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Scrutiny Health & Social Care Sub-Committee Agenda

To: Councillors Eunice O'Dame (Chair), Robert Ward (Vice-Chair), Adele Benson, Patsy Cummings, Sherwan Chowdhury, Holly Ramsey,

Gordon Kay (Healthwatch Croydon Co-optee) and Yusuf Osman (Resident Voice Co-optee)

Reserve Members: Sue Bennett, Mark Johnson, Humayun Kabir, Ellily Ponnuthurai, Helen Redfern and Manju Shahul-Hameed

A meeting of the **Scrutiny Health & Social Care Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 20 June 2023** at **6.30 pm** in the **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX.**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Simon Trevaskis
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www.croydon.gov.uk/meetings

Monday, 12 June 2023

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AGENDA – PART A

1. Apologies for Absence

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

2. Minutes of the Previous Meeting (Pages 5 - 12)

To approve the minutes of the meeting held on 16 May 2023 as an accurate record.

3. Disclosure of Interests

Members are invited to declare any disclosable pecuniary interests (DPIs) and other registrable and non-registrable interests they may have in relation to any item(s) of business on today's agenda.

4. Urgent Business (if any)

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

5. Integrated Discharge Frontrunner Programme (Pages 13 - 40)

The Health & Social Care Sub-Committee is presented with a report on the Discharge Integration Frontrunner programme, which aims to bring together transformation efforts from across Croydon to develop an effective, integrated system across hospital, social and community care.

The Sub-Committee is recommended to:

1. Note the strategic direction on the Integrated Discharge Frontrunner programme.

2. Comment on the highlighted risks and challenges from the presentation; identifying topics the Committee wish future reports to focus on.

6. Health & Social Care Sub-Committee Work Programme 2023-24 (Pages 41 - 46)

This item is an opportunity for the Health and Social Care Sub-Committee to consider areas it wishes to schedule for scrutiny in the year ahead.

The Sub-Committee is recommended:

1 Note the draft version of its Work Programme, as presented in the

report.

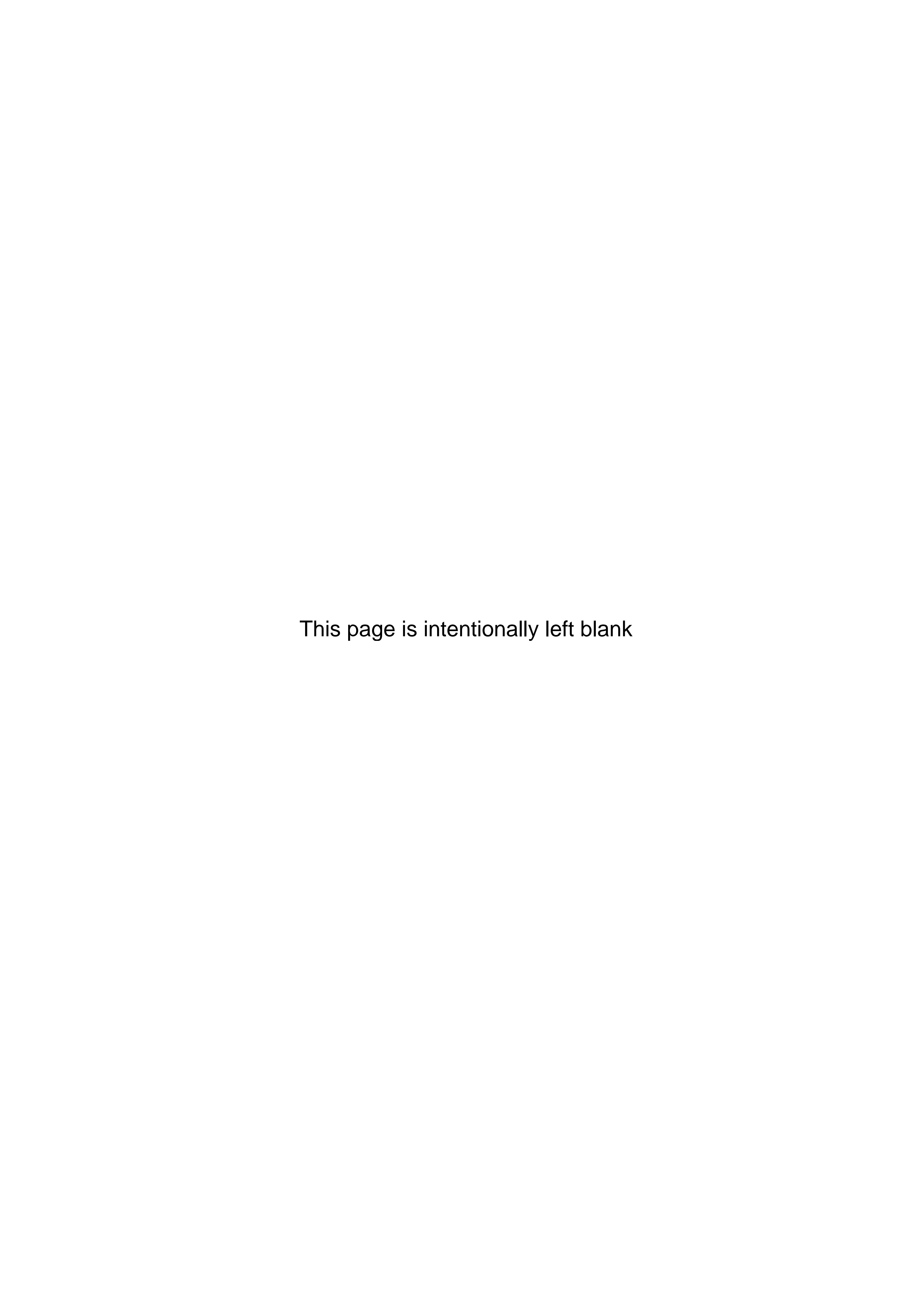
2 Consider whether there are any other items that should be added to the work programme for scoping as a result of the discussions held during the meeting.

