday period and how they can help.

Careline and assistive technology have full day and night shift cover, along with an on call manager.

3.4 Social work teams capacity across Christmas & New Year

Funding through the iBCF has facilitated sustainable year round weekend working within the social work teams.

The hospital discharge social work team, Coleby reablement service and Care Line staff cover plan outlines adequate staffing levels over the Christmas and New Year period. (The staffing cover levels for each service have been developed and are currently held by the Heads of Service who will be covering over this period)

To further support winter resilience, Adult Social Care have restricted annual leave across teams so that available staff will be in work across the Christmas and New Year period and also to ensure effective response to unpredictable spikes of activity. All staff will be directed to work on whatever the prioritised pressures are for adult social care during this

time, rather than attend to what may be their usual caseload. This will support the overall resilience of the system.

3.5 Mental Health

Work is underway to enhance the existing Approved Mental Health Professional (AMHP) provision across Croydon, to extend the core delivery hours from 8.45 – 5pm Monday to Friday, to 8am – 8pm, 7 days a week. Mental Health beds often become available later in the day, and with the current service this results in cases being passed to the Council's Emergency Duty Team (EDT). The new service will significantly reduce the need for this to happen, enabling an improved response to urgent assessments for example in A&E.

There will be reliance however on NHS partners to be able to provide beds for people assessed by AMHPs as requiring this service. The new service will also enable more proactive planning to take place such as booking Doctors in advance so preventing delays. As well as supporting an improved response to people requiring assessment in Hospital, the new service will facilitate an increased AHMP availability in community. The Mental Health team will continue to participate in weekly DTOC teleconferences with health partners. They also attend weekly meetings with the CSU – Advanced Discharge Planning Group, aimed at achieving flow through mental health beds. Team managers in the CMHTs remain involved in weekly meetings where they identify their service users who are in hospital and look at how they can support timely discharge. The Mental Health Service Manager is also in regular contact with SLAM's capacity and flow manager re any delays to potential discharges from in-patient services and look at solutions to unblock these.

3.6 Flu Pandemic preparations

The Council's Public Health Service working in partnership with our Human Resources Department have made available free flu jabs for key front line workers. Staff information regarding flu vaccines and keeping well is available on the Intranet

It has been predicted the UK may be facing its worst flu outbreak for many years this winter. Croydon has been preparing for this. Having a flu jab is the most effective way of preventing the spread of flu and protecting yourself, your family and vulnerable people in our community.

All managers in the Council have been attending Flu Pandemic preparation workshops since September 2017 as part of our Corporate Resilience Plan

3.7 Crisis support and support for homeless and rough sleepers

- There are a range of services, a rough sleepers outreach team that gets people off the street and into hostel provision & B&B, a night shelter run by volunteers that runs November to March and there is also a pan-London Severe Weather Emergency protocol when temperatures reach zero degrees or below – if no local provision is available the Croydon Reach outreach team take rough sleepers to a central London shelter
- The main local contact is Croydon Reach 020 7870 8855 Croydon_Reach@thamesreach.org.uk

- The out-of-hours contact for public to report rough sleeping out of office hours is 0300 500 0914
- The Careline and assistive technology service operates a 24/7 365 days a year service and the number of people receiving the service is expanding. This supports early invention and appropriate support for vulnerable people. This is accessed by each individual service user who has a pendant alarm

3.8 Customer Contact

- Customers can access many Council services online, 24/7 via My Account – www.croydon.gov.uk/myaccount Alternatively customers come into Access Croydon (a customer space that brings all services together, offers more flexible choices and a better service for our residents) or call the council
- For adult social services:- **020 8726 6500**, for children: **020 8726 6400.** Outside regular opening hours and in an emergency, ring **020 8726 6000**. If necessary, customers will be put in contact with the appropriate council emergency service (for out of hours, this will be our Emergency Duty Team).

Christmas and New Year opening times are:

Access Croydon, Bernard Weatherill House

- Monday 25 December Closed
- Tuesday 26 December Closed
- Wednesday 27 December 9am to 4pm
- Thursday 28 December 9am to 4pm
- Friday 29 December 9am to 4pm
- Monday 1 January Closed
- Tuesday 2 January 9am to 4pm

Croydon Council call centre

- Monday 25 December Closed
- Tuesday 26 December Closed
- Wednesday 27 December 9am to 4pm
- Thursday 28 December 9am to 4pm
- Friday 29 December 9am to 4pm
- Monday 1 January Closed
- Tuesday 2 January 9am to 4pm

Section 4. Additional plans & actions

The Adult Social Care and All Age Disability Service is also implementing a range of plans, commissioning intentions and actions which will support winter resilience 2017/18. These include:

