One Croydon

NHS
Croydon Health Services
NHS Trust

NHS
Croydon Clinical Commissioning Group

Croydon Whole System Planning for Winter

Scrutiny Health & Social Care Sub-Committee

December 2018

Introduction

A whole system winter plan has been developed, identifying key activities across the whole Croydon Health and Care system that will support performance throughout the significant pressures expected through Winter 2018-19. This includes:

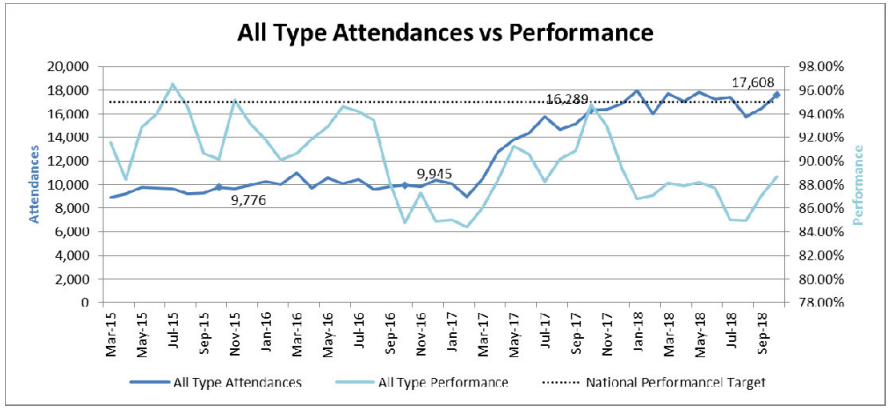
- Establishment of strengthen system-wide governance to support proactive and reactive responses
- Additional out of hospital capacity in primary and community based care to support prevention, earlier intervention and faster discharge
- Demand and Capacity modelling based on predicted hospital activity
- Focus on the launch of Croydon Health Service's new Emergency Department; and
- Improvement and maintenance of patient flow within and discharge from hospital

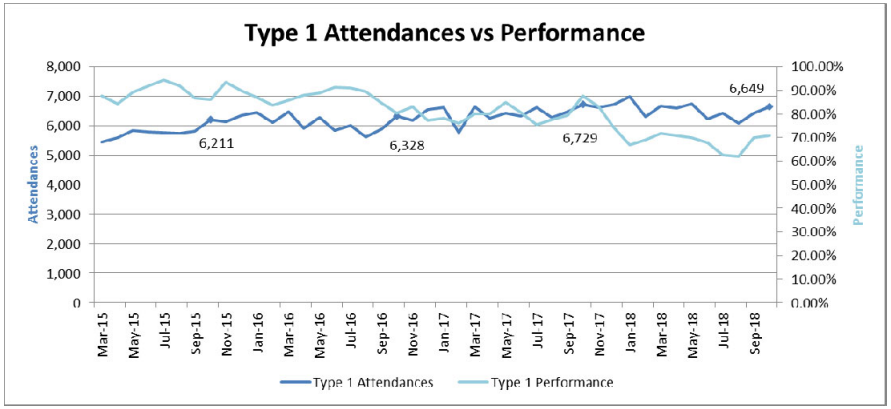
Urgent Care Services in Croydon

GP Hubs (8am – 8pm, 7 days a week)	East Croydon Parkway, New Addington Purley War Memorial Hospital
Urgent Treatment Centre (24/7)	Croydon University Hospital (Access via Mayday Road)
Emergency Department (24/7)	Croydon University Hospital (Access via Mayday Road)

