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

Document information	
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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.
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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
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Contents

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.