PART B

7. Exclusion of the Press and Public

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

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

Meeting held on Tuesday, 16 May 2023 at 6.30 pm in the Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES

Present: Councillors Sean Fitzsimons (Chair), Councillor Sherwan Chowdhury (Vice-Chair), Adele Benson, Patsy Cummings and Robert Ward

Also Present: Councillors Yvette Hopley (Cabinet Member for Health & Adult Social Care) Margaret Bird (Deputy Cabinet Member for Health & Adult Social Care)

Apologies: Councillor Fatima Zaman, Gordon Kay (Healthwatch Croydon Co-optee) and Yusuf Osman (Service User Co-optee)

PART A

14/22 **Minutes of the Previous Meeting**

The minutes of the meeting held on 4 April 2023 were agreed as an accurate record, subject to the following clarification that Councillor Adele Benson had attended the meeting remotely.

15/22 **Disclosure of Interests**

Councillor Sherwan Chowdhury disclosure that he was employed at a project that received NHS funding, although that project was not based within Croydon.

16/22 **Urgent Business (if any)**

There were no items of urgent business for consideration of the Health & Social Care Sub-Committee at this meeting.

17/22 **Croydon Health Services NHS Trust - Quality Account 2022/23**

The Sub-Committee considered a report on pages 3 to 110 of the agenda which set out a draft version of the 2022-23 Quality Account for Croydon

Health Service NHS Trust (CHS). A draft of the Quality Account had been provided for the comment of the Sub-Committee, which would be taken into consideration by CHS in preparing the final version of the document.

The Chief Executive of the Croydon Health Service NHS Trust (CHS) and Croydon's place based leader for health, Matthew Kershaw attended the meeting for this item, to provide an introduction and answer questions arising.

During the introduction of the Quality Account, it was highlighted that the report had been structured into two parts, one reviewing the performance of CHS against the organisational priorities set the previous year and the other looking forward, by setting out the priorities for the year ahead. It was advised that of the twenty priorities set for 2022-23, positive progress had been made in most areas and thanks was given to CHS staff for all their work.

There were a few areas where further improvement was needed, including the following: -

- Although there had been improvement in the friends and family test response, the target had not been achieved. A new system had recently been installed which should make achieving the target easier in the forthcoming year.

- The target to review 95% of risks within the required timeframe had also not been achieved, with 82% of risks overdue for review at the end of April 2023. However, the implementation of Radar, a new risk management system, would quicken the pace of improvement and help to ensure the target was achieved going forward.

- The target to ensure that 95% of all clinical and non-clinical policies were up to date and available online had not been met. CHS were working to address this and in the short-term prioritising updating any policy that was no longer applicable.

- The target to reduce healthcare acquired infections had not been met. CHS had performed well on minimising Covid infections but post the pandemic there had been an increase of MRSA and C-Difficile infections above the targeted rate. These increases mirrored the performance across the health service nationally and CHS had put measures in place to reduce the rate of infection back below the targeted rate.

The six priorities for 2023-24, had been identified through the use of data. The priority areas were improving capacity assessments for all patients, improving the performance of public health nursing, improving timely access to critical medications, baseline ward accreditation assessments for all adult inpatient wards, improving patient experience of their environment across Trust services and ensuring the Trust had effective systems in place to maintain up to data risk registers.