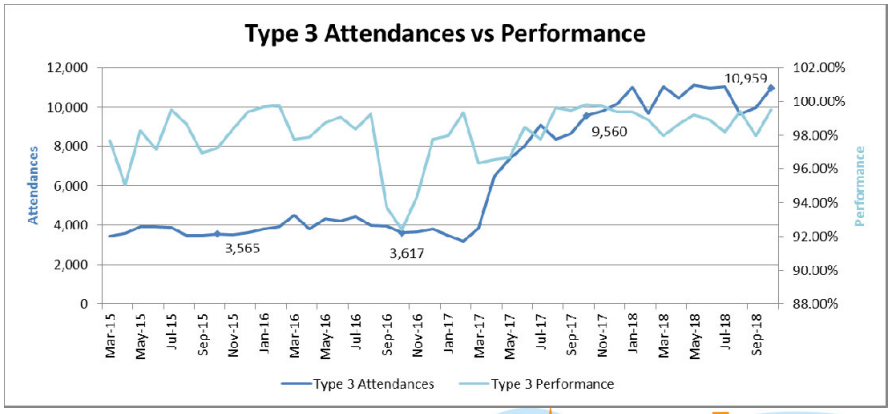
KEY CHALLENGE: ADDRESSING DEMAND

A&E 4hr Wait – 3 year trend





- Attendances across the system have shown an increase through 2017/18.
- This increase in attendances is primarily due to GP Hub over performance.
- This has resulted in a stabilisation of Type 3 performance as the GP Hubs significantly increase attendances and rarely contribute any breaches.



Urgent Care/Out of Hospital

Croydon offers a number of different urgent care services to meet the needs of the population, with the key challenge of ensuring that patients are aware of these, know which is appropriate for their needs, and how they can access them.

This is a particular challenge following the opening of the new ED at CHS, which is expected to bring with additional activity, though this is expected predominantly in the Type 3 activity (attendances at the Urgent Treatment Centre and GP Hubs). In order to support this, there are a number of key focus areas:

- Patient education through appropriate winter communications to ensure patients are aware of available services. This needs to be an ongoing plan, recognising the fluidity of the Croydon population.
- Strengthening redirection at the front door at Croydon University Hospital to support patients being directed to offsite services (e.g. self-care, community pharmacy, primary care) and to the Urgent Care Centre instead of ED as appropriate.
- Ensuring key services are available at appropriate times and commissioning additional capacity when needed.

Winter Communications

Winter Communications is being co-ordinated at a SW London level and is aligned with the national "Help Us Help You" campaign. This is in addition to the Flu Campaign, which has been running since October 2018.

The campaign in Croydon is primarily targeted on working age adults, young people, and parents, ensuring that we can support appropriate access to services for paediatric patients. The campaign hopes to achieve two key behavioural changes:

- Encourage patients to use community pharmacy more for low acuity presentations; and
- Promote the Health Help Now app as a means of identifying appropriate services for their needs.

There are three key strands to the campaign:

- Self-care agenda;
- Community Pharmacy; and
- NHS 111

Croydon also has a Winter Champion (Bruce Cronx – a French Bulldog), who will be putting out messages on social media across the Christmas and New Year period to support patients to choose the right services.

Out of Hours Dental Services

Out of Hours Dental Services have been commissioned at a pan-London level. Details of this have been circulated to all appropriate services, including CHS ED and the UTC.

Flu Vaccination Programme

Croydon has not met its two key targets for flu vaccinations by 3rd December: uptake in the over 65s was 54.8% compared to a target of 60%; and uptake in frontline health care workers was 50%, compared to a target of 55% and actual update to the same point last year of 62%.

To support improvements in these statistics, the following actions are underway:

- System-wide flu meeting planned for 18th December 2018 with support from the Public Health team to support maximising uptake in the next few weeks;
- CHS focusing efforts on meeting the Frontline Healthcare Workers uptake target. This may include efforts learning from NHS Kingston, who have already hit the 75% target; and
- Support from the LMC encouraging practices to share the aTIV vaccine stock to ensure that key target groups can access the vaccination.

GP Extended Access Hubs

In 2018, Croydon has commissioned additional primary care capacity through GP extended Access Hubs. This provides additional appointments outside of standard GP hours and is in addition to the existing GP Hubs.

