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Scrutiny Health & Social Care Sub-Committee Agenda

To: Councillor Sean Fitzsimons (Chair), Councillor Andy Stranack (Vice-Chair), Pat Clouder, Andrew Pelling, Scott Roche, Callton Young and Gordon Kay (Healthwatch Croydon co-optee)

Reserve Members: Jan Buttinger, Patsy Cummings, Jerry Fitzpatrick, Clive Fraser, Toni Letts and Helen Redfern

A meeting of the **Scrutiny Health & Social Care Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 22 September 2020** at **6.30 pm**. **This meeting will be held remotely.**

Jacqueline Harris Baker
Council Solicitor & Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
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www.croydon.gov.uk/meetings
Monday, 14 September 2020

PLEASE NOTE: Members of the public are welcome to remotely attend this meeting via the following web link - http://webcasting.croydon.gov.uk/meetings/10623

The agenda papers for all Council meetings are available on the Council website www.croydon.gov.uk/meetings

If you require any assistance, please contact Simon Trevaskis as detailed above.

AGENDA – PART A

1. Apologies for Absence

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

2. 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.

3. 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.

4. Chair's Update on the South West London & Surrey JHSC Sub-Committee - Improving Healthcare Together 2020 - 2030 (Pages 5 - 28)

The Sub-Committee is asked to review the information provided, along with an update given by the Chair at the meeting, with a view to reaching a conclusion as to whether any further action is necessary.

5. Croydon: COVID-19 & Winter Preparedness (Pages 29 - 56)

The Sub-Committee is asked to review the information provided in this report and at the meeting, with a view to forming conclusions and recommendations.

6. 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.”

PART B

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REPORT TO:	**HEALTH & SOCIAL CARE SUB-COMMITTEE 22 September 2020**
SUBJECT:	**Chair's Update on the South West London & Surrey JHSC Sub-Committee – Improving Healthcare Together 2020 – 2030**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Councillor Sean Fitzsimons – Chair of the Health & Social Care Sub-Committee**
PUBLIC/EXEMPT:	**Public**

POLICY CONTEXT/AMBITIOUS FOR CROYDON:

By scrutinising health care provision affecting the borough it helps to ensure that outcomes are being achieved for the residents of Croydon.

Corporate Plan for Croydon 2018-2022

ORIGIN OF ITEM:	The Chair of the Health and Social Care Sub-Committee is appointed to sit on the South West London Joint Health Scrutiny Committee. This report provides an update on the recent work of its Sub-Committee focussed on the Improving Healthcare Together Plan.
BRIEF FOR THE SUB-COMMITTEE:	The Sub-Committee is asked to review the information provided, along with an update given by the Chair at the meeting, with a view to reaching a conclusion as to whether any further action is necessary.

1. CHAIR'S UPDATE ON THE SOUTH WEST LONDON & SURREY JHSC SUB-COMMITTEE – IMPROVING HEALTHCARE TOGETHER 2020 – 2030

1.1. The South West London Joint Health Scrutiny Committee (JHSC) consists of elected Members from the London Boroughs of Croydon, Kingston, Merton, Sutton and Wandsworth and was established to provide oversight of health care provision across South West London. The Chair and Vice-Chair of the Health and Social Care Sub-Committee are appointed as Croydon Council's representatives on the JHSC.

1.2. In October 2018 the JHSC decided to set up a Sub-Committee to scrutinise the Improving Healthcare Together 2020-2030 Plan (IHT) that was being developed by NHS commissioners. Representation was also invited from Surrey County Council to reflect the areas covered by the 3 Clinical Commissioning Groups (CCGs) responsible for the plan (NHS Surrey Downs, Sutton and Merton).

1.3. The Sub-Committee has held a number of meetings, the agendas and minutes of which can be found at the following link:-

1.4. The IHT, which includes the possibility of significant service reconfiguration for the Epsom and St Helier Hospitals and the provision of a specialist emergency care hospital to be located at either Epsom, St Helier or Sutton sites, has been subject to public consultation. At their last meeting on **4 June 2020** the Sub-Committee considered its own response to the consultation, a copy of which can be found appended to this report as **Appendix A**.

1.5. The consultation period has now ended and it has subsequently been confirmed that Sutton site is the preferred option. Had there been agreement between the boroughs, the JHSC could have made a joint referral to the Secretary of State for Health asking for this decision to be reviewed. However, it was decided at an early stage in the process that the right to referral would be retained by individual boroughs.

1.6. The London Borough of Merton has submitted a referral to the Secretary of State for Health asking for this decision to be reviewed. A copy of the Merton's referral can be found appended to this report as **Appendix B**. At this stage it has not been confirmed whether any of the other boroughs will be making their own referrals.

1.7. The purpose of this report is to update the Sub-Committee on the what had happen to date and to ask for the input of Members on how to proceed going forward.

1.8. Potential options for the Sub-Committee to consider are:-

- Taking no further action
- Endorsing the referral made by LB Merton
- Making a separate referral on behalf of Croydon.

1.9 Following the meeting the decision of the Sub-Committee will be reported back to the next meeting of the IHT Sub-Committee in October.

CONTACT OFFICER: *Simon Trevaskis – Senior Democratic Services & Governance Officer – Scrutiny.*

Contact: simon.trevaskis@croydon.gov.uk

APPENDICES TO THIS REPORT

Appendix A: South West London & Surrey JHSC Sub-Committee – Response to the Improving Healthcare Together consultation

Appendix B: London Borough of Merton – Referral to Secretary of State for Health

Improving Healthcare Together Joint Health Scrutiny Committee (IHT JHSC)
Response to NHS consultation on plans for Epsom and St Helier Hospital under their programme Improving Healthcare Together 2020-2030.

1. Summary

1.1. The IHT JHSC asks that NHS commissioners consider the following. The JHSC has resolved to provide comments to the CCGs but none of the comments set out below should be interpreted as recommendations.

(i) commissioners to provide further explanation of what they will do to provide better access and transport services ; how they will work with relevant partners to deliver and ; how funding will be secured to deliver (see paragraphs 4.1, 4.4, 4.9 - 4.15)
(ii) commissioners to further address actions to minimise impact on deprived communities (see paragraphs 4.19 - 4.21)
(iii) commissioners provide further information on the impact of Covid-19 in particular addressing implications for bed numbers and infection control ; deprivation and ; the impact on BAME communities (both patients and staff). (See paragraphs 4.4, 4.19 - 4.21, 5.3 - 5.6)
(iv) Commissioners to work with relevant Local Authorities regarding the wider impact on the local economies of both the chosen Specialist Emergency Care Hospital (SECH) site and the District Hospital sites (see paragraphs 4.1, 4.18, 4.22 - 4.23)
(v) commissioners ensure that development of the wider community based services and facilities happens before or in parallel with move to the new clinical model (see paragraph 4.2 , 4.4)

2. Background

2.1. Since being established in October 2018 the JHSC, (in its discretionary stage and post-publication of the formal public consultation in its mandatory form), has scrutinised the work being undertaken by the 3 CCGs responsible for the NHS plans,(NHS Surrey Downs, Sutton and Merton), exploring ways we can address local health challenges and make sure NHS services are sustainable and fit for the future.

2.2. Improving Healthcare Together (IHT) 2020 to 2030 sets out proposed changes to hospital services across the Epsom and St Helier University Hospitals NHS Trust. To summarise;

- Both Epsom and St Helier hospitals are facing significant challenges to delivering services across the two sites
- In September 2019, the trust was allocated £500 million to improve the current buildings at Epsom and St Helier hospitals as well as build a new specialist emergency care hospital on one of the three sites – Epsom, St Helier or Sutton.
- IHT proposes to bring together at one site (Epsom, St Helier or Sutton) six core (major) services for the most unwell patients and those who need more specialist care in the form of a single specialist emergency care Hospital
- The specialist emergency care hospital would be complemented by the existing district hospitals each with its own Urgent Treatment Centre (UTC), open 24 hours a day 365 days per year, continuing to treat a significant proportion (80%) of existing demand.

2.3. The IHT process has resulted in a shortlist of three options.

- Epsom as the site of the specialist emergency care hospital This would include UTCs at both Epsom and St Helier hospitals
- St Helier as the site of the specialist emergency care hospital This would include UTCs at both Epsom and St Helier hospitals
- Sutton as the site of the specialist emergency care hospital This would include UTCs at Epsom, St Helier and Sutton hospitals (IHT preferred option).

2.4. The role of the JHSC is to scrutinise the proposals of the NHS and take a policy view which takes into account the collective view of the Councils represented on the committee and all of the issues which impact on residents' use of healthcare, including access, transport and the consequences for employment, the local economy and wider public services.

2.5. As part of its responsibilities during the mandatory stage the JHSC is permitted to delay making its consultation response until after the full public consultation has been completed so that it can then be informed by the findings and conclusions arising from the public consultation.

2.6. On this basis the JHSC held a meeting on 4 June 2020 to receive and be briefed on the analysis and findings of the public consultation and the latest version of the Integrated Impact Assessment (IIA).

2.7. The IHT JHSC response to the consultation below is informed by the information and briefings it has received, the questions asked of NHS commissioners, other stakeholders and members of the public across all the meetings held since October 2018.

2.8. The response uses the questions as set out in the public consultation to provide a framework for the responses to more specific areas. The response also raises a number of concerns regarding the process that has been followed, particularly in light of Covid-19 outbreak.

3. **Points related to consultation questions** (original consultation questions shown in italics)

3.1. As representatives of the local communities affected by these plans the committee focuses its attention on the wider non-clinical aspects of the proposals and wishes here to re-enforce the points it has made over the duration of the committee's oversight. In particular this concerns issues around:-

- Consideration of transport and accessibility issues including the balance between public and private transport modes
- Consideration of the impact on deprived communities resulting from changes to the location of certain service provision
- Consideration of the impact on the wider local economies and potential regeneration
- Impact on staff not only in the Trust itself but also support organisations such as the voluntary sector and local government (adult social care)
- Impact on the environment eg: air quality.

3.2. It is acknowledged by the JHSC that without significant capital investment the model for acute hospital provision within the borough is currently unsustainable and needs to change. Whether this investment needs to include a new third site is the subject of this consultation.

3.3. *Our Model of Care (or New Way of Working) Our proposal is to keep most services at their present hospitals in refurbished buildings, and bring together six core (main) services for the most unwell patients, those who need more specialist care, and births in hospital, onto one site in a state-of-the-art new specialist emergency care hospital.*

3.4. Whilst the committee welcomes some aspects of the new model of care, most members believe that there are also a number of areas of concern where we have not been able to get the assurance we would need to fully support these ideas. There are continuing concerns around:

- The fact that the new model will both be new and unique in London
- The extent to which preparations would be in place to ensure patients, families and carers understood the effect of the new 'architecture' of care,
- The extent to which the companion community-based service changes and facilities would be ready in time and sufficiently bedded-in
- The implications for existing users from deprived communities resulting from changed locations of provision
- The travel, transport and accessibility (public and private) issues arising from the changes
- The impact on staff and the ease with which new or replacement staff can be recruited to work for the Trust, particularly at the site(s) which are not chosen to be the major centre.
- The costs and complexity of district hospital services and major acute services being on different sites requiring inter-site patient transfers

If the new model of care is adopted then these concerns will need to be addressed, and a Sub-Committee of the JHSC will be tasked with assuring that this happens. To ensure that the views of all affected areas are properly represented, working groups of the Sub-Committee will ensure that they include representation from local Borough and District Councils.

3.5. *The location of the specialist emergency care hospital : Sutton Hospital as our preferred location / St Helier Hospital as the location of the new specialist emergency care hospital / Epsom Hospital as the location of the new specialist emergency care hospital*

3.6. As the IHT JHSC is made up of members of six local authorities who are in varying degrees impacted by the proposals it will necessarily be the case that the different local ambitions and priorities will influence the responses. This IHT JHSC response is therefore a combination of aspects where there is broad agreement and more specific local views. This is specifically the case when it comes to the location of the new acute hospital. NHS commissioners will also need to take into account the specific responses made here and in the individual responses as below. The IHT JHSC cannot therefore express a consensus view on the location of the specialist emergency care hospital.