Following the introduction, the Sub-Committee was provided the opportunity to ask questions and comment upon the information provided within the Quality Account report. The first comment highlighted that the report mentioned Croydon being the youngest borough in London but did not acknowledge it also had the ninth highest number of people aged over 60 as well. It was agreed that this would be picked up and reflected in the report. It was suggested that it may be helpful include graphs or diagrammatical indicators within the Quality Account to better help demonstrate performance.

Further information was sought on the barrier to achieving the priorities set out in the report and the lessons learnt through the process over the past year. It was advised that the barriers would be different for each priority. For instance, the volume of healthcare acquired infections had historically been reduced each year. The number of c-difficile infections had previously remained below the target of 20 infections annually year on year, but this year had increased to 36. The high volume of patients within the system made it increasingly challenging to maintain the flow through the system and infection control. There was also a view within the infection control community that there were new variants of c-difficile that were more easily transmitted. CHS continued to improve processes and practices to minimise the risk of infection within the hospital, but research on variants was beyond the control of CHS.

The importance of the workforce upon the delivery of services was highlighted, with it questioned whether workforce issues had impacted upon the performance of CHS. It was advised that staff had been required to work through a tough set of issues including going through the pandemic, ongoing industrial action, and a high level of vacancies. Targeted work had reduced the number of vacancies in the nursing workforce, with CHS having a lower level of vacancies than had in recent years. Both the health and wellbeing, and the support of and engagement with staff would continue to remain a top priority.

It was confirmed that CHS had undertaken local, national, and international recruitment campaigns for staff, with a fantastic lead in place helping to support staff from overseas to acclimatise. This had helped the Trust to

reduce the use of agency staff and lowered vacancy rates. The recruitment of physio and occupational therapists remained a challenge, with avenues such as apprenticeships being explored.

There was an ongoing programme of work targeted at improving staff culture and delivering cultural change. The delivery of this programme had been brought back in-house which was providing added value. The next stage of the process was due to be launched on 17 May 2023 with senior clinicians and managers looking at how the Trust could ensure staff felt supported and engaged. It was important to ensure that engagement with staff was used to improve service delivery on areas such as patient pathways.

Regarding the priority on delivering the national patient safety strategy, it was acknowledged that the work on this had not been fully completed. Level one training was available and being accessed by staff, which demonstrated that progress was being made. The level two training would be implemented as quickly as possible, but this had been delayed by the readiness of partners involved in delivery.

Regarding priority 5 on clinical assessments, it was advised that this related to the prevention of blood clots and testing patients who were not very mobile. It was advised that this priority had been rated as green in the RAG rating provided in the Quality Account as the assessments were taking place, although it could sometimes be a challenge to provide documented evidence that all assessments had been delivered. There would be further work in the forthcoming year to continue improving the level of documentation.

It was confirmed that priority 6 aimed at improving patient discharge times had been met. It was also clarified that all the priority areas for 2022-23 would continue to be monitored going forward, but this would be as part of ‘business as usual’ rather than as specific priorities.

CHS was congratulated on its maternity services achieving a good rating by the Care Quality Commission (CQC). The hospital was one of only two maternity units in London that achieved a good rating on the safe care and well led aspects in the CQC inspection. CHS had a new Director of Midwifery in place who was leading the ongoing improvement work and had connected well with both staff and patients. It was important for CHS not to become complacent on the performance of the service, as the provision of midwifery was a tough challenge across the country, requiring a continued focussed.

In response to a question about the stroke facilities in the borough, it was advised that these had been reorganised several years ago, with St George's University Hospital in Tooting becoming the local unit for specialised stroke care. Clinical evidence indicated that having specialised urgent care services for stroke patients located in one hospital improved patient outcomes. The stroke facilities available in Croydon provided rehabilitative support for patients in their recovery post-stroke, once they no longer required the urgent care provided by St Georges.

Given the priority for hospital acquired infection had not been achieved, it was questioned whether this should be a worry for residents. It was acknowledged that the risk of infection was a significant concern for patients, but the historic performance of CHS in this area was good and the hospital had good infection control processes. It was hoped that there would a reduction in the number of infections in the forthcoming year.

It was highlighted that there was a national issue within maternity services, with BME patients facing worse outcomes. As such it was questioned whether CHS could provide data on the performance at Croydon University Hospital. It was confirmed that this was a core issue in Croydon due to the diverse population with the Health Equity and Racial Disparity in Maternity (HEARD) campaign targeting improvement in this area. It was confirmed that metrics from the HEARD campaign and the core maternity service could be shared with the Sub-Committee. It was suggested that this may be an area of scrutiny to schedule in the forthcoming year.