The additional capacity is provided at five sites from three different providers and includes:

- Over 10,000 minutes of extended access appointments per week;
- Delivered by a mix of GPs, Nurses and HCAs

The capacity is provided at three sites aligned with the GP Hubs, as well as the Brigstock Family Practice and the Shirley Medical Centre.

New Emergency Department

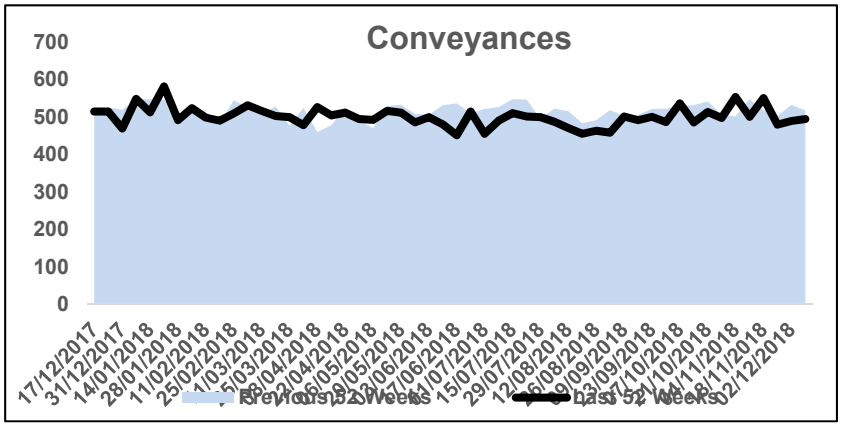
Launch of the new ED on the 2nd December 2018 went smoothly. However, a significant increase in attendances the following day put pressure on the system, with recovery continuing through the week. A number of new processes have been introduced to improve flow:

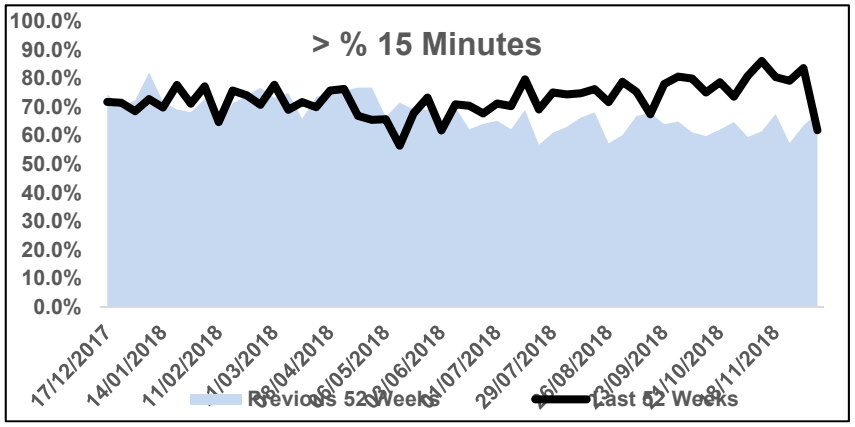
- *Ambulance Handover*
  Single point of clinical handover with LAS streamer (now 24/7) with removal of RATT and placing of patients directly into cubicles and entry of handover PIN in cubicle. Handovers under 15 mins increased from 13.92% to 37.27% for the periods Sunday to Thursday before and after the move. Further improvements are expected as crews adjust to the new process.

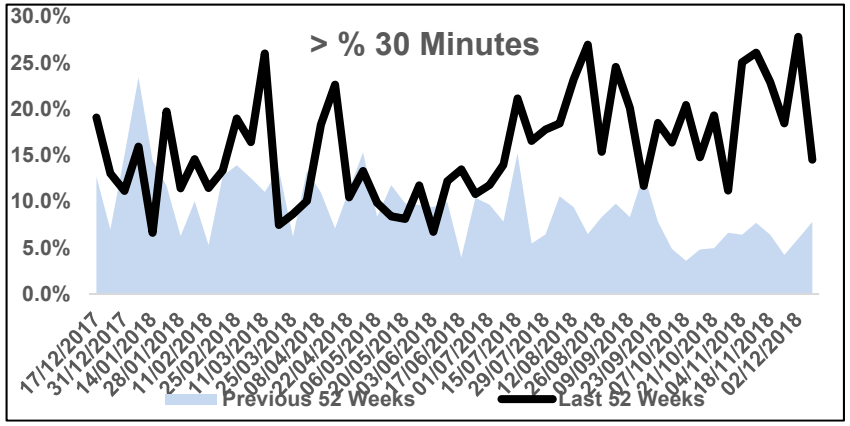
- *Zoning*
  Cubicles will be zoned with a named Doctor and Nurse for each Zone. These would receive, treat and manage the patient through their entire pathway. This is expected to reduce ED blockages.