3.7. The individual views of the councils involved in terms of the options presented in the consultation are available via the links in Appendix one.

3.8. *What would help improve transport and travel? What would improve public transport and travel to the new specialist emergency care hospital for any of the three options?*

3.9. As noted above issues around travel transport accessibility and the increase / changes to flows around the re-modelled sites is a very important issue. The committee has seen various information based on traffic modelling which provides some theoretic outcomes for travel times etc. The Integrated Impact Assessment notes that some people from deprived communities and older people are disproportionately affected by the increased travel times. These disparities are accentuated when public rather than private transport needs to be used as is often necessary for these groups of people.

3.10. Regarding the transport considerations for each site this needs to include more detail on those groups whose travel times are lengthened by the Sutton site option and link this to higher historic use of A&E by these groups, which will not necessarily be mitigated by an Urgent Treatment Centre at St Helier.

3.11. While the committee understands that major public transport providers such as Transport for London (TfL) have been involved in some early discussions by necessity these can only be very provisional, being based on the possibility of any one of the three options being chosen. It is also not clear that any required additional funding would be provided for the relevant transport providers, the committee's understanding being that the £500M relates to hospital spend only. It is not clear whether the mitigations for adverse impacts proposed in the IIA final report are feasible or affordable.

3.12. The JHSC notes that further work will be needed to improve transport access, both public and private, to the new SECH and ensure that these improvements are in place by the planned opening date in 2025. The JHSC expects the design and implementation of this improved public transport and road network will be carried out in conjunction with local authorities and will address issues and concerns raised by the JHSC relating to travel times, transport costs, parking and other access issues impacting on residents, particularly those in areas of high deprivation. The JHSC calls on NHS commissioners to work closely with the relevant local authorities to make the case to the Government to give assurance that sufficient funding is available to deal with transport issues arising from the anticipated increased population of the wider catchment area, together with the impact of the implementation of the IHT programme.

3.13. We also believe that the impact of longer journey times, poor bus connections and insufficient train routes and car parking are inter-related risk factors which require further mitigation. Some of the evidence presented in the Deprivation Analysis indicates greater healthcare usage by deprived communities. We note that a key concern from the formal consultation has been about poor health outcomes as a result of longer journey times.

3.14. Longer journey time concerns have repeatedly surfaced throughout the process and in particular in the consultation process. The YouGov and Ipsos MORI findings support this feedback. The London Borough of Merton St. Helier Survey results also refer to longer journey times. Importantly, across the entire formal consultation exercise, concerns were

raised about longer travel times, separation of services/maternity services and pathways and patient flow.

3.15. A potential risk to parking capacity at the preferred acute site may also materialise if "non-patient" usage exceeds expectation. Parking capacity at Sutton hospital is currently well below that of Epsom and St. Helier. Considerable investment would be required to allow for increased number of visitors at the preferred site, especially in acute maternity/birthing and paediatrics.

3.16. *How would our proposals affect you and your family? If you think any of our proposals would affect you, your family or other people you know, either positively or negatively, please tell us why you think this using the space below.*

3.17. As noted above in the general section the JHSC's response reflects our position as local community leaders for both our individual communities and across the sub-region.

3.18. Recognition should be given to the role of the local councils with regard to their communities in terms of accessibility, transport, deprivation and the impact on local economies.

3.19. Throughout both the engagement phase and during the public consultation members have expressed concerns about and pressed IHT Commissioners about the impact of the proposals on deprived communities. The deprivation impact analysis and Integrated Impact Analysis have provided some information with regard to these concerns.

3.20. However the JHSC is still concerned that the particular impacts of changes to the location of services for deprived communities are not sufficiently considered in terms of accessibility and transport and the specific clinical needs of those from such communities. This is also shown in the actions and mitigations which reflect on these issues in the Integrated Impact Analysis.

3.21. As the programme moves to the development of its Decision Making Business Case the JHSC would like to see more substantive detail on the implications and mitigations which would be necessary.

3.22. At this stage of the proposals it is not possible to provide anything like a full consideration of the potential impact of the choice of one site over the other two in terms of resulting development (opportunities) or diminution of the impact on local economies for each site.

3.23. As local authorities with responsibility for our areas as a whole it is vitally important for JHSC members to consider this alongside the medical aspect of the proposals. The JHSC and relevant local councils will therefore want to work closely with NHS commissioners as and when the project moves forward to ensure that full and proper consideration is given to maximising benefits and avoiding or minimising any possible downsides irrespective of the site chosen.

4. **Procedural Considerations**

4.1. The Committee does not believe it has been presented with the information needed to effectively carry out its scrutiny in a timely manner. From the start and during the process

the JHSC has been concerned about and registered comments about the way in which the information provided by the NHS has often been in an incomplete or draft form and has had the impression of the JHSC being 'drip-fed'. Whilst fully recognising the range and complexity of the issues it has too often felt as if the JHSC involvement was being treated as a series of steps to be achieved on a largely predetermined path.

4.2. On a similar theme members were also not helped by the fact that important contributory papers such as the IIA were still not being provided to them in final version form. In particular the final report of the IIA was not made available to the JHSC members before the 4 June meeting. JHSC members understand the iterative nature of such work and the timing issues that can arise when having to work to statutory publication deadline for committee papers but the fact is that the timelines for this piece of work were in the control of the programme and the committee management deadlines are well known in advance.

4.3. The JHSC and some of the individual councils raised concerns towards the end of the period of public consultation when the lockdown effects of Covid-19 were introduced and caused face-to-face elements in the remaining consultation period to be cancelled. Whilst recognising that online paths did remain open, members were concerned that people would not have the opportunity to respond and would rightly be prioritising themselves and their families health rather than participating in a consultation.

4.4. The JHSC is disappointed that requests either for an extension to the consultation or a pause were rebuffed. The committee has not seen any evidence to support the stated view that the impact of Covid-19 was minimal and is concerned that this demonstrates a continuation of approach whereby the IHT programme presses ahead on the basis of its own timetable with little or no thought for the impact on wider stakeholders.

4.5. At the JHSC meeting on 4 June the committee heard that the programme was undertaking work to inform itself of potential issues arising from the recent and ongoing Covid-19 pandemic. This is to be welcomed. However members were very concerned to hear that the information, which would be being shared with the CCGs, would not be available to the JHSC to help inform their considerations to this written response. This would appear to be a major hindrance to the JHSC's ability to carry out its statutory function. In particular it is stated in the IIA final report (published after the 4 June meeting) that if any changes to the programme are proposed in the light of COVID, the impact assessment "should be reviewed and reassessed". Until JHSC has seen the work on COVID-19, it will be unable to take a view on whether the IIA is sufficient in its present form.

4.6. Whilst some further information was shared with the committee after the meeting and there was also more information contained in the IIA final report which was also published after the 4 June meeting which is to be welcomed members were concerned to see that more work particularly in the areas of the impact of Covid-19 on deprived communities and BAME groups should be included and be available for the JHSC to consider. Members would expect the findings and mitigations of this work to be fully reflected in the final business case and would therefore be available for the JHSC to review.

APPENDIX ONE

Council	Preferred option	Link
Croydon	Not available	Not available
Kingston	Sutton (with essential actions and mitigations to ensure those “patients” and “non-patients” in the more deprived areas can access the new SECH site via bus or tram link).	Not available
Merton	St Helier	See item 6 here
Surrey	Supports the new model of care but has not received the assurances needed to give its support to a specific location.	See item 5 here
Sutton	St Helier	See item 45 here
Wandsworth	Sutton	See item 16 here

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COUNCILLOR PETER McCABE
(Labour, Ravensbury Ward)

Matt Hancock MP
Secretary of State for Health and Social Care
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Date: *27 July 2020*

Dear Mr Hancock,

I am writing on behalf of the London Borough of Merton ("**the Council**") to make a formal referral to you of the decision proposed to be made by the Surrey Heartlands and South West London CCG ("**the CCGs**") as a result of the meeting of the Committee in Common of the CCGs at their meeting on 3 July 2020 to approve the Decision Making Business Case ("**DMBC**") for the reconfiguration of hospital services in CCGs' areas in accordance with the Improving Healthcare Together 2020 to 2030 ("**IHT**") programme.

This reference is made under Regulations 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("**the Regulations**"). The Council makes this report to the Secretary of State because it is considered that the CCG's consultation on the IHT has been inadequate in relation to content or time allowed, in the context of the increased demands on NHS resources as a result of the COV19 pandemic (and potential future pandemics), and because the Council considers that the proposed decision would not be in the interests of the health service in its area.

In accordance with Regulation 23(7)(a), the Council has notified the CCGs of its decision to make this referral which was taken by a majority decision at the Council's Heathier Communities and Older People Overview and Scrutiny Panel at its meeting on 21 July 2020. That Panel carries out the Council's health scrutiny functions. The matter was also considered by the Joint Health Scrutiny Committee (JHSC) established for that purpose by the London Boroughs of Croydon, Kingston upon Thames, Merton, Sutton and Wandsworth and Surrey County Council on 3 July 2020. The JHSC submitted comments to the CCGs but did not make any recommendations.

The full suite of documentation relating to the IHT can be found on the dedicated website, a link to which is set out below:
IHT website

The Council would draw the Secretary of State's particular attention to the following:

1. Submission from Merton Council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.1-Merton-Council-Submissions.pdf

2. Siobhain McDonagh MP's July 2020 response to the consultation and submission to the CIC meeting on 3 July 2020
Siobhain McDonagh's response to consultation
Siobhain McDonagh MP's Submission to the CIC

3. Statement from Chris Grayling MP

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/07/2.-Chris-Grayling-MP_Written-statement.pdf

4. Submission from Dr Rosina Allin-Khan MP whose constituency includes St Georges Hospital and who also works there.
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.3.1-DrRosena-Allin-Khan.pdf

5. Submission from Sutton council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.6-Sutton-Council.pdf

6. From Community Action Sutton
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Community-Action-Sutton_CVS-Scheme_Report_FINAL_Apr-2020-2.pdf

7. From Merton Voluntary services
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Merton-Voluntary-Services-Council_CVS-Scheme_Report_FINAL_Apr-2020.pdf

8. Submission from GMB union
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.1-GMB.pdf

9. Submission from Trades Council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E42MER1.pdf

10. .Submission from Epsom and St Helier Unison branch
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.3-UNISON-Epsom-and-St-Helier-University-NHS-Trust.pdf

11. Submission on behalf of local campaigners (KOSH and KOEH)
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E51KEE1.pdf

10. Report from the Clinical Senate June 2019
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-

These documents detail the shortcomings of the proposals in full and explain the errors made in the documents and processes undertaken by the CCGs. This letter seeks to summarise key points but the Secretary of State is asked to consider these reports in full.

The Council invites the Secretary of State to refer the proposed decision to the Independent Reconfiguration Panel ("**IRP**"). The Council is confident that the IRP would conduct a proper analysis of the merits of the proposal and will see the obvious flaws in the approach taken by the CCGs. For the reasons set out below, the Council does not accept that there has been an adequate and thorough evaluation of the many criticisms made of the PCBC nor any opportunity for stakeholders to respond and engage with the DMBC. Further, there has been no proper evaluation of future health and social care needs notwithstanding the COV19 pandemic and the potential for future pandemics. The Council considers that anyone outside the CCGs and the Epsom and St Helier Hospitals NHS Trust ("**the Trust**") would inevitably reach the conclusion that this proposal is premature, does not represent the best option commanding the agreement of stakeholders and is not convincing as a robust and resilient solution to current and future requirements. It is detrimental to the interests of Merton residents and would result in (or introduce a substantial and unacceptable risk of) a substantially inferior health service for NHS patients generally.