It was confirmed that although maternity services were not included as one of the six priorities identified for 2023-24, priority 4 - Baseline ward accreditation assessments for all adult inpatient wards, would include maternity wards. It was advised that improving business as usual services, such as maternity service, remained a high priority, even if not explicitly included as a priority in the Quality Account report.

It was clarified that a treatment escalation plan referred to under priority 5 for 2022-23, was aimed at ensuring patients had a plan of care in place to cover the potential need for advanced care, should escalation be required. Approximately 10% of patients would need an escalation plan.

A question asked about the support provided for staff as a result of the Mental Health Units (Use of Force) Act 2018. It was advised that there had been a lot of effort invested in training and support to best equip staff to help patients with mental health need. This included specific training for areas of high need such as the Accident & Emergency (A&E) services and wider general training

for all staff. Trained mental health staff were based in A&E and CHS worked with the South London and Maudsley NHS Foundation Trust (SLaM) team to provide support along with mental health liaison staff. It was highlighted that it was a continual process to ensure staff had the experience and skills needed to support patients with mental health needs and there were longer term workstreams aimed at improving pathways for mental health patients.

Regarding patient complaints, it was acknowledged that there had been a slower level of response following the pandemic, which had created a backlog that was being addressed. In the past two to three months CHS had brought in additional capacity to help respond to complaints, which was getting on top of the backlog, with responses sent to most of the outstanding complaints from 2022.

Regarding Priority 1 for 2023-24 related to improving capacity assessments for patients, it was questioned at what stage a capacity assessment would be needed. It was advised that the Mental Capacity Act was well established and an important part of the assessment process. Part of the standard process was to seek assurance that a patient had the mental capacity to be involved in decision making on their treatment. If it is determined that an individual does not have capacity, then CHS would look to engage with family members or friends where possible. Capacity assessments would be undertaken for most patients, but there will be occasions, such as in an emergency, when the documentation process needed to be improved. It was highlighted that the process to determine capacity was complex and needed to be routinely reviewed as an individual's capacity could change depending on their condition.

It was agreed that health visiting was an important issue and although some progress had been made, it remained a massive challenge. New birth visits had been prioritised for improvement as these were a crucial point of assessment for the early identification of potential issues. It had been included in the Quality Account to ensure there was a greater level of focus on the Trust's performance in this area. It was suggested that it may be helpful to share the work plan for the service with the Children & Young People Sub-Committee.

Regarding priority 5 focussed on improving the patient experience of their environment across Trust services, further clarity was provided on the target measure. Although the target was to set up a group to oversee the work on the patient environmental experience, setting up the group would not be the determination of success, instead it would be on the improvements to the

patient experience delivered by the group. It was suggested that further text could be added to the target to provide this clarity.

At the conclusion of the item, the Chair thanked the officers and Members in attendance for their engagement with the questions and comments of the Sub-Committee.

Conclusions

Following the Sub-Committee's discussion of this item, the following conclusions were reached: -

1. The Sub-Committee welcomed the opportunity to review the draft Quality Account 2022-23 for Croydon Health Service NHS Trust and had been satisfied with the responses provided to their questions on the content.
2. The Sub-Committee agreed that the six priorities identified for 2023-24 were reasonable, outlined the measures of success and in areas, such as health visiting, were strongly welcomed.
3. Although the Sub-Committee raised a number of areas where it felt additional clarity would be beneficial, it was acknowledged that the Quality Account 2022-23 was a largely positive indicator of the performance of the Trust against a challenging environment for healthcare services nationally.

18/22 **Exclusion of the Press and Public**

This motion was not required.

The meeting ended at 8.05 pm

Signed:

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Date:

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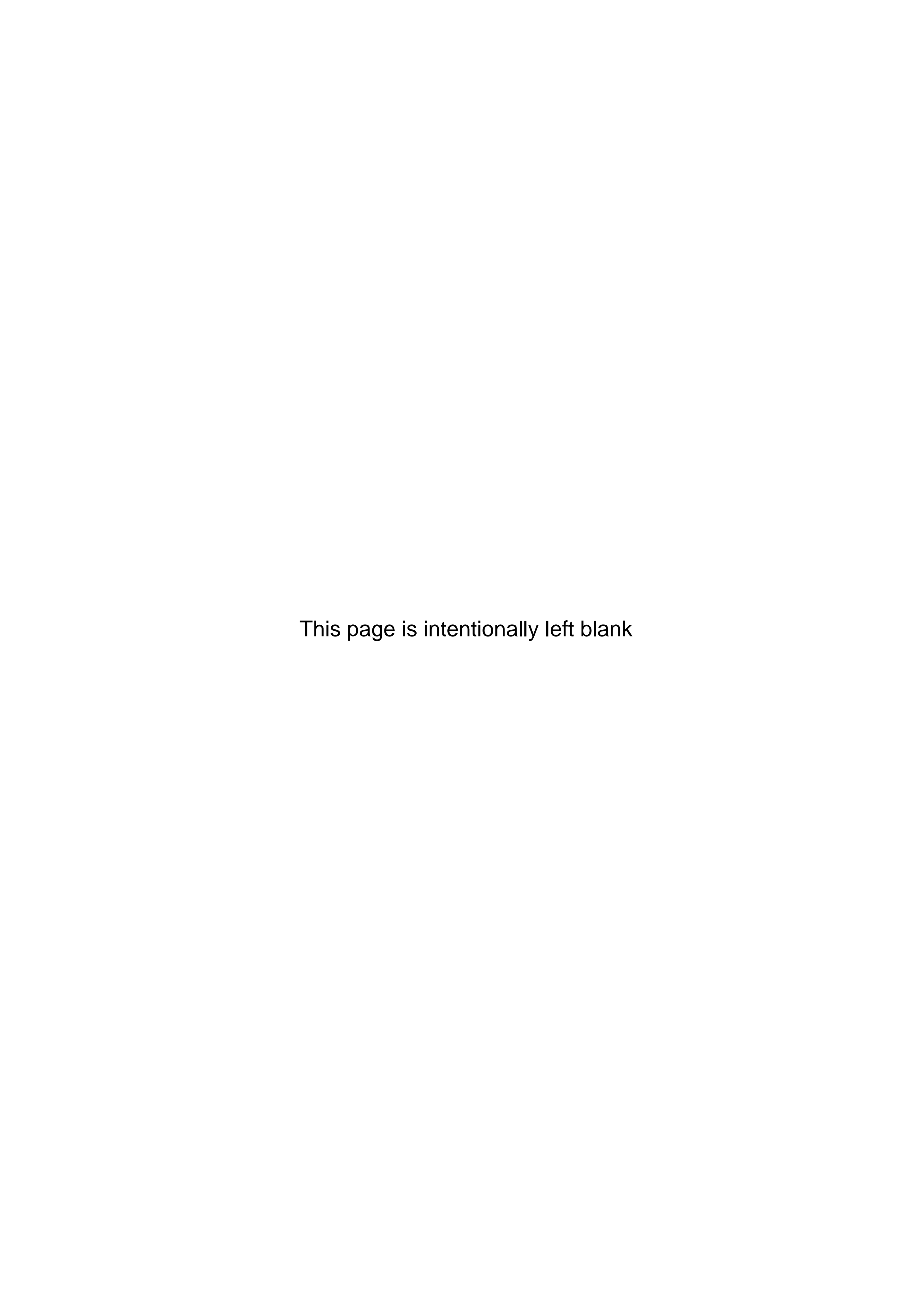
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LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**
DATE OF DECISION	**20 June 2023**
REPORT TITLE:	**Integrated Discharge Frontrunner Programme**
CORPORATE DIRECTOR	**Annette McPartland** Corporate Director Adult Social Services **Lee McPhail** Chief Operating Officer, Croydon Health Services
LEAD OFFICER:	**Laura Jenner** Deputy Director, One Croydon Alliance **Cynthia Abankwa** Programme Lead, Integrated Discharge Frontrunner Programme, One Croydon Alliance
LEAD MEMBER:	Councillor Yvette Hopley Health And Adult Social Care
AUTHORITY TO TAKE DECISION:	The integration between health and social care partners to deliver improvement in hospital discharge has been a regular area of scrutiny for the Health & Social Care Sub-Committee.
WARDS AFFECTED:	**All**

1. SUMMARY

1.1 In December 2023 Croydon was selected as one of six national Frontrunner sites in England and awarded £800,000 funding by NHSE to build on the success of its ground-breaking integration work by the One Croydon Alliance.

1.2 The Discharge Integration Frontrunner programme aims to bring together transformation efforts from across Croydon to develop an effective, integrated system across hospital, social and community care.

1.3 The Frontrunner programme objectives include the following:

- Develop a granular multi-dimensional baseline to map the activity, workforce, challenges, and existing initiatives across the system.
- Review and redesigning patient pathways to develop the right reablement and care offer for the Croydon population.
- Improve the integration of teams across the system, in terms of:
    - IT systems and data.
    - Funding.
    - Leadership and workforce.
    - Developing the right resources (workforce, IT systems) to deliver effective care provision.