- Better data quality and visibility is in place to support social work community teams to manage their work and waiting lists. This will continue to enable increased productivity within teams, ensuring that people receive more timely assessments in the community. The InTouch service, is also supporting social work teams to manage their work and waiting lists. This will continue to enable increased productivity within teams, ensuring that people receive more timely assessments
- The reablement service provides a domiciliary, reablement and residential nursing care finding service 24 / 7 over the Christmas and New Year period.
- Our Brokerage service provides a domiciliary and Reablement finding service 7 days a week. By October 2017 the service will also provide the residential care finding service over 7 days.
- The capacity in the Occupational Therapy service has been increased in order to both lead the newly redesigned Reablement service, as well as better meet the demand for moving and handling assessments in the community.
- Recommissioning of Reablement Services has taken place following remodelling across Croydon, which will enable greater numbers of people to benefit from this service. In turn this will reduce some of the pressure in the Homecare market and support the reduction of delayed transfers of care.
- The contracts team have used a checklist for assessing robustness of provider business continuity plans as part of their contract monitoring visits
- Croydon monitors alerts from the Met office and subsequently sharing with providers where there are risks highlighted and business continuity plans may need to be implemented
- Meals on Wheels Service. We commission this from Apetito - Christmas is ‘business as usual’ for Apetito. There is no change in service and they are operational for the same hours as normal, with a staffed office. Apetito have a business continuity plan, specific to the winter period.
  Contact details are as follows:
  Tel: 01225 809 105
  Fax: 01225 777084
  Email: info@apetito.co.uk
- There are support centres across Croydon which offer a luncheon service where older members of the community can purchase a lunch and activity. These services can be arranged on the same day.
- Some of our residential homes offer Christmas lunches to members of their community, reducing social isolation at Christmas.

Appendix A: Intermediate care provision an crisis capacity across Croydon

Area	Where is the availability / service provided
Community beds and hospital discharge	Hayes Court common intermediate care (CICs) = 12 beds designated discharge Barrington Lodge have 7 intermediate care / step down beds In house reablement will be available over Christmas and New Year to cover the South of the Borough SureCare domiciliary care agency have block contracts to cover the North of the Borough the South will be covered by the reablement framework agreement D2A – care within 2 hours • Operate 7 days a week from 8am to 8pm significantly improving access • Receive referrals through the Single Point of Access. The team will also accept referrals from hospital discharge teams and will start working with clients during their hospital stay to help get them ready for hospital discharge. The majority of referrals and activity will be within normal operating hours but there will be arrangements in place with out-of-hours services to ensure continuity and consistency of service for people who require a rapid response that will prevent an acute admission • Implement interim domiciliary support packages of care within 2 hours of assessment / step up existing social or continuing health care packages
Reablement hours	The Hybrid model which includes 12 Council reablement workers and the Commissioning of contracted hours for two - four reablement providers (North and South)
Crisis support	• There are a range of services, a rough sleepers outreach team that gets people off the street and into hostel provision & B&B, a night shelter run by volunteers that runs November to March and there is also a pan-London Severe Weather Emergency protocol when temperatures reach zero degrees or below – if no local provision is available the Croydon Reach outreach team take rough sleepers to a central London shelter • The main local contact is Croydon Reach 020 7870

	8855 Croydon_Reach@thamesreach.org.uk The out-of-hours contact for public to report rough sleeping out of office hours is 0300 500 0914
Careline	The amount of people using the Careline service varies but the average amount is – • Sheltered housing units – 1100 users • Community – 1600 users • **Total 2700** Care line have 24 / 7 cover over the Christmas and New Year period to support vulnerable people. Referrals will be taken from hospital and the community. Careline Plus have 2 4x4 vehicles to ensure service continues in adverse weather

Appendix A: Domiciliary, residential and nursing care capacity

<table>
<tr><th>Provider type</th><th>Number of providers</th><th>Numbers of hours / beds</th></tr>
<tr><td>Domiciliary care</td><td>Croydon has 50 providers for approximately 2000 service users

During the Xmas and new year period, our brokerage and EDT have access to all these although we will put in place arrangements that emergency packages will be delivered by SureCare and our in house reablement service</td><td>23,000 hours per week</td></tr>
<tr><td>Residential / nursing care</td><td>Planning ahead - there is currently a stock of 50 block beds with 24 interim (step down) beds occupied at various rates dependant on need. Of the 24 step down beds 12 are community intermediate care.