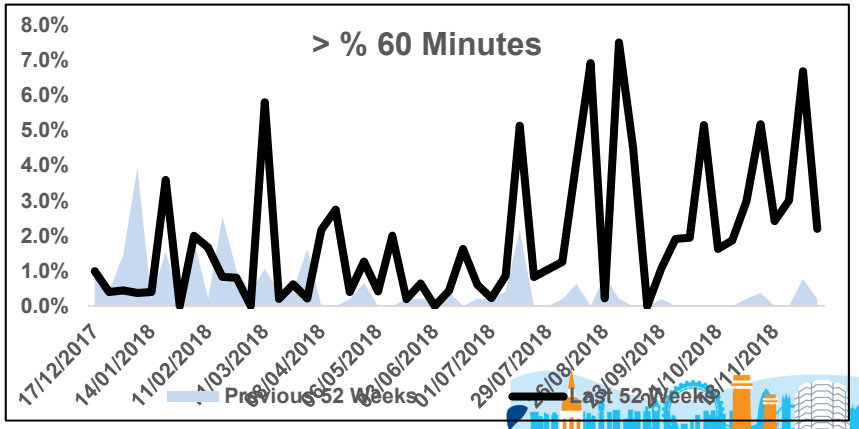
- *ISTAT*
  Integrated See, Treat and Triage, at the front door, managed by a senior decision maker, focused on supporting provision of ambulatory care.

LAS Ambulance Handover









ED Management and Working with Wards

A number of new initiatives are being introduced at Croydon Health Services NHS Trust to support improved performance:

- *Admissions Lounge*
  This is a 10-bed space that will operate from 08:00 – 18:00, aimed at relieving pressure in ED by housing patients with DTAs. Patients may also be discharged from here if their pathway supports it

- *Transfer Team*
  Support for transfer of admissions to wards between 6pm and 2am is to be piloted ensuring that clinical staff can remain on the ED floor and focus on providing care to patients. This will comprise of a Band 5 Registered Nurse and a Band 2 Healthcare Assistant.

Escalation Capacity and Flex

There are several focuses for the management of the bed base at Croydon University Hospital with a view to ensuring that capacity can be flexed to support performance through winter.

- Following a Demand and Capacity Modelling exercise, Fairfield 2 was converted from surgical to medical beds. This has been developed into a therapy-led ward allowing more effective and efficient management of these patients, allowing for more rapid discharge. This was moved to a newly refurbished location on 14th December 2018.

- Fairfield 2 will now be opening as formal escalation capacity late December / early January, which will allow more efficient staffing model, compared to current piecemeal approach across the Croydon University Hospital site. Should escalation be required beyond this, current facilities (e.g. CathLab, Ambulatory, Recovery) will be used as further escalation space.

- Assessment capacity will be ringfenced and protected from bedding to ensure that these continue to operate as part of the assessment model, channelling patients appropriately through the system and avoiding hospital admissions where appropriate.

Mental Health Initiatives

The management of mental health patients in urgent and emergency care settings has been a challenge in through 2018. To support an improvement in this area, South London and Maudsley NHS Foundation Trust (SLaM) have put in place a number of initiatives:

- *Multi Agency Discharge Events (MADEs)*
  Mental Health bed MADE events. These identify key blocks to discharges from mental health inpatient beds and support system collaboration to remove these blocks and support patients being transferred to a more appropriate care pathway.