The background.

There is a long history of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier Trusts were merged. Each of these plans has presented differing rationales for changes to NHS acute services and each has offered different potential solutions to perceived problems.

At the end of 2000 the "Investing in Excellence" plan proposed downgrading services in Epsom to centralise acute services at St Helier Hospital, which is located within the area of Sutton Council. In the autumn of 2003 a Clinical services Review Team proposed closing Epsom's A&E and temporary centralisation at St Helier pending the building of a new critical care centre: the plan was abruptly dropped, but not before the Epsom MP had proposed the expansion of Epsom and the downgrade of St Helier as a counter proposal. This was followed by the 2003 consultation on "Better Healthcare Closer to Home" ("**BHCH**"), which involved the proposed closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed 'Critical Care Hospital' at St Helier, Sutton or Priest Hill, and a group of ten local care centres which were said to facilitate a reduction in activity of up to 50%.

These proposals were rejected at the end of 2005 following strong local opposition. In January 2006 plans for a single site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned. The Sutton Hospital site is actually in Belmont, which is within the administrative boundaries of the London Borough of Sutton but is south of Sutton town centre and close to the boundary with Surrey and therefore further away from the residents of Merton. For the purposes of this reference, the Sutton Hospital site will be referred to as "Belmont".

In 2009 with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative. However it came to nothing.

After the election of the coalition government in 2010, another reconfiguration proposal, "Better Services, Better Value" ("**BSBV**"), was introduced in May 2011 and in effect killed off the refurbishment plans. BSBV was put forward as a clinical initiative led by local GPs and hospital clinicians, and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

The next proposals were to break up the Epsom St Helier Trust, with St Helier to be merged with St George's and Epsom to be merged with Ashford and St Peter's in Surrey. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems. Eventually in 2014 after much controversy BSBV plans were dropped after failure to present a compelling business case and to secure agreement across stakeholders in SW London and in Surrey. Just 3 months later a new 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning," effectively cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Belmont site, but also called for "service changes ... across the provider landscape which would deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients." It proposed to expand Kingston Hospital and increase bed numbers at St George's.

By 2016, much of the "strategy" appeared to be forgotten or discarded because the new Epsom St Helier Chief Executive began promoting plans for a new 800-bed single site hospital. This hospital was proposed to replace the 1,162 beds provided in the existing Epsom and St Helier hospitals.

The most recent IHT proposals, formulated in 2017/18, have sought to overcome past problems by:

- narrowing the scope of proposals to three CCG areas rather than as a pan South West London solution
- cost shifting the impact of reducing local capacity to other providers, social care providers and community services;
- using the main argument that this is because staff cannot be recruited to support two A&E departments at St Helier and Epsom ,and,
- securing pre-approval from the Secretary of State for up to £500m of resources ear marked now in future capital spending rounds as an incentive to proceed quickly.

These announcements were made in the run up to the last election and thus there is legitimate public expectation that spending pledges will be fulfilled; albeit that the caveat was made that plans would be subject to business case approval. Many may be forgiven for thinking this is a minor technicality but in

reality it remains a significant hurdle, not least in that the financial case seems weak and stakeholders are fiercely divided on the legitimacy of the processes for selecting options to be shortlisted, on the adequacy of the analysis presented so far, the viability of the severely reduced scale of acute bed provision outlined in the preferred option, and for the selection of the preferred option for centralising major services at Belmont. These doubts have now been compounded by fears of inadequate capacity revealed by the COV19 pandemic and the need for the NHS to be ready to meet the demands of future pandemics.

IHT seeks to promote a preferred option of removing all major services (A&E services, maternity and paediatrics, emergency surgery and acute medicine) from both Epsom hospital and St Helier hospital to a site in Belmont where, in effect, a new hospital will be built. The pre-consultation business case ("**PCBC**") suggests there should be what are termed "district hospital services" based on the existing sites at Epsom and St Helier. This is a mis-use of language. The proposal does not intend to create the same range of services at Epsom and St Helier as would usually be provided at a "District General Hospital". The range of services at a "district hospital" will be substantially reduced because there will for example, be no A & E service , no consultant-led maternity service or access to emergency surgery, intensive care and other back up as would be expected at a District General Hospital. Specifically in relation to maternity services, there appears to be an assumption that more women will choose to have home births although there is little or no evidence to support this assumption.

The Council and other stakeholders have been led to believe this will be cheaper, safer and provide higher quality accommodation on a more sustainable basis, principally by being easier to recruit and retain staff. However, the Council remains unconvinced because the new model will treat fewer patients with a significantly reduced number of consultants. There are significant concerns about the complex, risky and expensive three site configuration proposed and the credibility of the claims for increased efficiency, cost savings and improved quality of services. In particular we note that significant savings are claimed for consolidation of A&E services which are not backed up by reference to the latest guidance from the Royal College of Emergency Medicine and was highlighted in the Clinical Senate report (R30 p25) in 2019.

There are equally some difficult issues around the proportion of qualified nurses required to cover the reduced number of acute beds and downgraded beds at Epsom and St Helier.

The CCGs have proceeded with public consultation quickly before establishing a broader understanding and agreement across stakeholders of the risks the NHS would be taking in making these changes without having secured the necessary support.

The nature of the Council's objections to the proposed CCGs decisions.

The Council has reached the view that the CCGs consultation on the IHT has not been adequate in relation to content or time allowed and that the proposed reconfiguration decision would not be in the interests of the health service in its area, for the reasons set out below.

1. **The decision fails to give effect to the NHS's commitment to tackle health inequalities.**

The Council is hugely sceptical about whether it is in the interests of the users of the health service in its area for acute services at Epsom and St Helier hospitals, in effect, to be amalgamated on a single site. The reasons for that scepticism are set out below. However, if the acute services at Epsom and St Helier hospitals are to be amalgamated on a single site, the Council considers that there is an overwhelming financial, clinical and legal case for that site to be St Helier Hospital as opposed to either Epsom Hospital or a new build on the Belmont site.

A proposal to locate acute facilities in Belmont would be yet another example of the NHS taking decisions to move acute care facilities away from lower socio-economic areas and to build them up in more affluent areas, despite the benefits of improved access for poorer people of developing service where those services are most needed.

The proposal to invest the bulk of £500M of public money to create a single major acute site at Belmont, the location of a new Specialist Emergency Care Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals involves moving substantial services away from St Helier Hospital and thus reducing the ability of poorer communities with higher levels of deprivation and greater health inequalities to access NHS services. The plans are redolent of thinking which has failed to learn lessons from the original Marmot Report into health inequalities in 2011 (which build on a series of earlier reports) and the recent Marmot review report in February 2020. The 2020 Report said:

> *"Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18 ….*
>
> *The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010"*

An approach which fails to give proper regard to health inequalities breaches the CCGS' duties under section 14T of the National Health Service Act 2006 ("**the NHS Act**"). Endorsing such an approach would breach the Secretary of State's duties under section 1C of the NHS Act.

The DMBC found:

> *"This analysis shows a clear and consistent association of higher rates of A&E attendance for those living in the more deprived communities" [p100]*

It then said:

"The IIA found that the planned changes to district services may lead to the enhancement of local service offerings which may in turn lead to improved health outcomes for those from deprived areas and bring about changes which may help to reduce health inequalities [p101]"

The Council considers that the IRP will see the obvious flaws in that approach, namely that this wording appears to suggest that reductions in the range of Accident and Emergency Services at St Helier, which is the hospital serving the populations with the highest level of health inequalities, will "*help to reduce health inequalities*". That is an example of a conclusion being drawn before the evidence is considered. It is totally nonsensical because there is no evidence that a reduction in services to the poorest communities will or even has the capacity to reduce health inequalities.

The methodology used in the DMBC to analyse inequalities is also at fault. No proper age weighting appears to have been used for the analysis. One key aspect of health inequalities is that people in poorer populations suffer illnesses earlier in life than those in more affluent areas. That flaw is shown clearly in the DMBC at p113 where is says:

"Of note within the analysis overall is the increased rate of non-elective medical admissions for the Surrey Downs area per 1,000 residents in comparison with either the Merton area and Sutton area. This is largely attributable to the higher proportion of elderly residents in the Surrey Downs area. In terms of the association between lengths of stay in hospital and deprivation, there is no pattern of consistency"

Thus, in assessing health inequalities, the DMBC made fundamental errors. The extent to which the DMBC has totally failed to understand or take account of health inequalities is demonstrated by the recommendation that further work should be undertaken on health inequality issues. Recommendations 12 and 13 were:

"12. Review district service provision against local health inequalities

13. Re-assess accessibility issues for deprivation groups for preferred option"

However the Council believes that this work ought to have been undertaken before the decision is made on location, not afterwards. In any case it is impossible to believe that any objective assessment could reach the conclusion that the relocation of services serving the most disadvantaged away from the location at which such persons live could be to their advantage when it is fully justifiable to develop those services on the site closest to those with greatest disadvantage. There are no compelling advantages that could not have been secured more directly otherwise e.g. by .training more staff.

This absence of due regard being had to health inequalities is shown in the list of "legal duties" to which the CCGs had regard as set out at page 31 of the presentation to the final decision making meeting. The key duty to tackle health inequalities was absent from this list.

The final integrated impact assessment recognised that socio-economic status and deprivation is directly linked to health inequalities [see p97]. That report noted:

"Of the 11 LSOAs in the top quintile, none are in Surrey Downs, four are in Merton, and seven are in Sutton. Sutton also has the LSOA with the most deprived population (in Beddington South)"

These LSOAs are substantially in the area around St Helier Hospital.

The report recognised that there was disadvantage to people in deprived areas of the chosen location for acute services, albeit that it suggested that other factors had a greater impact. However, as the IHT decision was only about acute services, the impact of other measures to tackle health inequalities was irrelevant unless it also contained detailed other proposals to tackle health inequalities, which it did not.

Thus the Report recognised that there were disadvantages for deprived communities in moving services away from locations where they could access them easily but the CCGs failed to take that into account when making this decision.

2. The failure to model the effect of displacing patients away from the Trust and towards other hospitals and social care.

The Council is concerned that, despite the considerable proposed investment, the plans will result in fewer doctors, fewer beds and an overall reduction in services for local people. That reduction is planned against the background of a historically low level of hospital beds to meet the needs of local people. The DMBC assumes a 2% per annum reduction in emergency admissions up to 2025/26 and a 3% per annum reduction in activity overall, with a 3% per annum bed savings by reducing length of stay. These are not only untested assumptions but the evidence from elsewhere in the NHS shows they have not been achieved. Overall the new configuration proposes a reduction of 80 acute hospital beds but this number is arrived at taking into account by "district" hospital beds which lack the necessary comprehensive support found in acute settings. The real cut in major acute beds is 452. The problem, from the Council's perspective, is that fewer hospital beds being provided in a less convenient location will lead to the following outcomes.

a) Merton residents will not seek emergency NHS treatment in Belmont, they will go to their nearest hospital which is likely to be another London hospital, notably St George's, Tooting. Thus downgrading St Helier will not result in patients relocating from St Helier to Belmont but from St Helier to St George's. That transfer will put additional pressure on St George's. There is no assessment as to whether St George's can absorb that additional work. However the movement away from "payment by results" means that (unless financial arrangements change) the St George's Trust will not be provided with further financial resources to fund this additional work, nor is the physical capacity available at St George's (and no expansion is planned or budgeted for);

b) There will be fewer patients attending the Belmont site and thus, in effect, the block payment to the Trust by the CCGs will fund services for significantly fewer more affluent patients. Whilst that may well be good news for the more affluent patients, it is really bad news for those with the highest level of health needs. They will find fewer services for them and less funding for those services; and

c) Fewer patients will be seen within acute hospitals, causing increasing strain on already overloaded community and social care services.