Overall numbers in Croydon, at a Glance — Figures
<table><tr><td>Total number care homes registered with CQC located in Croydon</td><td>134</td></tr><tr><td>Total number of Nursing homes registered with CQC located in Croydon</td><td>36</td></tr><tr><td>Total number of Residential homes registered with CQC located in Croydon</td><td>98</td></tr></table>
Care home Specilisms
<table><tr><td>Total number of care homes with Learning disability specialism marked in their CQC registration</td><td>62</td></tr><tr><td>Total number of care homes with Mental Health specialism in their CQC registration</td><td>48</td></tr><tr><td>Total number of care homes with Physical Disability specialism in their CQC registration</td><td>20</td></tr></table></td><td></td></tr>
</table>

	Total number of care homes with Sensory Impairment specialism in their CQC registration	12	
	Total number of care homes Registered with CQC for over 65 service users	61	
	Total number of care homes Registered with CQC for under 65 service users	47	

Appendix B: staff cover

1. Emergency duty team

EDT are on duty 365 days throughout the night to cover all social care emergencies. EDT covers:

- Children's social care
- Adult social care
- Emergency housing

EDT is resourced to cover **new** emergencies which commence **after 5pm** Monday to Friday and **throughout** the weekends and bank holidays.

Staffing

There is a unit manager, some business support, 5 advanced social workers who work shifts and 3 sessional members of staff who occasionally cover shifts. However, there is **only one social worker on duty** throughout the night. The unit manager is Natasha Thomas – Natasha.thomas@croydon.gov.uk

EDT are located at BWH on the 4th Floor, Zone D. There is usually a member of staff at the desk between 5pm and 8pm Monday to Friday.

EDT are able to offer you a self-help service for resources:

- Telephone number for a senior manager so you can present and resolve your case
- Telephone numbers for emergency foster carers
- Telephone number for a taxi so you can mobilise
- Telephone number for out of hours legal advice so you can receive guidance and follow through any actions required.

Limitations:

- EDT will not be able to take over case work. This must be resolved or contained until the next business working day by the allocated social worker or colleagues in the host unit or team
- EDT are not able to take children or young people to placements on behalf of social workers
- EDT are not able to release social workers from events that overrun. You need to negotiate the support needed to complete tasks with your line manager and colleagues who work alongside you

- EDT do not undertake visits to monitor families.

How to access EDT

EDT does not have a direct line.

You must call 0208 726 6000 and your call will be answered by a call handler. Please leave your best contact details as well as a short description as to the nature of your call. The EDT social worker will call you back as soon as possible.

You can email the emergency social worker via SSD-EMERGENCY-DUTY-TEAM@croydon.gov.uk; the social worker will read your information or call you back if requested. EDT's response time is 2 hours, although they strive to respond as quickly as possible.

What does EDT find helpful?

- Up to date case summaries, as they provide the case history/background in one place
- Clear case notes on current issues which include a plan to resolve
- Up to date contact details and address recorded on AIS, as well as care agency contact numbers, next of kin and key safe information, if applicable.
- Clearly titled case notes applicable to the case.

2. **Staff cover across ASC and All Age Disability**
    - In addition to EDT, senior managers in the service are on a rota to cover out of hours during the Christmas and New Year period. The rota is centrally held by each SMT member and this has all the contact numbers and details.

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For general release

REPORT TO:	***Scrutiny Health and Social Care Sub Committee*** ***Date: 21st November 2017***
SUBJECT:	***One Croydon Alliance Agreement Extension***
LEAD OFFICER:	***Guy Van Dichele, Interim Director of Adult Social Care and 0-65 Disabilities & Andrew Eyres, Interim Accountable Officer Croydon CCG***
CABINET MEMBER:	**Councillor Hall, Cabinet Member for Finance and Treasury and Councillor Woodley, Cabinet Member for Families, Health and Social Care**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	***Rachel Soni, Programme Director One Croydon Alliance***

ORIGIN OF ITEM:	**The committee has identified this as an item for Scrutiny**
BRIEF FOR THE COMMITTEE:	**To Consider the Croydon Alliance Agreement**

Any additional guidance to report author from Scrutiny Officer:

1. EXECUTIVE SUMMARY

1.1 Following agreement by Cabinet in December 2016, Croydon Council along with five other partners (Croydon Health Services, Croydon GP Collaborative, Age UK Croydon, South London and Maudlsey MHT and Croydon Clinical Commissioning Group) entered into an Alliance Agreement for the delivery of Health and Social Care to Over 65s in Croydon on the 1st of April 2017. This Agreement is for a term of 1 year (Transition Year) with an option to extend for a further 9 years; the decision to extend is supported by demonstrable delivery of the transition criteria as set out in the Transition Plan in the Alliance Agreement.

1.2 This report gives an overview of progress against the two key components of transition year; year one transformation and transition criteria. Year one transformation includes the Living Independently for Everyone (LIFE) programme and the Integrated Community Networks (ICN) Programme, the transition criteria includes the development of the year 2-10 business case.