- *Commissioning Additional Beds*
  Commissioned from East London Foundation Trust, these beds provide additional capacity and have allowed Croydon patients in out of borough capacity to be brought back to more locally based provision and have helped reduce waits in ED.

- *ED Assessment Beds*
  These beds have been commissioned for short stays for assessments. They are aimed at patients where there is some block/decision that needs resolving to ensure patients needs are met in an appropriate environment rather than ED.

KEY CHALLENGE: WORKFORCE

Workforce

The workforce position continues to be challenging in Croydon with significant vacancy rates across services, but particularly notable in the clinical workforce at CHS, the LIFE team and social care.

This challenge will take time to resolve in the long term, with the immediate challenge being addressed through bank staff where this is appropriate. Some explicit challenges include:

- Paediatric workforce is recognised as a pan-London challenge, with CHS regularly having to reduce the paediatric capacity owing to staffing issues;
- A LIFE team vacancy of approximately 25%, reducing the impact of this service model; and
- Unfilled shifts in ED, though this has shown an improvement since September 2018.

To address the ED issue, a new medical model is being development by CHS, with the new model expected to be shared for review in January 2019.

KEY CHALLENGE: DISCHARGE

Discharge

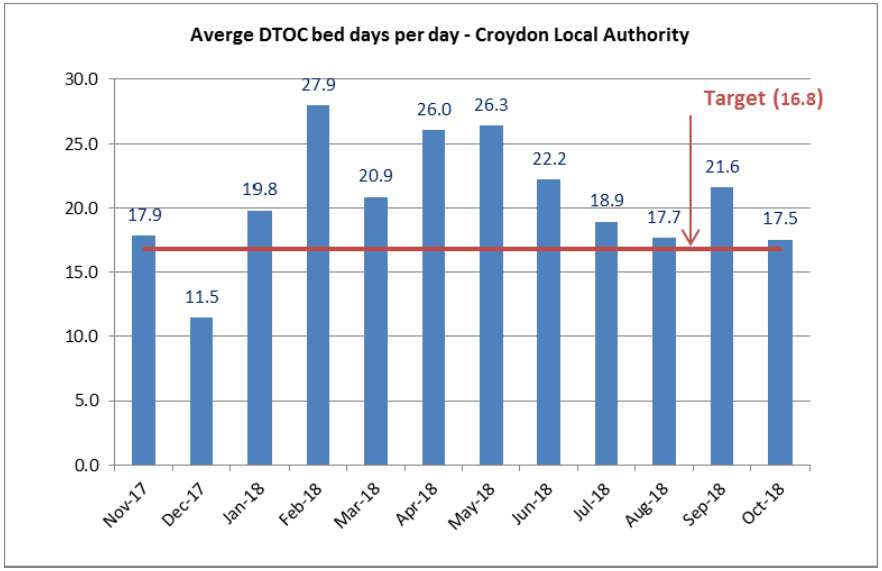
Patient flow is essential to delivering excellent performance against the A&E 4-hour constitutional standard. This is supported by the correlation between period of challenged performance at CHS and high levels of both stranded and long stay patients in the bed base at CHS.