Thus Merton residents will not only find acute services harder to access as those services move away from them if this misguided decision is implemented but they will also have fewer services to access if they do seek to access services.

3. The Council refutes the suggestion that achievement of defined clinical standards make the best use of limited NHS and social care resources.

The Council challenges whether there is a proper evidence basis to support larger hospitals based on the achievement of clinical standards. The problem, in summary, is that clinicians have looked at the type of environment that works best from a clinician perspective within a hospital. That approach inevitably leads to larger and larger hospital units, which can only operate successfully if these larger units serve the needs of more and more patients. However there are serious questions about whether improved clinical standards do, in fact, come from larger hospitals. Fewer, larger, hospitals mean increased lengths of journey for patients and visitors, with the risk of creating a reluctance for patients or visitors to attend because of the distance and there is real doubt as to the evidence that, despite predictions "bigger is best" for health outcomes. This consultation was supposedly based on a desire to achieve these standards but the real question for debate should have been whether those standards were realistic, achievable and make the best use of limited NHS and social care resources. If the questions were posed in that way, the obvious answer is that a sole focus on achieving these standards does not make the best use of limited NHS and social care resources.

Indeed the CCGs appear to be saying that the most telling argument for reducing services is that it is not possible to train and recruit sufficient staff locally, not that there isn't a need for local services. The Council would like to see this problem addressed strategically rather than be asked to accept that services must be built around the contrived constraint of a shortage of clinical staff.

4. Learning the lessons of the Covid-19 pandemic.

Fourthly, the CCGs have moved too quickly and, as a result, will almost certainly have failed to learn the lessons of the Covid-19 pandemic. It is far too early properly to learn the entirety of the lessons from the pandemic, but the emerging evidence is that more hospital beds will be needed in the future, not less. The days of NHS hospitals being able to run at capacity rates of more than 95% ought to be over. If the CCGs had a combination of wisdom and humility, they would accept that this is <u>not</u> the time for the NHS to be making long-term decisions to reduce capacity further. The work that the CCGs have done to assess the impact of Covid-19 has been superficial and inadequate. In particular, no proper account has been taken of the emerging evidence that people from BAME communities have been disproportionately affected by Covid-19, both in terms of susceptibility to the virus and the seriousness of its impact. In fact, the 5 page document produced by the CCGs in seeking to assess the impact of the Covid-19 failed even to mention BAME

communities. This work came to the conclusion that the strains that the pandemic had put on the NHS in fact supported their plans. However that conclusion does not bear proper examination as it is frankly far too early to know how the pandemic will affect future NHS planning.

Thus the Council believes that the CCGs ought to have halted this consultation process, waiting until it was clear what lessons were being learned from the pandemic and then recommenced the consultation process. We consider that the need to learn lessons from the pandemic means that this was the wrong time to complete the consultation and thus the Secretary of State should set aside this decision under Regulation 23(9)(a).

5. The misrepresentation of the public voice in the DMBC

The DMBC substantially misrepresents the outcome of the consultation exercise. It misrepresents the views expressed by the public and misunderstands the way in which the public responded to the consultation process. The details of the errors are set out in the excellent and detailed report prepared by the local Member of Parliament, Ms Siobhan McDonagh which is annexed to this letter. We can do no better than to refer you to the details set out in that report which it makes it clear that in almost every aspect of the consultation responses there was overwhelming opposition to the Belmont option.

The way in which the CCGs explained how the public responded to the consultation has been indicative of the fact that this appears to the Council to be a reconfiguration project which has been "ego driven" by senior Trust managers who have used force of personality to drive forward the reconfiguration agenda rather than being an "evidence driven" process. Senior managers at the Trust have created a wholly artificial focus on the hospitals within the Trust instead of focusing the planning around the needs of health and social care more generally across South West London. As a result the NHS has developed plans which do not make any sense for the wider health and social care economy.

As a result, the plans are a colossal waste of tax-payers' money. There are far better ways to apply the substantial investment monies than those proposed in the DMBC, as the material provided by the Council to the CCGs has clearly demonstrated. However, once the NHS train was put on the track with the aim of creating, in effect, a new white elephant hospital in Belmont and down-grading the services at St Helier, no amount of evidence appears to have been able to persuade the CCGs that this was a crazy plan.

6. The money does not add up

The Trust is in significant financial deficit and requires support from NHS England to continue in operation. However, the plans are built on expectations of financial savings by the creation of new clinical models which have not worked elsewhere. An Independent expert review has cast doubt on the reliability and accuracy of the savings claimed and it is significant that the plans have not been assured by NHS London or NHE England finance professionals as is stipulated in guidance.

The Treasury, who approve all capital projects of more than £50m at the moment, issue the Green Book and the Guide to developing the Project Business Case. These lay down clear guidance for on the process involved in investment appraisal, particularly the options appraisal process and the

requirement to consider properly lower cost do-minimum options. Further guidance on multi –criteria analysis of the type deployed in the PCBC can be found in a manual issued by central government and the guidance on economic modelling issued in December 2019. This guidance does not appear to have been followed, with inadequate consideration of lower cost options and options involving behavioural changes which, taken together with some much needed capital investment in the existing buildings would reduce the need for such radical and expensive changes to buildings as a so-called solution to recruitment difficulties. Further detail of the flaws in the financial analysis and particularly the assessment of net present value can be provided in due course. It should be noted that in making the announcement of the funding for Epsom and St Helier capital development, you also said that future details of a new capital funding regime would be published before the end of 2019. It is still not clear either what that the future system will be; or the system for future funding of social care, again long promised.

Page 31 of the DMBC contains a long list of services that the Trust would like to see delivered in the community. But there is no agreed funding to expand community services to pay for those services. Hence the clinical model proposes moving services out of an existing hospital environment (where they are funded) to community locations (with no identified funding).

If funding is diverted to support all of the community services that are described in the DMBC, the proposal becomes unaffordable. However without that funding being part of the overall plan, it is unrealistic.

Overall, the Council does not consider that this proposed decision is well thought through or has been subject to the type of thorough analysis needed before major changes are made to NHS services. That so many other key stakeholders, including the staff, and many thousands of the public think similarly reinforces our position.

The consultation should not have continued through the Covid-19 pandemic and everyone should have stopped and asked themselves difficult questions about whether this was the right way forward. That was not done. The Council thus invites the Secretary of State to refer this matter to the IRP for a thorough analysis.

The matters set out in this letter and the attached documents are, by definition, at a high level. The Council will co-operate the IRP to develop the arguments and analysis.

I should be grateful if you would kindly acknowledge receipt of this letter.

Yours sincerely

Peter McCabe

Councillor Peter McCabe,
Chair, Healthier Communities and Older People Panel
London Borough of Merton

Cc Andrew Murray, SW London NHS Clinical Commissioning Group
Charlotte Caniff, Surrey Heartlands NHS Clinical commissioning Group
Sarah Blow, SW London Alliance
Matthew Tait, Surrey Heartlands

REPORT TO:	**HEALTH & SOCIAL CARE SUB-COMMITTEE 22 September 2020**
SUBJECT:	**Croydon : COVID 19 and winter preparedness**
LEAD OFFICER:	**Guy Van Dichele** **Executive Director Health Wellbeing and Adults** **Matthew Kershaw** **Chief Executive and Place Based Leader for Health**
CABINET MEMBER:	**Councillor Janet Campbell** **Cabinet Member for Families, Health & Social Care**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Guy Van Dichele** **Executive Director Health Wellbeing and Adults** **Matthew Kershaw** **Chief Executive and Place Based Leader for Health**
PUBLIC/EXEMPT:	**Public**

POLICY CONTEXT/AMBITIOUS FOR CROYDON:

Covid-19 has had an unprecedented impact on a global scale, including the UK and Croydon. Our response has been wide ranging, as will the recovery, covering all aspects of the Corporate Plan, including:

- People live long, healthy, happy and independent lives: through our public health messaging, adult social care and support for vulnerable residents.

ORIGIN OF ITEM:	Scrutinising the response to the challenges presented by the Covid-19 pandemic has been identified as a key role for the Sub-Committee throughout 2020-21.
BRIEF FOR THE COMMITTEE:	The Sub-Committee is asked to review the information provided in this report and at the meeting, with a view to forming conclusions and recommendations.

1. EXECUTIVE SUMMARY

1.1. This report provides the Health and Social Care Scrutiny Sub-Committee, with highlights into the COVID 19 planning, and services delivered across the borough by health and care services.

1.2. It also provides insights from the lessons learned, and how these are being used to inform planning for winter and / or a second wave of COVID 19.

1.3. Above all else, this report can go no further, without first paying tribute to the memory of those Croydon residents, health and care staff who have died due to COVID, those who are recovering, and those who continue on the front line and in any role that supports the borough in this time.

2. VULNERABLE AND SHIELDED RESIDENTS

2.1. A key area of work during the pandemic has been supporting our most vulnerable residents, including those that have been encouraged to shield and stay home at all times. The number of shielded residents in Croydon is set out in the table below.

	14-Aug
Total Shielded	15021
Total registered Shielded	8044
Registered Shielded Contacted & triaged	8044
Registered Shielded Contacted & triaged no support required	7185
Registered Shielded Contacted & triaged support being provided	859
Registered Shielded who cannot access supplies	2316
Total council deliveries	2171
# delveries to shielded	1378
# deliveries to non-shielded	793
Total VCS deliveries	2210

2.2. The Council used a variety of communication tools to contact shielding residents, including letters and written advice sent directly, telephone and text to contact everyone that was identified as needing to shield to confirm what support they require.

2.3. GP practices have proactively reached out to both shielded and highly vulnerable patients to ensure appropriate care and support is in place, in partnership with the local authority and Croydon Health Services. This also included targeted support for shielded patients and people with serious mental illness and learning disabilities. From early in the pandemic, telephone, online and Video GP consultations were offered to patients, supporting triaging for those who need a face to face consultation. This continues and GPs also continue to make home visits as needed where clinically appropriate, working closely with community services to ensure patient and staff safety.

2.4. Prior to the COVID-19 many community pharmacists were providing a delivery service for patients who were unable to collect their medicines from their pharmacy. Following announcement of the national lockdown, the government launched the NHS volunteer responders scheme in conjunction with the GoodSams App. As part of this scheme, patients or community pharmacists could access the service to be linked with a community response plus volunteer, who could support the shielded patients with the delivery of

their medicines and medical devices. Whilst the NHS responders scheme was being set up, in Croydon the CCG, community pharmacists and the Local Authority worked together to utilise existing volunteers to support identified shielded patients who needed support with delivery of their medicines or medical devices in the interim.

2.5. From 9 April 2020 NHS England & NHS Improvement (NHSE&I) commissioned the Community Pharmacy Home Delivery Service. This service was designed to support shielded patients in England to access their prescribed medicines and appliances while they are self-isolating at home during the pandemic period. This service ran until 31st July 2020 when shielding was officially paused.

2.6. Support for vulnerable residents has been a partnership activity, with a network of voluntary and community groups across Croydon providing food, other essential supplies, shopping and befriending. The latter has been particularly important for residents whose independence has been impacted by the pandemic.

2.7. The Government provided food parcels to shielded residents direct from wholesalers. As of 26 June, there were 2,518 residents in Croydon that were registered as shielding and were unable to access supplies. In addition to this the council provided 1371 deliveries to residents in the shielded group by the pause date and the voluntary sector well over 2000.

2.8. The Government announced that shielding would pause on 31 July and with it the food parcel service. At this point residents became free to leave their homes and therefore secure their own supplies. Many residents, however, were concerned having shielded for such a long time. We therefore worked closely with voluntary and community sector to prepare for this change, and prioritise support to the most vulnerable.

2.9. The council put in place a pausing shielding team and contacted directly all those in receipt of government food (approximately 2,500 people) supporting them with alternative arrangements. About 100 people were supported or signposted to other services, supermarket support, or adult social care and gateway services for financial support. Each resident received a letter with how to access support and our website was updated. The council received significant positive feedback from local residents about the support offer.