1.3 Performance of the transformation programmes and the development of the year 2-10 Business Case will inform the Alliance Boards' recommendation as to whether or not to extend the Alliance Agreement for a further 9 years for over 65s. The development of governance and decision-making process for possible future extensions to the scope of the transformation which may be delivered through the Alliance Agreement during the term will be developed and taken through appropriate governance.

2 Year 1 Transformation Programmes

2.1 Living Independently for Everyone (LIFE)

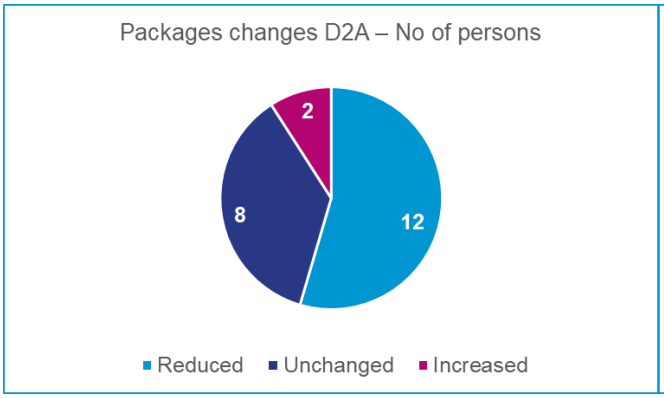
2.1.1 The LIFE Programme (Living Independently for Everyone) has established an integrated Reablement and rehabilitation service across the borough, comprising services from across Adult Social Care, Croydon Health Services and Croydon University Hospital. The long term ambition of LIFE is that it will see key services brought into a new LIFE integrated Reablement and Rehabilitation service – a new intermediate care service.

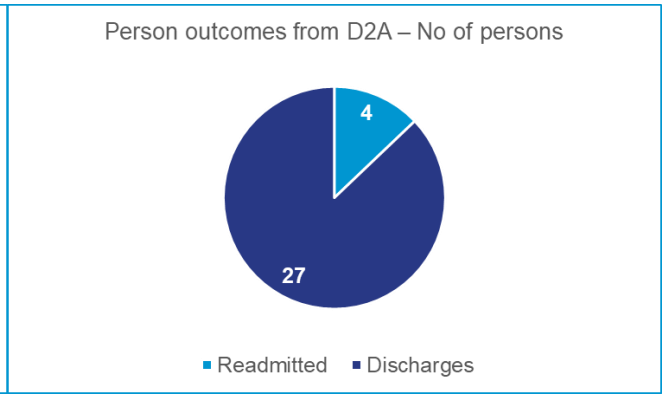
2.1.2 The integrated service model ensures a one name, one budget one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes. This service will contribute to reductions in systems duplication, in non-elective hospital admissions and bed days, will enable targeted and focussed effective use of more community services upstream for people to reduce high cost packages of care and create capacity with an increase in flow at an earlier stage for people in need of the service. Services are more person and outcome focused improving the person experience of health and care.

2.1.3 A key component of the LIFE service is Discharge to Assess (Home First Pathway 2), and from September 2017 Croydon Health Services NHS Foundation Trust introduced this pathway 2 in three hospital wards (Purley 1 & 2 and Wandell) with the expectation of a full rollout by March 2018. At the writing of this report, the service us live on 11 wards in CUH. This service ensures people are supported through a muti-disciplinary approach to reduce their length of stay in hosipal, assess them in the best place to determine care and establish outcome focused care plans that aim to reable and maximise independence.

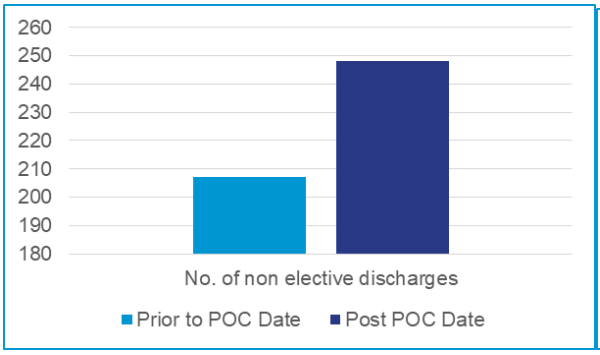
2.1.4 There is a bespoke performance tracker for the LIFE service enabling the project team to extract data to monitor the success of the programme.