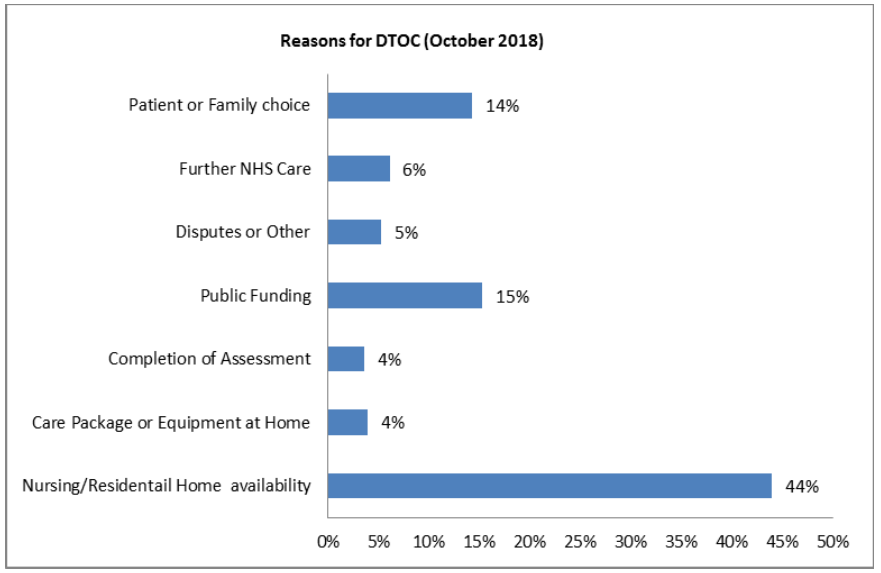
There are a number of areas of focus underway to support improved discharge processes to enable better patient flow through the system and improved performance:

- Enhancing the resource available for the discharge team and launching the Integrated Discharge Team;
- Continued system-wide focus on stranded and long stay patients, with 21-day MDTs, a new Executive-led approach, and scheduled multi agency discharge events (MADEs) and mini-MADEs;
- Work on developing and implementing Pathway 3 for Discharge to Assess to support patients to receive a CHC assessment in the community; and
- Further development of system-wide ownership of the discharge challenge and agreed resolutions.

Delayed Transfers of Care (1 of 2)

- DTOC bed days show a significant decrease from **26.3** in May to **17.5** in October. Residential/Nursing homes accounts for **44%** of delay reasons and Public funding is **15%.** Total delayed beds in October is **544**.
- **November** DTOC is **576**.
- The trust will be going live with weekly validation of data, so we should have access to a a more accurate picture
- **December**, month to date, **323** (unvalidated), which is above the same time in November. There has been additional focus this week, which will be demonstrated in the figures next week.