2.10. The Council has also worked with Healthwatch Croydon, to develop a ‘shielding experiences’ survey. This has been sent to 240 residents, randomly selected by Healthwatch Croydon, but who had been specifically contacted by the Council due to shielding. The survey will close at the end of September, and the results will be used to help ensure the shielding / vulnerable people support offer is communicated and delivered effectively to residents.

2.11. If the government reinstates shielding or a local lockdown (on this latter point it will require a proportionate response), the Council will be required to comply with the Local Framework for Shielding, ensuring support to Clinically Extremely Vulnerable residents is in place in regard to food support, social inclusion and their wellbeing. Partnership working with the NHS and General Practice and direct contact with those asked to shield is required.

3. PARTNERSHIP WITH THE NHS AND NHS DELIVERY

3.1. Health partners are working towards four phases in response to the pandemic. Phase 1: Response formerly began in March, moving to Phase 2: Restart Safely by the end of April and now Phase 3: Refresh and Reshape which began at the end of July. Phase 4 will be the post COVID response.

3.2. During Phase 2 health partners have been working to increase the COVID aftercare and support in community health services, primary care, and mental health, as well as restarting urgent and other elective services. Some examples of the services in place include:

- **Community health services** run by Croydon Health Services (CHS) have been supporting the increase in patients who have recovered from COVID and who having been discharged from hospital need ongoing health support. This includes integrating a GP within the Rapid Response Team, the continuation of the strengthened discharge pathway, the piloting of a telehealth solution to support recovery and ensuring sufficient Intermediate Care capacity in the community. The Integrated Community Networks Plus (ICN+) Early Adopter has also gone live in Croydon North East (Thornton Heath), bringing together a multidisciplinary team with an integrated manager, proactive support around long term conditions and links into the local voluntary and community sector and mental health services.

- **Mental Health services** have established all-age open access crisis services and helplines and promoted them locally. For existing patients known to mental health services community teams and voluntary sector have provided support on a regular basis with face to face appointments made available based on patient's needs. Children and Young people services offer online, skype and phone sessions, with access to information on the CCG and LA websites and shared with social care colleagues. Psychological support is available for all Croydon NHS and social care staff via IAPT, Improving Access to Psychological Therapies, with a dedicated number for quick access by NHS staff with targeted supported, advice and therapy.

- **General practice** continues to restore activity with an aim to return to usual levels where clinically appropriate. Practices are proactively contacting their vulnerable and high-risk patients with ongoing care needs and those whose care may have been delayed ensuring they are accessing needed care and treatment. They have adapted their premises to ensure social distancing and isolation areas are achieved. They are providing care via online and virtual

consultation as well as but also Face to Face where clinically necessary with patients' views taken on board. Practices are ensuring all people with learning disabilities have their annual heath check and are addressing the backlog of childhood immunisations and cervical screening by using their capacity differently including the use of extended access appointments. Further support to care homes with complex care pharmacist within the Care Home multidisciplinary meeting (MDT) and Learning Disability pharmacist to support medication reviews of learning disability residents. Care home links with Primary Care have been strengthened to ensure care homes have use of digital tools to make referrals and manage digital consultations (e.g. Video, Phone, Email, Message, Face to Face) and care home access to records e.g. the Airedale service is in place.

- **Acute Health Services.** Latest performance analysis (August 2020) ranks Croydon Health Services NHS Trust as one of London's leading Trusts for the recovery of elective surgery. The Trust is also currently shown as the furthest ahead in South West London for restoring routine outpatient appointments for people who have had non-urgent care postponed due to the first wave of the pandemic.

  Last month the Trust achieved 83.9% of elective activity, above a national target of 80%. All trusts were also required to deliver 100 per cent of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September 2020, with a target of 90% in August. Croydon has exceeded this target to achieve 122.8% of outpatient activity in August 2020. The new targets were set out in July 2020 by NHS England & Improvement, which explained the system priorities for Phase Three of the NHS response to COVID-19. This included:

  - Preparations for winter
  - The recovery of primary care and community services
  - Expanding the provision of mental health services, and care for people with learning disabilities and autism
  - The importance of system working, including the local authority, with statuary NHS Continuing Healthcare assessments to resume from 1 September.

  Specifically, Phase three requires the NHS to "return to near-normal levels" of non-covid services. The Trust has made significant progress to sustain its strong performance in both elective procedures and outpatient care, however further work is needed to meet the levels of MRI/CT and endoscopy procedures required, with an ambition to reach 100 per cent by October.

3.3. Entering Phase 3 health colleagues are now redoubling focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This includes delivering the same or more elective activity than pre COVID in order to reduce the backlog. CHS is working collaboratively with other acute South West London Trusts to

develop specific pathways; with CHS leading on the development of the gynecology clinical network. The phase 3 shared focus for the NHS is

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter.

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

3.4. A South West London Health and Care Partnership plan setting out priorities for the rest of 2020/21 is currently in development. The Health and Care Partnership want to respond well to Covid and to recovery from Covid in the context of the following recovery objectives:

a. Maintaining our shared vision for local people and work together to adapt this.

b. Continuing to innovate and ensure services are safe and reflect best practice.

c. Renewing our commitment to working with partners, particularly at borough level with our Local Authorities.

d. To set our delivery plan for the next two years which recognises the strategic ambitions set in the South West London Five Year Plan as well as phase two of Covid-19.

e. Support our staff through and beyond recovery – making SW London a great place to work.

f. Building on over two years of public and clinical engagement, as well as strong partnership work in developing the six Local Health and Care Plans and the SW London Five Year Plan.

g. Making sure that Health inequalities and prevention actions are in place and that they are effectively supported with a population health management approach.

h. Equality, inclusion and diversity is a critical system priority for our partnership over the coming years.

3.5. **Primary Care:** For many people, GPs and primary care are the front door into the NHS. To help reduce the spread of COVID-19 all GP practices in Croydon are operating a telephone triage and remote consultation service model to reduce risk of transmission in GP surgeries and make the environment safer for patients. People who need to be seen by their GP following these initial

assessments can attend in person if this is clinically assessed as necessary and if patients are happy to do so. Infection control guidelines are followed closely to protect staff and any patients attending their GP practice. Many new ways of working have been implemented recently that practices tell us they want to continue – for example, video consulting – and we are supporting this to happen in ways that encourage and enable people to use the new systems to their benefit but acknowledging that one size does not fit all. We are working with practices, clinicians and local people to understand the barriers to consulting virtually, to improve access for those who need it most and make sure we are always working to help reduce health inequalities.

3.6. We are working with all GP practices to ensure they can continue providing effective care to COVID patients in a safe environment, whilst minimising the risk of infection to all staff and patients. Supporting patients in this way also helps protect the capacity of our acute hospitals. General practice will remain at the heart of the NHS, and we will be taking pro-active steps to support resilience whilst at the same time making the most of opportunities to provide the best care to patients in new ways.

3.7. **Restarting elective surgery** – On 6 July 2020, Croydon Health Services opened Croydon Elective Centre, a dedicated area of Croydon University Hospital for patients to come in for treatment that adheres to strict infection control policies and controlled access, ensuring we protect both our patients and our staff. These include rigorous cleaning procedures, asking patients to self-isolate before treatment and separating the working environments for staff to provide a protected zone for delivering elective care.

Over the past eight weeks, a total of 1,493 people have been treated in the Croydon Elective Centre (CEC) for routine day case and inpatient procedures. Activity in the CEC has been gradually increased to ensure all of the measures taken to protect patients and staff from COVID-19 are safe and effective. Elective activity at the Trust is also continuing to be increased at pace but in a carefully managed way to ensure there are robust systems and resilience to cope with any outbreaks or surges in cases, whilst doing everything possible to ensure patients are waiting no longer than is absolutely necessary.

Croydon Health Services are now back up to around 83% of business as usual elective activity and for outpatient activity we are now seeing around 122% of business as usual activity before the pandemic. This is local activity is above the goal set for the NHS to achieve 80% by September. We are pleased to be exceeding this target and we are on track to achieve 90% by October 2020.

Work is now underway to encourage people to use the NHS when they are unwell, and reassure them of the extensive steps in place to protect them from coronavirus. Collectively, the Trust and primary care services are engaging with local community groups to help reach diverse communities in

the borough. Croydon's NHS has also produced a range of new material to help inform and engage people, including films with clinical chair and Croydon GP, Dr Angelo Fernandes and surgeon and clinical director at the Trust, Ms Stella Vig on the measures taken to keep patients and staff safe from COVID-19 at CUH in the Croydon Elective Centre https://youtu.be/u0m5ZUoOb3M

3.8. **Cancer care** Urgent suspected cancer referrals reduced by 50% during the COVID-19 response with the PTL (patient tracking list which we use to manage the waiting list of patients) reducing size to 600 patients. All patients were risk assessed and prioritised based on clinical need, with first outpatient cancer appointments held virtually instead of face to face to avoid increasing delays for patients. Where clinically appropriate, diagnostics were ordered prior to the first appointment and then clinically reviewed. If a face to face appointment was required, patients were risk assessed by a clinician prior to attending their appointment.

3.9. All invasive cancer diagnostic and treatment procedures were clinically reviewed by the Cancer Prioritisation Group (CPG), on a weekly basis. The CPG was created to ensure senior clinical oversight of all cancer activities during COVID-19. During the first wave of the pandemic, no inpatient cancer procedures were performed at CHS due to risk of COVID-19. All breast, urology and gynaecology cancer procedures were conducted without an overnight stay in the hospital's Day Surgery unit. Colorectal elective cancer cases were undertaken at the Cromwell Hospital that was one of the Royal Marsden Partner Cancer Hubs. This has ceased now that the Croydon Elective Centre has opened.

3.10. The Cancer Services Office continued to monitor all patients and work with services to identify key issues through the weekly PTL. It also held monthly breach panel reviews, led clinically to review all patients treated 63 days plus to identify the impact on patients and to share any lessons learned to inform the next stage of the Trust's response.

3.11. Referrals steadily began to increase from the first week in June and are currently 80% compared to pre-covid levels. The PTL is currently 1,485 which is similar levels to pre-covid.

3.12. From the 6 July 2020, when services re-opened all diagnostic and treatment cancer procedures have now re-started. Identified capacity pressures are sector wide issues and RM Partners network are supporting providers across South West London. They include:

- **Endoscopy services** have increased activity levels in line with guidance since the 4 July, although still below pre-COVID levels. Apart from patient choice, the department has booked all long waiters by the 30th September.

- **CT colonoscopies** have also increased capacity, and with the additional the CT scanner due to be commissioned in September, this should increase capacity to 20% above pre-COVID levels.

- **Histology reporting times** has been highlighted as an issue with South West London Pathology. This is being managed through monthly contract meetings although is not an immediate issue at present.

There has been particular focus on patients waiting over 63 days plus. All patients are again clinically reviewed with next steps identified to ensure clinical safety is maintained, with appointment bookings prioritised to reduce any further delay.

3.13. **Diagnostic services** to increase capacity, a new CT scanner will be operational at Purley War Memorial Hospital by September in addition to a new ultrasound at the main Croydon University Hospital site.

The Trust is also increasing endoscopy capacity and are in talks with InHealth to double the number of patients that can be seen through the provision of a MRI scanner at CUH.

Across London, daily imaging and endoscopy activity has dipped below 80% of pre-COVID levels but recovery plans are being developed to help the Trust achieved the expected levels by October 2020.

Our current challenge continues to be getting some of our patients in for diagnostic imaging, including CT and MRI scanning, and we are working hard with teams to provide not only operational support but additional admin capacity to be able to make progress on this.