1.4 One Croydon has received £800k from NHSE to support the development and implementation of the frontrunner programme and requires the support of a 24-week programme that will focus on developing a baseline of the Croydon system and agreeing a delivery model and supporting the mobilisation and implementation process.

2. Overview of Phase 1 of the programme:

- Generate a multi-dimensional baseline of the current system through an iterative process of data analysis and interviews / observations with system partners.
- The baseline will capture existing initiatives, quantitative analysis (activity, workforce, and finance) and qualitative insights (challenges, bottlenecks, processes) including whether current pathways are working effectively.
- This will be followed by stakeholder engagement and alignment process with the outcome to create a **'one version of the truth'** baseline as well as agreed priorities for system-wide transformation.

- This phase will also develop initiatives and workplans for agreed long term priorities, and a delivery model to implement agreed transformation initiatives over the long-term programme (6 to 18 months).

3. Phase 2 of programme (12 weeks):

- Phase 2 of the Frontrunner programme will focus on the development and initial implementation of a blueprint for the Transfer of Care Hub (TOCH), building upon the baseline and the initial discussions from Phase 1. The blueprint will agree the following:
  - The functions and teams within the TOCH.
  - The architecture and standard operating procedures within patient journeys.
  - The capacity required to deliver care.
- To support the development of the blueprint, the programme will 'pilot' emerging concepts (e.g., blended assessor roles and new ways of working within the hospital integrated discharge team).
- To implement the agreed TOCH blueprint, the programme will develop a detailed action plan with owners and timelines. These actions will be split across several workstreams including to include:
  - in-hospital assessments.
  - internal hospital ways of working.
  - recovery care (reablement/rehab).
  - Communications.
  - organisational development/training.
  - IT/data, estates; and
  - funding, etc.

3.1 The transformation programme aims to reduce the amount of time that medically well people are spending in hospital awaiting discharge, allowing the hospital to prioritise in-demand beds for those who are most critically ill and injured.

3.2 The move will also help free-up hospital beds so people can be admitted more quickly from A&E to wards, reducing pressure on the borough's Emergency Department at Croydon University Hospital and speed-up ambulance handovers to help get paramedics back on the road to care for the critically ill.

4. RECOMMENDATIONS

4.1 The Health & Social Care Sub-Committee is recommended to:

1. Note the strategic direction on the Integrated Discharge Frontrunner programme.
2. Comment on the highlighted risks and challenges from the presentation; identifying topics the Committee wish future reports to focus on.

5. NEXT STEPS

5.1 Following receipt from Sub-Committee Members on further areas for focus, officers will prepare detailed reports for presentation at the designated future meeting.

CONTACT OFFICER:

Laura Jenner

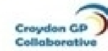
Deputy Director, One Croydon Alliance

APPENDIX 1 - PowerPoint presentation: Croydon's Integrated Frontrunner Programme

Frontrunner Transformation Programme

Update – June 2023

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE



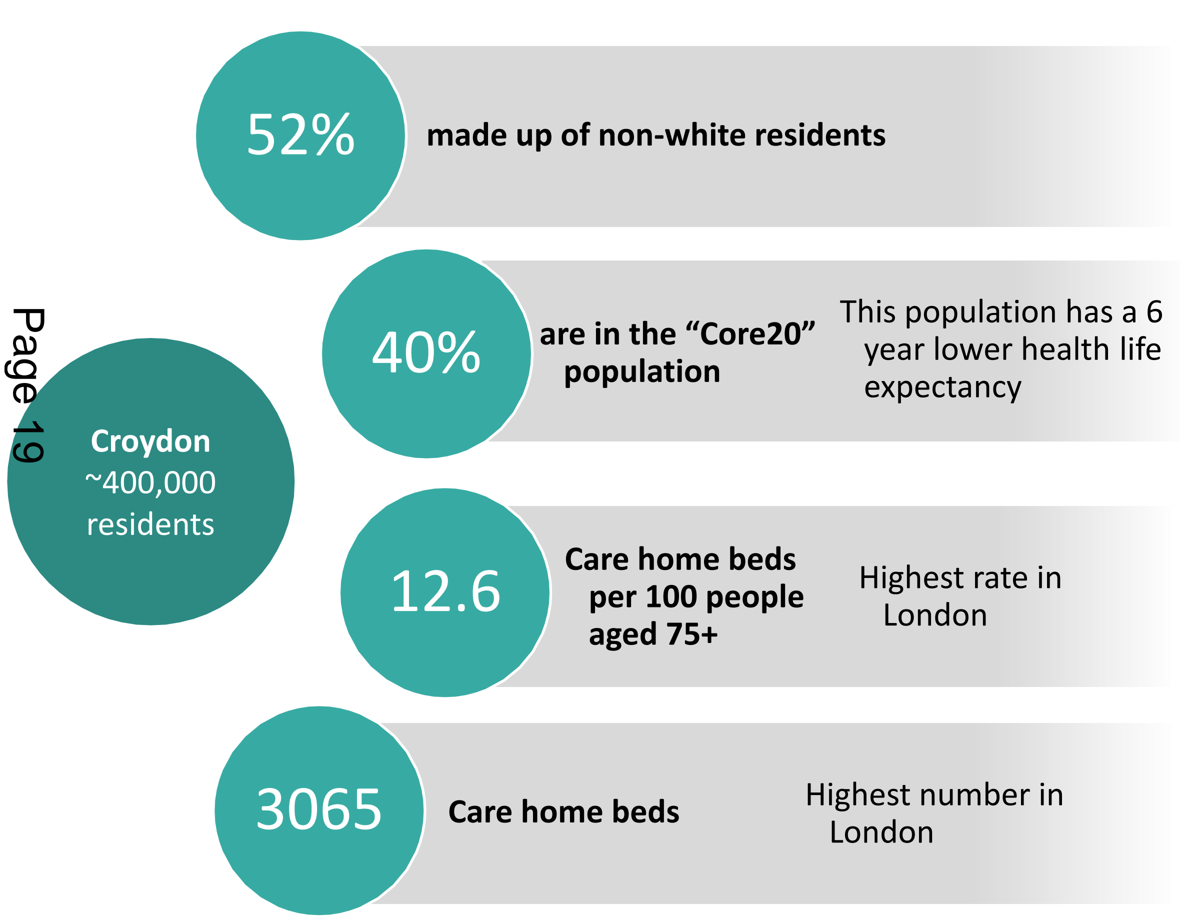
Agenda

- Croydon: About our system – (pp. 3-4)
- Our Frontrunner journey – (pp. 5-6)
- Developing a system solution – (pp. 7-9)
- Hospital pilot case study: A patient's discharge experience – (pp. 10-11)
- Answering our 3 supporting pillars – (pp. 12)
- Appendix – Data explained (pp. 13-23)

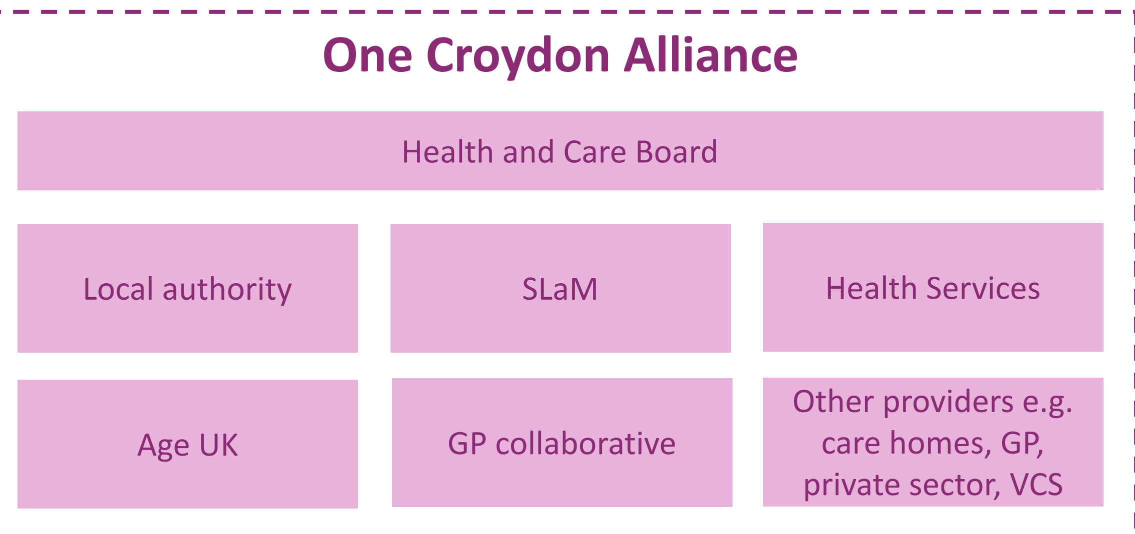
NHS

About Croydon

Diverse population, with a high level of deprivation

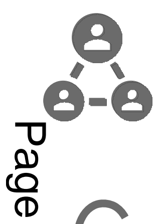
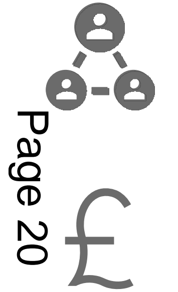