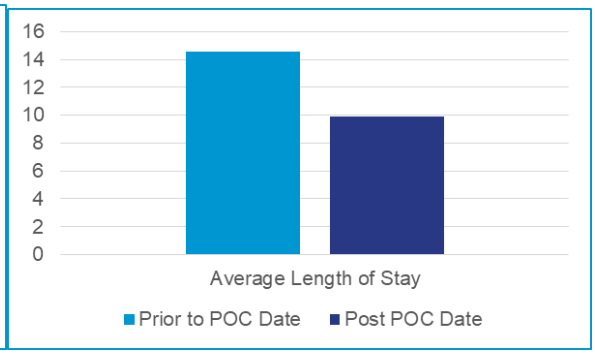
2.1.5 Initial performance data for the services shows a positive impact against the outcomes and is shown in the tables below. The Discharge to Assess (D2A) Pilot shows that of 31 people discharged with this service in the first 4 weeks 21 were seen within 2 hours. 12 of 22 packages of care were reduced. The trend for D2A shows that performance across all of these areas continues to improve. In addition, there has been a 19.8% increase in discharges and a 32% reduction in Length of stay at 127 days (compared to one month prior to D2A pilot). The service are working with Healthwatch aiming to obtain person experience feedback following the use of this service.





Number of people seen	No of people seen within 2 hours of discharge	Part B completed within 24 hours	LoS Reduced
31	21	16	126.9





2.2 Integrated Community Networks (ICN)

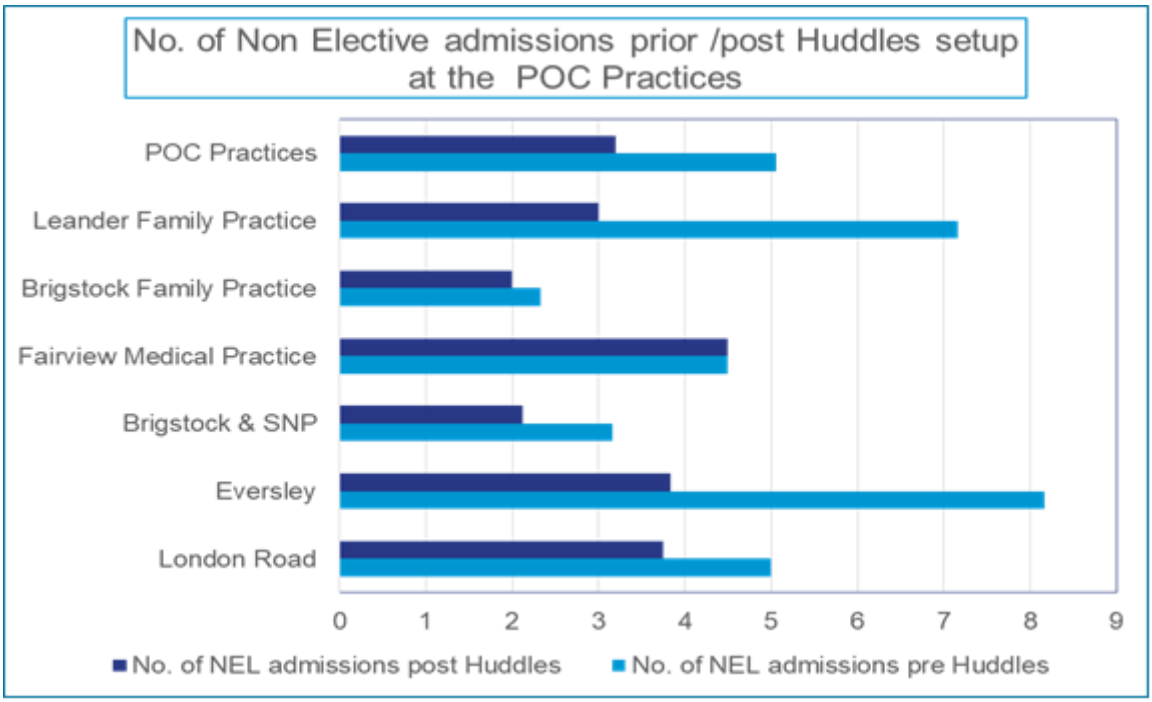
2.2.1 The Integrated Community Networks (ICN) Programme is comprised of the following features:

- Huddles (proactive weekly case management by multi-disciplinary team working from GP practices)
- Complex Care Support (specialist support for issues such as mental health and frailty and support for care homes);
- My Life Plan (Co-ordinate My Care – shared care record);
- Personal Independence Coordinators (PICs – person centred support for non-medical issues);
- Active and Supportive Communities (people and communities as assets)

2.2.2 The key aim is to engage, empower and build-up the Huddles so they are responsive, timely and flexible to individual needs. Huddles will focus on preventing admissions and focus on high risk and need people who have more than one long term condition initially and aims to enable individuals to support their own health and independence. Care will be organised around the individual, breaking down the boundaries between health and social care and the voluntary and community sector, and between formal and informal support.