3.14. **Outpatient activity**. Outpatient activity at CUH is rapidly returning to normal. Before COVID, the Trust would normally see around 7,000 routine outpatient appointments on average every week. Latest monitoring shows that almost 6,000 outpatients were seen week commencing 23 August 2020, with the vast majority seen virtually by telephone or screen. However, not every patient can be seen virtually, so clinical teams are working to ensure we can see safely see patients face-to-face where necessary.

In many areas of the hospital, including outpatients, it is not possible to apply the same extensive controls that we do in the Croydon Elective Centre (where planned care patients are being asked to self-isolate to prevent them from bringing the virus into hospital).

Outpatients is a COVID managed area where staff must use strict infection control and, where possible, screen out patients with symptoms of coronavirus to ensure they get the appropriate care and to protect our other patients and staff.

Full risk assessments of clinical spaces have been completed to identify areas where additional measures are needed, such as extra spacing, wayfinding

signage around reception areas and the provision of Personal Protective Equipment (PPE).

All of our visitors must also wear face coverings when on site, maintain safe social distancing and wash their hands regularly, including when they enter and exit clinic areas.

The Trust is also contacting patients a week in advance of their outpatient appointment and will be screened again on their arrival for any symptoms of COVID-19.

3.15. **Improving Emergency Care in Croydon** While emergency care has continued throughout the COVID-19 pandemic, Croydon Health Services did see a reduction in the number of patients coming into the Emergency Department (ED). As those numbers start to increase again in some areas we need to make sure that we are ready to respond to this demand, while planning for a second wave of COVID-19 and a challenging winter.

3.16. From May to July 2020, the Trust delivered its best performance in six years against the national four-hour standard. To sustain this, health and care partners are working together in Croydon and in south west London to transform how urgent and emergency care and make it easier for local people to access the services they need within the borough.

The main strands to this work are:

- **Improving flow through the hospital** - Starting as soon as a patient walks through the front door and depends on the strong partnership working between staff working in the hospital and the community, as well as those in mental health and in social care, to support patients to leave hospital in the right way, at the right time.

- **Increasing the availability of our same day emergency care services** – Including the Trust's Edgecombe Unit which can provide specialist care for patients, including the frail or elderly, without waiting in the Emergency Department. Croydon is also to be a London pilot for working with colleagues in primary care, the London Ambulance Service and NHS 111, to allow them to booked appointment for patients in Croydon's urgent and emergency treatment services. The aim in doing this to help free-up staff to care for the most critically ill and injured, reduce waits in A&E and avoid overcrowding in the Department to protect patients and staff from coronavirus.

- **Providing additional support for patients in mental health crisis** – the Trust is seeing increasing numbers of patients who are coming into the department who need medical attention, but also mental health support in hospital or in the community. Croydon's Emergency Department is one of the few in London that has dedicated mental health facilities for adults, as well as adolescents and children. However, this space is limited and so together as a health and care system in Croydon are actively considering what more can be done to provide emergency care for someone with a physical health need,

while also providing a safe, comfortable environment to support their mental health needs.

3.17. Following the peak of the coronavirus pandemic in March/April/May, the ambulatory same day emergency services had to be stepped down, as staff were redirected to support provide patients being admitted/seen by the hospital. Following a reduction in covid cases from June, some of the same day emergency services namely the Acute Elderly Care unit (ACE) and Medical SDEC were relaunched on the basis of a 12 week pilot to enable new ways of working to be reviewed and further enhanced as the model of care is adapted to meet need more effectively and efficiently.

3.18. This service gives us the opportunity to improve the experience of emergency care for both our patients and staff, while supporting us to better manage the flow of patients with conditions such as chest pains, DVTs and heart failure, through the emergency department and into the hospital.

3.19. **NHS 111 First** Croydon Emergency Department will be an early adopter site for the national NHS 111 First initiative which aims to encourage local people to contact NHS 111 before attending A&E. Think NHS 111 first is the national drive to support people to access care in a timely way, in the right place by the right professional. This national policy drive encourages direct booking of 111 callers into a range of health services to meet their needs ranging from GP practices, same day emergency care, the urgent treatment centres or emergency department.

Direct booking into GP practices is already underway and Croydon is one of the five London early proof of concept sites for scheduled access into Emergency Department. Work is currently underway to mobilise this and it is anticipated this service will be launched on 23 September 2020. In addition, Croydon is seeking to pilot a local integrated virtual clinical assessment service (IVAS) which will further enhance direct booking into the urgent treatment centre and emergency department whilst facilitating direct booking into same day emergency care. It is anticipated that the IVAS pilot will be launched at the end of October 2020.

This means that from late September, if someone believes they need urgent care and are thinking about going to the emergency department, they should contact NHS111 first, either online or by phone. A GP, nurse, paramedic, or trained advisor will then help them get help quickly and safely – whether that is a prescription from a pharmacist, a virtual GP appointment, a slot at a GP hub or urgent treatment centre.

If a patient needs an urgent face-to-face appointment, this will be arranged for the same day, with measures in place to keep both patients and staff safe.

Contacting NHS111 first will help reduce waiting times for all patients and significantly lower the risk of Covid-19 transmission, with less time spent in the hospital and less people waiting to be seen – which is particularly important for people who are more at risk of infection.

The new arrangement builds on the existing role of NHS 111, with Croydon GPs using their local knowledge to advise people on what treatment is available close to where they live and where to go for care and support.

NHS111 is free to call and available 24 hours a day, seven days a week, which means help is available at any time.

Emergency departments need to be there for the most seriously ill and injured and this will not change – no one will be turned away.

NHS111 first will help ensure people get the right care quickly while protecting all patients and staff to help stop the spread of Covid-19.

3.20. **Encouraging patients back to the NHS** As part of our local 'NHS is here for you' campaign to reassure local people that it is safe to return to the NHS and seek advice and treatment when they need it, local clinicians feature in our new reassurance film for Croydon which you can watch here https://vimeo.com/455274202/2cf795d020

The film is in response to what the NHS has learnt from citizen insight to help understand the barriers for people not seeking NHS advice and treatment, in particularly for those not attending for diagnostics like blood tests or scans. The film shows how health services have changed to help keep our patients and staff safe.

3.21. **Mental Health, Learning Disability and Autism –** planning has resumed to focus on the pre-covid transformation work around expanding and improving services for people with a focus on community and locality based services in line with the phase 3 ask:

- IAPT services are being delivered to commissioned capacity with a mainly online offer with the option of face to face where clinically required or patient requested.
- Options are being explored around retaining and linking in with 111 the 24/7 crisis helplines for all ages that were established locally during the pandemic.
- Work is underway to maintain the pre-covid growth in the number of children and young people accessing support by offering both virtual and face to face support and ensuring there is Mental Health Investment Standard funding allocated to increase workforce skill mix and capacity.
- Secondary Care providers are ensuring that there is a proactive review of all patients on the community team caseloads and that the community offer is more robust to avoid relapse.
- Work continues on ensuring that communication with the public and stakeholders on changes is clearly advertised via the South London

and Maudsley (SLaM) website, Twitter, CCG websites and social media.

- Extensive capital plans are in place to support Croydon estate in response to the mental health capital funding pot.
- Care (Education) and Treatment Reviews have continued during COVID virtually to ensure people with LD or autism are being provided with the best alternatives to inpatient care and stepped down where appropriate.
- Learning Disability Mortality Reviews have continued to be undertaken and learning from COVID deaths is being shared with stakeholders to prevent future deaths.
- Health Checks for people with Mental Health and LD are being restarted and work is underway around how to support delivery post COVID in line with Primary Care new ways of working

3.22. **Health Inequalities** - prior to the outbreak the One Croydon planning included discussion about increasing scale and pace of all activities. COVID has however provided greater focus about where to focus and put in place activities that target some of the most vulnerable. Since the outbreak:

- Local Strategic Partnership is leading on an inequality's strategy, due by October 2020, which will reflect the learning from COVID 19. A draft plan is currently in review with short and long-term priorities. Whilst finalising the strategy actions being taken forward by organisations including communication and engagement, particularly with 'hard-to-reach' groups, and an emphasis on immunisation, diabetes control and weight loss.

- The Prevention Framework is also in development and will explicitly define our vulnerable and complex groups. It will also set out the focus of wider determinants of health as key driver of health inequalities.

- The strategy and framework will be underpinned by a review of Croydon's health inequalities which looks at who acquired and succumbed to COVID-19. It exposes the inequalities faced by local people and our staff.

- In addition, a mortality review has been undertaken demonstrating COVID-19 deaths through April and considering those areas to focus on. In addition, CHS has engaged with staff and will be refreshing its Equality, Diversity and Inclusion Delivery Plan by September 2020.

- The Croydon Local Out Break Control Plan has been developed by the Croydon Public Health Team led by Rachel Flowers, Director of Public Health and sets out the learning from the pandemic and targets action for those identified as at increased risk. Croydon's Outbreak Control Plan details how we will work with our partners and the community to prevent and respond to local outbreaks of COVID-19. The plan sets out how we will protect Croydon residents from COVID-19 by providing consistent advice to places and communities about how they can reduce the spread of infection, supporting

those who are most vulnerable and managing outbreaks of infection quickly. This is the vital in helping to prevent the further spread of infection with the aim of reducing the severity of any possible second wave. The Croydon Local Out Break Control Plan and our close partnership working supports our management and preparedness for the weeks and months ahead.

- Work is underway with the voluntary sector (VS) to review the VS offer and how to support resilience, to enable the scaling up of voluntary sector services in the community, support the most vulnerable groups as well as those - December 2020.

Lessons learnt and ongoing challenges

3.23. Croydon was one of the hardest hit hospitals in the country, yet the strength of our response to COVID-19 has been built on the commitment of our workforce and the success of our partnership working in the borough. Maintaining our support for staff and increasing the help we can give them to care for the safety and well-being has been lesson identified in the review of our response so far. We are also strengthening our planning and preparation to ensure our staff have the resilience to manage a sustained response to the virus, should there be a second spike or local outbreaks.

3.24. To identify lessons, the Croydon Health Services has been holding debrief sessions with staff who have given direct care to people during the pandemic as well as those working in supporting roles. The Trust has also surveyed staff and reached out to colleagues who have been shielding or who have been working from home due to their own health conditions or circumstance to learn about their experiences during COVID-19.

3.25. Analysis of the feedback has shown:

- most staff felt the Trust had responded well to the pandemic to date
- almost 80% felt that CHS had communicated well with its staff to involve them in the response
- many also said that leadership visibility was up, with clear direction from ‘GOLD command’ leading the Trust’s response and twice-weekly staff webinars ask questions of the senior team and be kept informed about the COVID response, within the trust and across the borough.

3.26. However, staff also said more could be done to:

- match peoples’ skills to areas of redeployment.
- to communicate and to support staff in community bases;
- and to help staff deal with the stress and mental strain of COVID-19.

3.27. As a result of this, the Trust is enhancing its support for staff, including the range of counselling and wellbeing support available for staff. Including support for staff with post-traumatic stress as well as 'wobble rooms' for staff to decompress and pause for breath.

3.28. **Bereavement support resources** have been created to help staff who have experienced the loss of a colleague, friend or family member. While we are beginning to feel the reality of COVID-19 as part of our new normal lives, the impact of a loss during this time will still be enormous. The online resources include practical advice and support, as well as signposting to other appropriate resources that consider the cultural diversity of our workforce.

3.29. **COVID-19 prevention and infection control:** Our Croydon Health Services infection and prevention control experts are working with their colleagues from across a network from the other three South West London hospital trusts and the Royal Marsden and come together regularly for South West London Infection Control Summit. Together, the group have decades of knowledge and expertise in infection prevention and control in hospital settings and most importantly bring together their learning and experiences during the pandemic so far. Immediate work has focussed on making sure we have shared guidance to support hospital clinicians to support elective and diagnostic services. They are also developing good general principles that can be tested across all our health and care settings to help support professionals across Croydon and South West London to provide services safely.