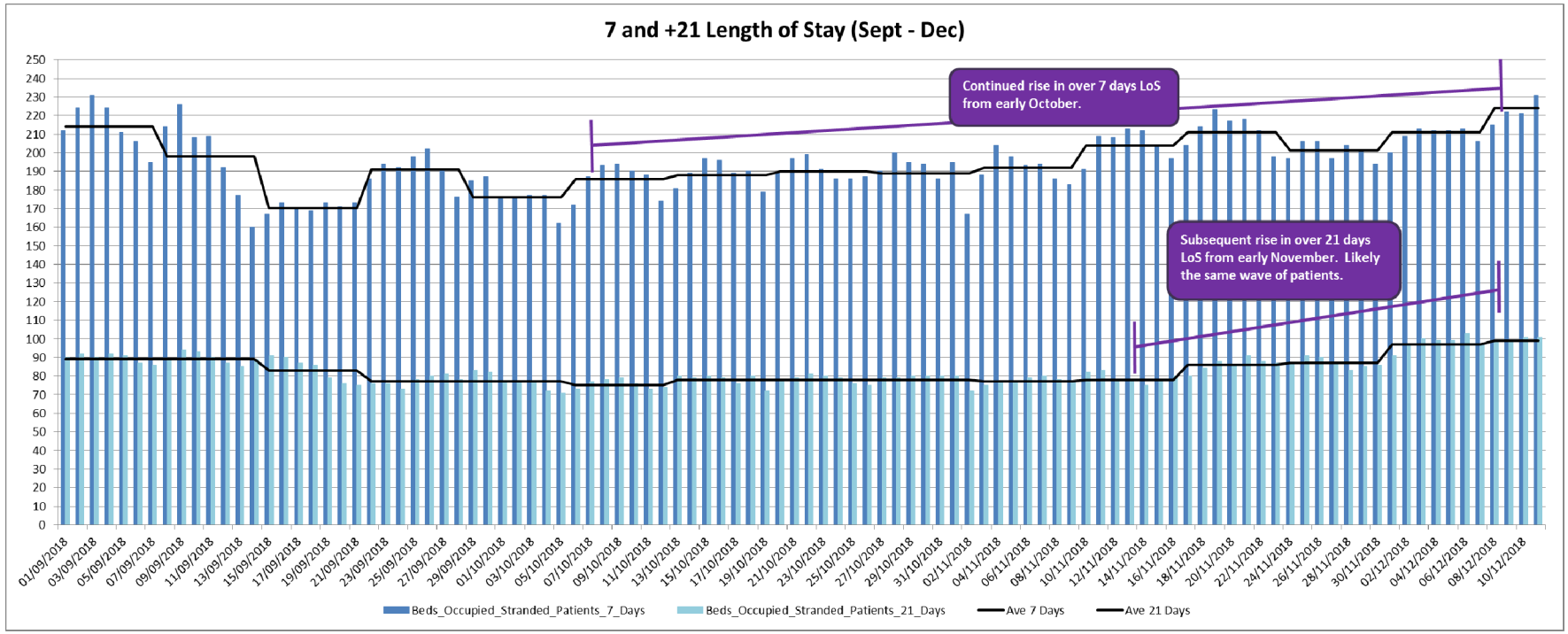


Delayed Transfers of Care (2 of 2)

Croydon GP Registered population (Oct 2017/18 YTD vs Oct 2018/19 YTD)				Croydon University Hospital (as a whole) Key indicators comparing a snap shot at Sept 2017 to Oct 2018				Social Care Indicators (Latest available data)	
Average LOS Non Elective	4.38	4.75	▲	% of Type 1 attendances	43% (Sept 2017)	39% (Oct 2018)	▼	% of over 65s discharged from hospital into reablement who are still at home after 91 days after 2016: 91.3%; 91.3% in Q1 2018/19	►
Average LOS OOH	8.83	8.41	▼	% of Type 1 admitted	36% (Sept 2017)	35% (Oct 2018)	▼	% of older people (65+) discharged from hospital who received reablement services 2016: 1.9%; 6.1% at Q1 2018/19	▲
DTOC bed days**	10,331 (to Aug 17)	6,785 (to Aug 2018)	▼	4 Hour wait	90.9% (Sept 2017)	88.7% (Oct 2018)	▼	Permanent admissions to residential or nursing homes for 65+ year olds .413.7 per 100k pop in 2016; 382.1 per 100K 2017/18 (29.1 – June 18)	▼
LAS incidents at Care Homes	1,100	848	▼	Escalation Beds	49 (30 Sept 2017)	10 (30 Nov 2018)	▼	Timeliness of ASC assessments for 65+ year olds 80% in 2016 ; 76% in Q4 2017/18	▼

Referrals to D2A as of M8 YTD = 802 against a target of 758 per year.
Forecasting 1020 by year end.

Stranded Patients – Daily Performance (1 of 3)



Discharge Processes

Discharges have long been seen as being essential to supporting performance at Croydon Health Services. Going into Winter 2018-19, a number of key initiatives have been undertaken to support this area of work:

- *Enhancing the Discharge Team*
  CHS have increased the resource for the discharge team for the period October 2018 to March 2019, with a view to supporting more timely discharge from the wards to free up capacity.

- *Integrated Discharge Team (IDT)*
  The IDT focuses on complex discharges through collaborative working, moving towards an integrated team with one management structure. This will also support reductions in stranded and long stay patients.

- *21-Day MDT Reviews*
  Twice weekly reviews of patients approaching or over 21 days LoS to support transfer of these patients to a more appropriate setting.

- *Executive Management*
  Building on the MDT reviews, this will involve the system executives reviewing key patients awaiting transfer to a more appropriate settings and resolving these issues with support from the executive team.

Social Care Winter Funding

The Council has been awarded an additional £1.4m for 2018-19 winter pressures. This will be allocated to support Croydon health and care provision in a number of ways:

- *Delayed Transfers of Care*
  Dedicated social care resource will be provided to the Integrated Discharge Team to support embedding ways of working, resolving issues and improving business processes and relationship development.