2.2.3 An accelerated ICN Huddle programme is being implemented and the number of huddles rolled out will exceed business case plans by October 2017 with all GP practices having them by March 2018.

2.2.4 The pilot Proof of concept performance data shows early indications that the ICN programme is being successful in meeting its outcomes, and in particular the number Non Elective Admissions has reduced post Huddle implementation, as shown in the following graph. Over 600 cases have been discussed during this period and PICs are working with over 300 people.



2.2.5 A key component of the ICN programme are the Personal Independence Coordinators (PICs). The PICs are a member of the core ICN team and are independent of Health and Social Care Services; they work intensively with people with long term conditions. Initial data shows an increasing trend in the number guided conversations and the proportion of people meeting their goals. A case study shows the impact and success of a PIC intervention and is detailed below.

Background

- Robert is 77 years old.
- He lives alone
- Same rented accommodation for 30 years
- His wife was bed bound and he cared for her
- He used to be a professional magician
- Daughter lives in Wallington

In January 2016 he experienced shortness of breath and rapid weight loss

- Admitted to hospital where he stayed for 11 months on and off
- Discharged in November 2016
- Wife passed away in that period
- He did not return to work

Outcomes achieved as a result of PIC intervention:

- Attendance allowance granted
- More independence at home
- Heating installed in some rooms
- Garden work done
- House clean
- Healthy living and gained weight
- Started driving again

2.2.6 The ICN model is supported by building up our community and preventative services. The model of care aims to do this through aligning our provision of voluntary and community services within each of the six GP

networks through appointing Locally Trusted Organisations and opening points of access, building awareness of assets and improving access and capacity.

3 Year 1 Transition Criteria

3.1 Progress against criteria is managed through the PMO.

3.1.1 The One Croydon Alliance Programme Management Office has been managing the delivery of the Alliance Agreement Transition Criteria through 10 workstreams, each having an executive responsible officer and lead officer. Progress against this criteria is continuously measured and reported to the Programme Delivery Board and the Alliance Board. The current progress and key challenges against the Transition Criteria (managed as workstreams) is set out in the following table.

3.1.2 The Transition Plan specified 3 Transition Checkpoints for May, July and September 2017 respectively to gauge the progress of the Transition Programme and its workstreams in meeting the Transition Assessment Criteria & Providing the Alliance partners with sufficient assurance to be able to decide to extend for a further 9 years.

3.1.3 At Programme Delivery Board on the 21 September, the Board agreed to move the final Checkpoint 3 from September to October 2017, to allow more time for Year 2-10 Business Case development, in particular Financial Savings Assumptions, and to a lesser extent the Alliance Risk Share agreement. The following table provides an overview of progress of these transition workstreams as reported at checkpoint 3.

#	Transition Workstream	RAG	Critical Path Summary
1	**Out of Hospital Delivery – ICNs**		The overall ICN programme is Green. 12 Huddles have now implemented with another 4 scheduled week commencing 30th October, and each subsequent week thereafter. PICs risk - with no risk stratification from Age UK PICs resource issue & them only picking up one patient per Huddle meeting until mid-November, this may impact outcomes and savings.
2	**Out of Hospital Delivery – LIFE**		Discharge to assess is now implemented on 10 wards. LIFE Manager and Health and Wellbeing advisors are currently being appointment. The team has now moved into Leonard Road and the assessment forms are on EMIS, CERNER and AIS.
3	**Y2-10 Business Case – Risk Share & Financial Model**		Workstream Red owing largely to incomplete Financial Savings Assumptions. Implementation plans also being progressed for completion. Final Risk Share session held 19 October with a number of follow-up 1-2-1 engagements with Alliance leadership being planned to conclude the risk share proposal.
4	**Y2-10 Business Case – Document**		Workstream Red as while progress has been made with the overall business case document, there are number of dependencies on key deliverables, namely financial savings assumptions, implementation plans and future governance structure.
5	**Y2-10 Contract & Performance Management Model**		Workstream Amber owing primarily to ongoing issue with CCG and CSU resolving the CSU engagement block, particularly around identifying a contract management and BI lead and providing data and input into the development of the Alliance Dashboard. This is currently being mitigated to some extent through workarounds i.e. input direct from CCG Commissioners etc.
6	**Y2-10 Financial Monitoring Model**		Work on Y2-10 Financial Monitoring Model progressing with phase 1 focusing on Out of Hospital monitoring and phase 2 on monitoring the initiatives in the Y2-10 Business Case. Contract Map and Maximum Affordable Budget timelines being confirmed. Financial savings models for LIFE and ICN now built and being validated and currently updating financial model with assumptions.