3.30. **Personal Protective Equipment update:** Throughout the pandemic, colleagues from across South West London worked closely together and continue to work hard to calculate requirements for Personal Protective Equipment (PPE) and clinical consumables over the next few months. This includes modelling for planned inpatient elective procedures, as well as for primary, community and social care, and mental health settings, as face-to-face services start to increase.

4. CARE HOMES

4.1. Care homes remain a key focus in our pandemic response, whose vulnerable residents are at greater risk if they contract Covid-19. Croydon has the largest care home market in London, with 230 care providers, 126 care homes (63 of whom support older people). While the impact of COVID-19 during the peak was significant, Croydon's care homes had the third lowest rate of excess deaths in London. The commitment and care shown by Croydon's care home workforce cannot be underestimated.

4.2. Croydon's care homes are responding well in partnership with the Council and health. The Council's Gold command has received daily updates on the demand for beds, the capacity within the sector and the impact of Covid-19 on care homes (including numbers of suspected cases). Whilst it is positive that

many care homes have told us that they have felt supported by the council, the scale of difficulties our care homes continue to face cannot be underestimated, particularly the emotional impact on families and care home staff where residents have lost their lives.

4.3. The council continues to support care homes closely to reduce infection rates and help them cope with the impact of the pandemic. This involves daily monitoring of key data reported by homes and regular calls to homes to see where extra support may be needed.

4.4. The increased testing and higher community transmissions in August has resulted in some positive results for residents and staff members. As of 14 September there are two homes with more than 1 case of COVID (an outbreak). There are 7 more situations across care homes and supported living. The majority of homes with positive cases are single cases suggesting that residents are being effectively isolated and infection control practice is being followed. Care homes are being reminded about the importance of sustaining infection prevention and control practice. The council are working with the Department of Health and Social Care to improve the national testing approach to ensure care homes have enough swab tests for residents and staff. Most care homes in Croydon have re-opened to visitors using outside space and separate rooms to do this safely. The council and health partners are supplying care homes with local information to help determine their local visitor policy.

4.5. Croydon's system wide care homes support plan (linked to below) was submitted to central government on 29 May and outlines all the actions we have been taking across the partnership in Croydon to support our care homes.

https://lbc-app-w-corpwebsite-p.azurewebsites.net/adult-health-and-social-care/care-homes-and-housing/care-homes-support-plan

4.6. Two representatives from Croydon's care homes attend a weekly strategy group with council and health leads to provide helpful feedback challenge on the impact our support is having, and what more we need to do.

4.7. In order to support providers with the financial impact of the pandemic the Council has moved to paying 4 weeks in advance and given significant provider sustainability payment as upfront support to help care homes with Covid-19 related costs. In addition to this, the commissioning team have distributed over £2m of funding to our social care providers from central government (the Infection Control Fund). These are short term fixes though and councils require longer term resources to maintain the levels of financial support in care homes as called for in the recent London Councils report (linked to below). The report also notes that the rapid discharge process

during the peak placed care homes at increased risk. For the last few months out of hospital testing is working well.

www.londoncouncils.gov.uk/members-area/member-briefings/health-and-adult-services/supporting-care-homes-during-pandemic

4.8. The Council has provided advice and guidance on the use of Personal Protective Equipment (PPE), in accordance with the government guidelines. The CCG have supplemented this with a training programme which has reached over 1000 staff in care homes.

4.9. Where required, emergency PPE supplies have also been provided 7 days a week to suppliers at no cost (including care homes, home care providers, children's residential providers & supported living providers), particularly in adult services. Recently a national portal has been set-up for emergency PPE orders taking over from the supply route the council set-up. The national testing programme in care homes slowly is increasing capacity but concerns remain about access to regular asymptomatic testing for residents and staff which is being raised at a local and national level.

5. ADULT SOCIAL CARE

Care Act Easements

5.1. Croydon Council has not engaged in Care Act easements during Covid 19.

Front line staff

5.2. Staffing numbers remain adequate at present. In October winter pressures will begin to be felt across the services and so staffing resources may need to be moved in order to address areas with the most pressing need. The final results of the staffing review need to be examined prior to this in order to fully appreciate how any resource allocation can best be completed.

Homecare reviews (during and post COVID)

5.3. Many reductions were made (197) during the peak Covid period to domiciliary care packages. This was mostly due to the client / their families not wanting a service (or the same level of), or not requiring it as family now at home chose to do the care. As such reviews were done before any reductions. A risk register was kept and monitored daily/ weekly (as per risk identified) and oversight was given to service managers. It is also important to note that these reductions have not been treated as efficiencies. Where required packages were increased and others returned to their previous hours.

Provider services

5.4. Active Lives and Dementia Day Services were suspended on 20th March, systems were put in place to maintain contact by telephone and email with service users and carers. In May, a digital offer, 'Friends Connected' was introduced to support Active Lives users and continues to be provided. Many staff were redeployed to support colleagues and tenants in Extra Care Housing, with the remainder supporting service users and carers and undertaking welfare checks.

5.5. Careline maintained a business as usual service throughout the lockdown and undertook regular welfare check calls to residents. Shared lives provided a virtual service to support carers.

5.6. Extra Care Housing suspended new tenancies at lockdown. Tenants received additional support provided by Day Service/Active Lives staff and additionally by Age UK.

5.7. Dementia Day Services and Active Lives Services have now resumed albeit with a reduced offer. This is in line with government guidelines, and to keep people safe. Digital offers have been maintained and work is progressing on extending these to other service user groups over the coming weeks.

5.8. Shared Lives are in the process of resuming face to face visits with carers and plans have been developed to resume placements.

5.9. Extra care housing has resumed, accepting new tenants and working with housing colleagues to turn voids around as quickly as possible.

5.10. All services are now up and running with adapted models and within government guidelines on social distancing. In light of the pandemic and lockdown a number of lessons have been learnt, including: digital offers need to be more available. Where digital offers are not appropriate, visiting service users and carers need to be maintained for some users groups, i.e. Dementia. Training on manual handling, medication management and infection control should be mandatory for all provider services staff, building assets can and should be used more flexibility across provider services.

Adult mental health

5.11. Adult Mental Health Services are provided in partnership with South London and Maudsley NHS Foundation Trust as part of Croydon Integrated Adult Mental Health Service based at Jeanette Wallace House, Purley resource Centre and Queen's Road resource Centre. All key front line services remained open throughout the pandemic with adjustments made for social distancing and PPE requirements.

5.12. The Council's Approved Mental Health Professionals (AMHPs) who undertake Mental Health Act assessments, adapted to using digital technology where permitted and using PPE where not, to ensure there were no breaches of the Council's statutory duties under the Mental Health Act.

5.13. A brief lull in referrals for Mental Health Act assessments has been followed by huge increases in demands for assessments. Our partners in the South London and Maudsley NHS Foundation Trust have helped to ensure sufficient AMHPs were released back to support vulnerable clients through care coordinator duties, by funding a supernumerary AMHP to work purely on the AMHP rota.

5.14. In terms of data, referrals services for Mental Health Act assessments are as follows: April: 57; May 97; June: 115; July 128; August: 101. Even with the April lull this is an average of 100 per month against an average of 84 per month for the same period last year.

Adult safeguarding and quality assurance

5.15. On the 20 March 2020, The Adult Safeguarding and Quality Assurance Service made a decision to take over the entire Adult Safeguarding process (from referral to enquiry and review) for all adult social care, in response to the challenges presented by COVID 19 on residents and resources. This effectively freed up capacity within the localities and the Croydon Adult Support Service in focusing on COVID 19 related intervention. This meant that the hybrid safeguarding model, where various safeguarding referrals and concerns were assessed or triaged at the point of contact by the Croydon Adult Support Service, Croydon Older Adults Services, Disabilities Services and other teams, were centralised and managed by the S42 Safeguarding unit.

5.16. As of the 09 April 2020, the safeguarding unit with the support of the Professional Standards Team responded to over 200 safeguarding concerns requiring triages, in addition to over 300 cases already located within the unit at various stages of safeguarding interventions. The flow was about 10-15 concerns a day leaving a waiting list for allocation of about 50 adult safeguarding concerns. Furthermore, the safeguarding unit inherited over 100 cases from the Croydon Adult Support service task list.

5.17. By the 19 May 2020, the Croydon Adult Support Service's Task List was cleared of historic and current safeguarding concerns to zero and the waiting list for allocation of concerns was down to just 19 effectively triaging over 500 cases. Despite this tremendous interventions, the incoming triages increased to over 300 cases per month with knock on impact on approximately 400 cases opened at various stages of adult safeguarding enquiries. The flow rate for enquiries being about 20-22 enquiries per week.

5.18. In order to address the above impact, the safeguarding unit with the support of the Croydon Adult Support Services, Disabilities and Older Adult Services devised a plan to move the safeguarding intervention back to the hybrid process, with the safeguarding triages returning to the Croydon Adult Support Service via a system of joint triage process involving various services, which has been effective in keeping a robust oversight over the safeguarding process.

5.19. At the time of this report, there are only 12 open safeguarding assessments to various Croydon Adult Social Care Teams and about 21 open safeguarding assessments to the Croydon Adult Support Service awaiting triages; a far cry to earlier report of over 100 cases in the front door alone, leaving the safeguarding service in a very strong position to prepare for any eventuality that may arise through a possible second wave of COVID 19.

5.20. Although, the number of open enquiries have reduced to about 330 at the time of this report, it still represents a significant achievement of a 17.5% reduction in total open enquiries amidst about 80 new enquiries a month.

5.21. Adult Safeguarding and Quality Assurance Services worked jointly with the Adult Commissioning Team through the peak of COVID 19 to provide effective oversight to the Provider Market (Care homes; Domiciliary Care Agencies and Supported housing/Supported living providers). This was through either partnership interventions with other agencies, or via the Croydon Intelligence Sharing Committee, or via specific quality assurance and monitoring process.

5.22. A major barrier/disruption to the above provider market interventions during the COVID peak period was the suspension or reduction in the number of visits to care homes, domiciliary care agencies, supported housing or supported living by the Care Quality Commission, Croydon Care Management Teams and Croydon Commissioning Teams with limited access to adults who were in need of adult safeguarding interventions.

5.23. The impact of the above was an increase of virtual online quality meetings with providers from 3 times a week to about 6-8 times a week. Visits were carried out on a case by case basis with emphasis based on managing high risk presentations and circumstances. Remote assessments were trialled by the Mental Capacity Act/DOLS teams in various interventions. There were parallel interventions supported by the Care Home Interventions Teams and Croydon Care Support Team in ensuring that concerns about providers were appropriately resolved.

5.24. The impact of COVID 19 has been a rigorous test to our preparedness and resilience in managing major disruptions to the status quo. As such, further work continues on establishing clear pathways in and out of safeguarding process; improving the identification of clear lines of responsibilities and case

management; improving the interface between adult social care and mental health; reducing handoffs; devising a multiagency risk assessment framework; working in partnership with various agencies to clarify criteria for interventions and acceptance; and seeking a more effective joined-up system with Children and Family Social Services (Transition, Leaving Care Team and their Commissioning Service) of managing the increased number of referrals from a cohort of younger adults-in-need who do not fit into defined pathways for adult social care intervention.

Hospital discharge

5.25. On 19 March 2020 the NHS issued *'COVID-19 Hospital Discharge Service Requirements'*. The Council used this document for the basis of its Adult Social Care approach to the pandemic.

5.26. As the guidance was clear on what Councils and Adult Social Care should follow the Council did not enact any easements of the Care Act as described in the '*Care Act easements- guidance for Local Authorities'* which was issued on 1 April 2020.

5.27. On 27 March 2020, to meet the estimated need of the hospitals and to support residents in the community in being admitted to hospital, the Adult Social Care, Living Independently for Everyone service (LIFE) and Placements & Brokerage teams started the Monday-Sunday 8am-8pm service as described in the NHS document with a focus on discharging residents from hospital within 2 hours after they were deemed fit to leave hospital. Increased staffing resource was moved from other departments within the Council to meet the increased demand and hours of operation.