- *Market stabilisation*
  Market failures have led to increased costs as a result of reprovision. A “Right Cost of Care” exercise is being undertaken to understand the rates paid and the impact of market stabilisation. This also includes conversion of a number of residential placement to nursing placements to support timely discharge of person-centred outcomes.

- *LIFE Demand*
  The demand for LIFE services is expected to be higher than the original forecasts (1,629 people versus 780 forecast), so additional funding will support the LIFE team to deliver care closer to home where appropriate.

Out of Hospital Initiative Objectives

Initiative	KPI (need to be ones that will achieve the savings)	Target	Current Performance	Impact on savings (comment or a figure?)
Integrated Community Networks (ICN)	People seen in ICN	7,341 per annum	2759 (Oct17 - Oct18)	239 New cases in Oct and 276 closed cases. 4582 below Target
Integrated Community Networks (ICN)	Admissions Avoided	2108 per annum	1039 (Oct17- Oct18)	135 admissions avoided in Oct accounting for 48.9% avoidance rate
Living Independently for Everyone	People referred to Discharge 2 Assess (D2A)	758 per annum	802 (Apr 18 – Dec3 2018)	The weekly average is currently 23
Living Independently for Everyone (LIFE)	Percentage of People Re-abled through LIFE (1st year performance as benchmark)	50%	43% (October 2018)	From April 3 – Dec 3 2018 235 out of 551 people referred reabled
LIFE Community	1811-758 = these referred from community = admissions avoided?	423 per annum	3 (Dec 3 2018)	This is a new addition

Community Initiatives

There are a number of initiatives in place in the community in Winter to support the system.

- *Falls Service*
  The falls service will be expanded to provide community falls clinics in GP practices, along with an expanded Otago exercise programme that will be targeted at dementia patients as well as developing closer alignment with other services such as LIFE, MSK and LAS.

- *Red Bag Scheme*
  The Red Bag Scheme is planned to be introduced in Winter 2018-19, which should reduce the number of long stay patients at CHS.

- *Intermediate Bed Capacity*
  Additional CICS bed capacity (6 additional beds, to a total of 20) has been commissioned, split across two providers for the north and the south of the borough. These will be opened as pressure requires, and there is the potential for further emergency capacity if pressure is deemed to warrant it.

GP Huddles

The introduction of GP MDT Huddles through the Integrated Community Networks has targeted an increase in admissions avoidance. This is still an area where further development can support a greater impact, though there have already been a significant number of admissions avoided.

While the huddles haven't seen as many patients as expected (2,759 compared to a target of 7,341 for Oct17 to Oct 18), there are identified opportunities to support an increase in patients referred in. This includes through collaboration with the streaming and redirection pilot to identify and refer frequent attenders, as well as through engagement with the Integrated Discharge Team.

For the period October 2017 to October 2018, 1,039 admissions were avoided through the huddles, though this was below the annual target of 2,108.

Care Homes

Croydon has a large care home population, so supporting this cohort of patients is a key focus of activity. There are a number of initiatives planned for winter that are aimed at reducing conveyances and admissions to hospital.

- *Telemedicine*
  The Airedale / Immedicare model will be rolled out to 20 care homes in December 2018, rising to 80 by March 2019. This provides iPad access to a clinical hub, supporting provision of appropriate care to patients in the care home setting while reducing LAS callouts and conveyances and CHS admissions from care home settings. **Expected impact 554 non-elective admissions, 767 A&E attendances**.

- *Care planning*
  Transformed end of life care services including enhanced advance care planning for care home patients, end of life huddles, additional palliative care capacity to provide admission avoidance support to the AMU/ED, and expanded community engagement programme.

- *Significant Seven*
  Training and support will be provided to unskilled workers in care homes to introduce the Significant Seven Package, which supports staff to identify deterioration earlier, resulting in residents receiving care at home rather than a hospital admission

ANY QUESTIONS?

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