7	**Contract Variation**		Workstream Amber: Out of Hospital transformation contracting commenced for LIFE and ICN and Legal advisros appointed for advice on variation for the 2- 10 Alliance Agreement.
8	**Workforce, OD, Comms & Engagement**		Workstream Amber as need to have Board Agreement for Strategic workforce group to secure engagement & leadership from all partners. Work also a key enabler to other workstreams. Comms and engagement plan is in place, several board and staff OD sessions conducted and a number planned.
9	**Y2-10 Governance Structure**		Y2-10 Governance Structure Workshop scheduled Monday 6 November to progress Integrated Management Team ToR. Draft ToR to be developed and shared with the group beforehand.
10	**Regulator Approval**		Proposed 2 phase plan to be enacted comprising initial 1-2-1 regulator engagement followed by joint engagement to include both NHSE and NHSI

3.2 Development of the Year 2-10 Business Case

3.2.1 The Croydon Transformation Board agreed on the 21st September that the years 2-10 Transformation Plan was sufficient to proceed with it into the Year 2-10 Business Case Development. The timeline for development is as follows:

▲ **THURSDAY 14TH DECEMBER: Alliance Board agrees Y2-10 Business Case & recommends sign-off to Governing Bodies/**

▲ **FRIDAY 26 JANUARY: Y2-10 Business Case Signed-off by Governing Bodies/Cabinet**

3.2.2 The Business Case Executive Summary has been drafted to establish content and the full document will be structured in five parts:

- Strategic Case
- Economic Case
- Commercial case
- Financial Case
- Management Case

3.2.3 There are a number of challenges in the development of the Year 2-10 Business Case, mainly dependent on the development of transformation initiatives and the robustness of understanding of their impact on the health and care system and outcomes benefits.

3.3 Financial Assumptions

3.3.1 Croydon Health Services and Croydon Clinical Commissioning Group has agreed the baseline for 16/17 with growth that provides the Do Nothing position and this will become the new alliance baseline for 17/18.

3.3.2 The assumption for the Out of Hospital Business Case (Year 1 Transformation) is an annual net saving impact to the whole system of £6.5m. The baseline budget, growth and target savings for the Council's in scope social care are shown in the table below:

Draft Budget, growth and savings for Alliance Social Care Scope:

Indicative projections for OBC in-scope services	2015/16 Actuals	2016/17 Actuals	2017/18 Part year forecast	2018/19	2019/20	2020/21	2021/22	2022/23
Base line spend (£m) included Fixed costs	43.5	43.5	43.5	45.4	45.4	45.4	45.4	45.4
+ Demographic Growth (£m)				2.5	3.5	4.5	5.6	6.8
+ Non Demographic Growth (£m)				1.0	2.0	3.0	4.0	5.0
+ Inflation ('Do Nothing' base case) (£m)	-	2.6	3.8	0.8	1.2	1.7	2.2	2.7
- Council efficiency savings (£m) 5% per year				-2.4	-4.7	-7.1	-9.5	-11.9
Forecast Expenditure	**43.5**	**46.0**	**47.3**	**47.2**	**47.3**	**47.5**	**47.7**	**48.1**

3.3.3 Up to a further £8.2 per annum system savings has been identified so far in the year 2-10 transformation plan. There needs to be some further work on removing any overlaps so these figures continue to change. A further phase of future opportunities are also being worked on.

3.3.4 Transformation leads will be able to articulate costs and savings for their chapter by the end of November. Planned Care and Active and Supported Communities assumptions are evidence based, with the other chapters underpinned by research. Mental Health transformation development is progressing but has some challenges in agreeing the schemes to be taken forward.

3.3.5 Next steps are to review all assumptions to ensure there is no duplication within the chapters (in costs or savings) and build the whole system model to review in/out and effect on whole system i.e. if unable to reduce beds or avoid activity the Alliance can model alternative options to achieve savings.

3.4 Governance

3.4.1 The Croydon Strategic Review commissioned for the health economy in summer 2017 recommended that Governance for the alliance be consolidated with the Whole System Governance as soon as possible to reduce time spent in meetings. This has been recommended and is being taken through governance to implement as follows:

In addition to this future Governance Structure is being drafted to enable further integrated and a planning session has been scheduled for the 6th November.