5.28. To meet this the Council imbedded the Discharge to Assess Pathways (D2A) for LIFE (people going home) and Residential/Nursing Care in its processes and created a single point of contact for hospitals for any discharge referrals. This meant as all discharges would be assessed at home/care home within 24 hours the Social Worker and LIFE teams in the hospital were moved out to support increased work in the community.

5.29. Overall the Council's response to hospital discharges and preventing people being admitted to hospital went well. Though the target of a 2 hour discharge from hospital was a very challenging target by the end of each day residents who were going home with a package of care either had been discharged or had a package of care confirmed in place for next day discharge.

5.30. Below are some of the key things that went well:

- Enhanced service operating hours (Monday-Sunday 8am to 8pm) was put in place within 8 days of the guidance being issued.

- Closer working relationships with hospital and health colleagues which improved the flow of information to support discharges.

- Seminars and webinars with Home Care and Care Home providers to provide them with key information and look at ways the Council can support them during covid-19.

- Moved to electronic systems which gave a better overview of discharge cases to allow resource to be allocated appropriately and to review demand.

- Home Care and Care Home providers moved to accepting discharges out of normal working hours.

- Created a local alert system (mirroring national covid-19 alert levels) that matches staff resources and procedures to demand. This then be can be ramped up or down to meet demand and lets have in place back up staff when required to meet any increased need.

5.31. There has been a lot of national focus on the response to discharge, especially around the Covid-19 status of residents before they were either discharged home or in to care homes. Updated guidance has now been provided on what information should be provided to Care Homes, and wherever possible residents with Covid-19 should not be discharged into homes. If they are then appropriate barrier control nursing and isolation for 14 days should be in place. Our approach in Croydon has been to work closely together across health and care services and we continue to do so to ensure residents are discharged appropriately and cared for in the best setting for their health and care needs, supported by sharing appropriate information.

5.32. The key things that need to change are:

- Feedback has been provided on a pan-London basis that the 2 hour discharge target is not always achievable. On a local level agreement for people going home, by the end of each day, a resident will either be discharged or have a package of care confirmed for a planned discharge date for the next day or future date. This is to allow a Care Home to carry out an assessment to ensure the needs of the resident can be provided by the home, then a 24/48 hour window needs to be the agreed target.

- Discharge information forms to be updated to provide greater clarity on the needs of the resident, their covid-19 status and that we have considered home first as an option at all times.

- That from a review of some initial cases that were discharged to Care Homes that approximately 25% could have been considered to go home rather than a care home.

- That on weekends the numbers of discharges were very low and over 95% of discharges even at the peak of covid-19 was carried out Monday-Friday. This meant that at times our staffing resource was not best allocated to meet demand.

5.33. Below are lessons learnt and how this will affect preparedness for winter/and or second wave and the Councils preparation to date:

Lessons learnt and future planning	**How this affects preparedness and what we have done**
That there were low numbers of discharges on the weekend but staffing levels were spread over the 7 day service	A local alert level system is now in place to match resource to demand. Staffing resource identified to meet demand if local need increases.
That the assessment forms could have more detail to support discharge teams	Discharge assessment forms to be updated by mid-September 2020.
That some residents that went into Care Homes could have returned home	A "two tick" system is planned with Health colleagues by which there is increased oversight for larger domiciliary packages and residential/ nursing home placements.
Resources needed for both winter planning and possible second wave	Staffing requirements identified and to be in place by beginning of October 2020.

Living independently for everyone service (LIFE)

5.34. At present the LIFE service remains busy and continues to operate a seven day a week service. It is however set up for working six days a week, but currently the level of work has dictated a need for additional work. The LIFE service remains exceptionally busy with winter level staffing operating across the summer. Around 22 staff members are in the team as we go towards winter which is unlikely to be sufficient. This has been identified by the Service Manager and additional staffing resource is being looked at from within adult social care.

5.35. Going forward an enhanced Part B assessment (assessment that takes place when the client has been discharged back home) is being considered in order to allow for a more comprehensive assessment when clients are discharged.

Impacts of the council staffing review

5.36. The Council staffing review consultation period is now complete, and the management response has been presented to the Unions.

5.37. We have listened to staff and partner concerns about winter pressure and general workload demands. In response we have sought funding through NHS routes for covid-19 winter resources, and will seek to move resource to high demand areas.

5.38. Through the above, successful redeployment, the deletion of vacancies, agency staff, acceptance of targeted voluntary severance and reduction in hours of social workers and health and wellbeing assessors, there are no compulsory redundancies to front line staff in adult social care.

5.39. Going forward, we will support the remaining workforce through the acceleration of integrated teams and use of strengths based practice. The improvement of systems and processes, including the introduction of Liquid Logic this month, will support some of the challenges we currently face, and we continue innovation programmes to make changes and improvements to broken processes where we can, as well as working as an integrated health and care system.

6. CROYDON WINTER PLAN 2021 AND A COVID SECOND WAVE

Principles of a winter plan

6.1. Winter planning is a core element of any local health and care system, although without doubt this year it has the potential to be a winter like no other. The core principles set out in the table below, are the launch point for an integrated approach, and already has enabled successful agreements on:

- Focussed additional funding to cover additional adult social care staff resources during winter for enhanced discharge from hospital, i.e. to cover longer days and weekend working (LIFE remains at 7 day working, and brokerage support is available at weekends).

- Enhanced senior management support over weekends to the hospital and community social work teams.

- Increased intermediate step down beds in the hospital, supported by the enhanced social work presence in the integrated discharge lounge at the hospital. Enabling proactive discharge of residents with a coordinated reablement offer.

6.2. Unlike the first wave of the pandemic, it is very unlikely that the NHS would pause any non-urgent elective activity should a second wave strike. To plan for this, the Trust is putting in a robust plan to both manage demand and ensure there are enough staff and capacity available to care for higher numbers of people should there be a second peak. The Croydon Elective Centre is a key element of this as described above.

Effective management of Covid-19 and other infectious diseases in the borough • Preventing healthcare-acquired Covid-19 • Emergency planning for potential second wave of Covid
Proactive and preventative approach to keep Croydon well over winter • Managing complex patients • Population health management approach • Supporting care homes staff and patients • Flu vaccination programme for staff and the community
Support the people of Croydon to stay independent and only admit to hospital if required and for minimum period required • Avoiding hospital admissions through community services • Proving same-day emergency care (SDEC) services to avoid emergency admissions where possible • Discharge patients as soon as they are medically optimised
Make sure we have the capacity to care for the people of Croydon in the right place at the right time throughout winter • Effective workforce management • Capacity plans (staff, equipment, inpatient beds) • Clear escalation actions within services, organisations and across system • Protect elective activity and integrity of ‘Covid Protected’ zone

Winter funding in Croydon

6.3. In August, the Prime Minister confirmed that Croydon Health Services had been successful in securing funding to upgrade its winter preparations, alongside 116 trusts in the country.

Croydon secured more than £2.5 million, which will be used for:

- Reconfiguring ward areas and installing additional equipment, creating safe clinical environment for patients who need to be treated somewhere other than in our ED.
- Providing a dedicated 'same day' mental health facility for patients who have both a physical and mental health need.
- Creating a dedicated surgical assessment unit to ensure that the number of medical inpatients doesn't impact on our ability to deliver same day emergency surgical care.
- Implement a community IV facility, reducing the number of patients who need to attend or be admitted to hospital for antibiotics.
- Expand our emergency diagnostic capacity by providing two dedicated emergency rooms, so that we can provide timely care in the Same Day Emergency Care unit (SDEC).
- Implement the direct booking from NHS 111 to SDEC, ED and our UTC, reducing footfall and waiting time in ED.

Test and trace and supporting vulnerable people

6.4. Our most effective tool for protecting Croydon's vulnerable population from COVID19, is communication both on social distancing, and what services (statutory and voluntary / community) are available to support people.

6.5. During shielding, the Council invested resource in proactively contacting residents to:

- Provide emergency support on access to food and medication
- Provide proactive and preventative information and advice
- Triage people with additional support needs, to voluntary and community support, or statutory support.

6.6. With the roll out of test and trace, the Council will need to be proactive in ensuring vulnerable residents identified via test and trace, have sufficient information and signposting on what statutory and community support is available.

6.7. A vulnerable people workstream (sitting within the Public Health test and trace programme) is developing plans for both test and trace responses, and how support to vulnerable and shielded residents could be provided.

7. TRANSFORMATION AND NEXT STEPS

7.1. **Transforming primary care** GPs across Croydon are working together to look at how we need to reshape primary care services in the context of living with COVID-19 and how we can adopt new ways of working, prioritising patient and staff safety and protection from infection. Part of this has involved collecting feedback from practices about issues regarding health inequalities and access that have arisen or been exacerbated during the COVID-19 pandemic and our response.

7.2. **Clinical networks, radiology and increasing ITU capacity** Clinicians across Croydon and the other five boroughs in South West London continue to prioritise the restart elective of procedures. Twelve south west London clinical networks consisting of specialists from all four South West London trusts, as well as colleagues from primary care, are now working together to safely and equitably provide elective care in these twelve priority areas. This work continues to expand across further specialties to safely treat as many patients as possible over the coming weeks and months. Expert clinicians are overseeing and prioritising a single patient list for each specialty across all our hospitals so patients have equal access to care no matter which borough they live in.

7.3. At the same time as restarting elective care, our clinical networks are looking ahead to 'Reshape' the work of each of these specialties. Acute and out-of-hospital clinicians and professionals will work closely together to consider the whole patient pathway and consider what changes should be made to ensure that care is as safe as possible and meets the needs of patients.

7.4. Growing our intensive treatment unit (ITU) capacity continues to be a high priority. We are assessing the costs and steps we will need to take to ensure we can safely treat people for COVID-19 and other very serious conditions into the future. We will be maintaining the expanded critical care capacity we developed during the first wave and are completing the business case for the new refurbished unit that will be a purpose built single unit for this expanded capacity.

7.5. **Supporting staff from BAME communities** We are continuing to learn about the disproportionate affect that the coronavirus pandemic has had on people of Black, Asian and minority ethnic (BAME) backgrounds. It is important that we continue to sensitively discuss and understand our staff's circumstances to ensure we are aware of the risks and are giving the right level of support – for example, by offering alternative options for personal protective equipment

(PPE). Resources are available to help managers talk with their staff about how COVID-19 is impacting them and their families.

7.6. **One Croydon and the South West London Health and Care Partnership** COVID-19 has also highlighted the increased need for partnership working to address long-standing health inequalities that have brought into sharper focus due to the pandemic. Building on the strength of the One Croydon partnership, our Integrated Care Network plus pilot in Thornton Heath, for example, is intended to make it easier for people to access the care they need and to reduce health inequalities.

7.7. One Croydon's LIFE (Living Independently For Everyone) team, as another example has seen referrals double since the pandemic began. This team combines health and social care staff to help people after hospital stays, keeping them well and often preventing hospital admissions in the first place.

7.8. The Trust has also reviewed its operational response strengthen its resilience and preparedness for a potential second wave. At the peak of the first wave, when the highest number of critically-ill patients required prolonged stays in intensive care or mechanical ventilation, the hospital was using double the normal amount of oxygen, placing the Trust's supply system under increased strain. Our oxygen supply for patients was maintained throughout, however work has now been completed to increase this provision should it be needed.

7.9. Working side-by-side with the Council, local GPs, care workers, mental health services and voluntary groups we are continuing to coordinate our care and support for people in Croydon during the pandemic. The borough is also aligning its efforts with the South West London Health and Care Partnership, neighbouring boroughs and regional authorities to provide a system-wide response.

7.10. In line with the latest national guidance, this includes meeting the requirements of any future COVID response, whilst maintaining our non-COVID elective services to care for people in Croydon.

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