3.5 Risk Share

3.5.1 The alliance agreement provides for binding risk and gain share arrangements. Risk Share development sessions have been constructive and the approach to risk share has been agreed for recommendation to board. The following principles will apply:

- **Simplicity** – managed through collective leadership and governance
- **Collective responsibility** – Collaborate to manage risk against a notional system control total that smooths the impact
- **Individual accountability** – Allocation of specific risks and liabilities to individual organisations should be by exception
- **Proportionality** – Sharing upside and downside proportionately
- **Limited liability** – There may be differential and absolute limits to avoid an individual organisation being worse off than do nothing scenario
- **Transparency** – The Alliance will implement open book accounting

- **Proactivity** – The alliance will manage risks proactively and deploy contingencies where necessary to minimise adverse impacts

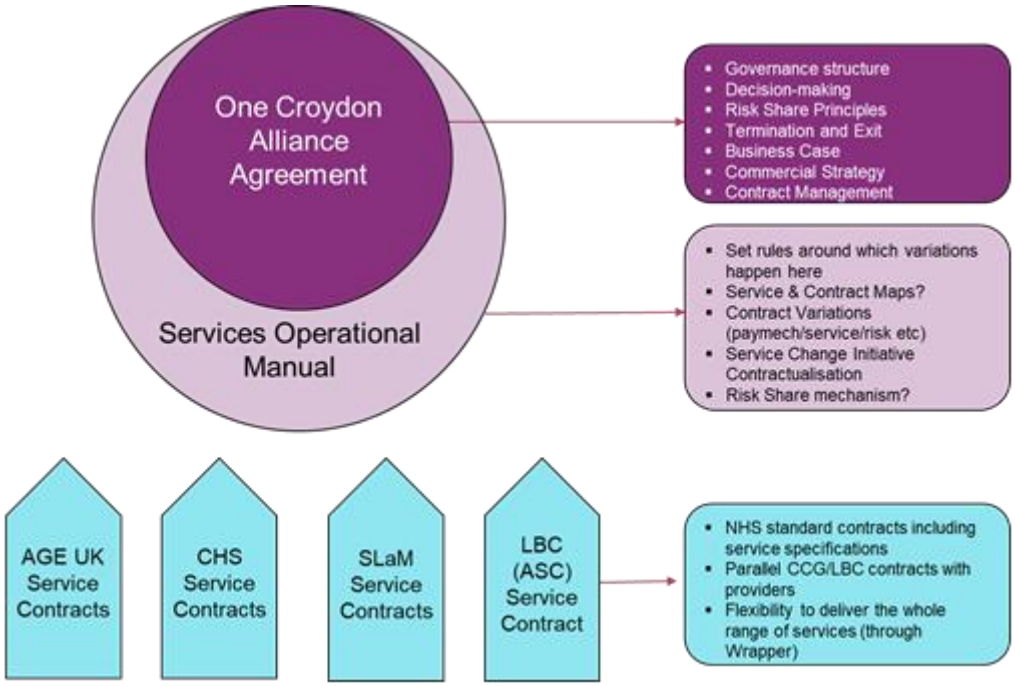
3.5.2 There are some outstanding items to be agreed by Alliance members such as materiality thresholds and liability caps. One Croydon Health Services and Croydon Clinical Commissioning Group have agreed a financial plan the risk share model will be updated.

3.5.3 Collaborative governance and operational management will be vital for enabling proactive risk management and a draft escalation process has been developed to ensure risks are identified early and mitigated.

3.6 Commercial Structure

3.6.1 A Commercial Structure has been developed (see below) to enable delivery of the year 2-10 Business Case as planned i.e. within an Accountable Care System (Alliance) Structure. This Structure does not limit the scope of the Alliance and any change in scope will be governed by the decision-making process (to be developed) and be planned and phased to allow the commercial structure to be amended i.e. service contracts to be added or Alliance membership to be widened.

3.6.2 The structure of the payment mechanism for the service contracts that sit below the Alliance Agreement are being reviewed to ensure that the most effective payment structure is achieved to allow maximum flexibility in the movement of resources and funds within the whole system.



4 Engagement

4.1 There is an active Service User reference group that meets on a monthly basis to ensure the views of people in Croydon in how we are meeting their needs are captured. The group are also actively involved in feeding into the design of transformation services, as well as the delivery and monitoring of services in scope.

4.2 A communications and engagement workstream has commenced and the PMO have recruited a dedicated communications and engagement officer that will be key in ensuring service user involvement and staff engagement continues to develop and that the workforce and organisational development workstream deliverables are achieved.

4.3 One Croydon is actively working with Croydon Healthwatch to capture people's experience of both the LIFE and ICN transformation programmes.

5 Next Steps

5.1 The next steps for the extension of the Alliance Agreement for Over 65s is as follows:

5.1.1 Health and Social Care Scrutiny Committee 21st November 2017
5.1.2 One Croydon Alliance Board by 14th December 2017
5.1.3 Council Cabinet 22nd January 2018

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BACKGROUND DOCUMENTS: None

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