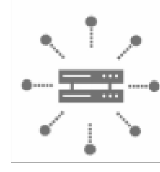
This is how we are working together to meet the health and care needs of our population



- Established Place Based Health and Care Partnership
- Health and Care Board has the delegated responsibility for setting the strategic direction for health and care
- Well established joint governance and a long history of partnership working
- 10 year Alliance agreement

Programme objectives



Areas	Objectives
How do we deliver **integrated care**, including best **architecture** for our discharge process?	▪ Simplify processes and SOPs and minimise steps to transfer of care ▪ Establish a true single point of access for hospital discharges and community step-ups ▪ Offer Discharge to Assess as default for all patients
What **integration / team structure / workforce**?	▪ Deliver a truly integrated discharge team ▪ Introduce blended roles ▪ Define the workforce and skill mix required
How can we maximise the impact of **the 'Croydon pound'**?	▪ Decide where to treat patients to maximise outcomes (home vs hospital) ▪ Optimise provision of social care and reduce overprovision ▪ Define joint funding arrangements and budget
How do we achieve **alignment and coordination**?	▪ Define clinical responsibility, oversight, and ownership for a truly integrated care offering ▪ Agree operational delivery by a single blended team with everyone managed under one collective ▪ Develop a permanent integrated health and social commissioning team
How can we optimise **data capture and information flow?**	▪ Define data we need to record to support operations and performance reviews ▪ Define KPIs and operational information for all teams ▪ Improve IT systems & interoperability

Overview of our progress so far and next steps

January 30th | April 19th | **Today** | July 1st | October

Baseline (diagnostic)

What we have done

- Developed a multi-dimensional baseline of the system including activity, workforce, and bottlenecks
- Aligned stakeholders on 'one version of the truth' baseline and agree priorities

How we involved our people

2 workshops with key stakeholders: Hospital MDT, IDT, LIFE, VCS, LA brokerage, CHC, primary care, commissioners (health and social), system leaders

Design (TOCH blueprint)

What we have done

- Principles of system design
- Functions and teams of the TOCH (E.g., assessment, coordination, placement)
- Architecture and SOPs of patient journeys
- Capacity required to deliver

How we involved our people

Weekly blueprint design working groups

- Including operational leaders from health and social

Pilot

- Test emerging thinking on IDT ways of working
- Capture learnings to guide development of TOCH blueprint

Finalising the blueprint

What we have done

Answering the 3 support pillars (difficult questions):

- Define clinical responsibility, oversight, and ownership for a truly integrated care offering
- Agree operational delivery by a single blended team with everyone managed under one collective
- Develop a permanent integrated health and social commissioning team

How we involved our people

Weekly blueprint design working groups

- Including operational leaders from health and social

Continuing engagement sessions

- Hospital doctors, community geriatricians, primary care
- Adult social services
- Patient representatives

Implementation

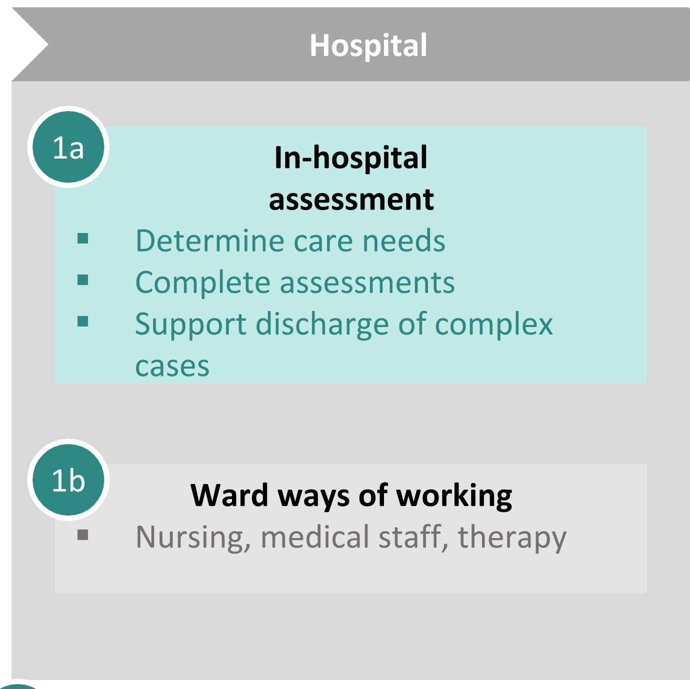
What we have done

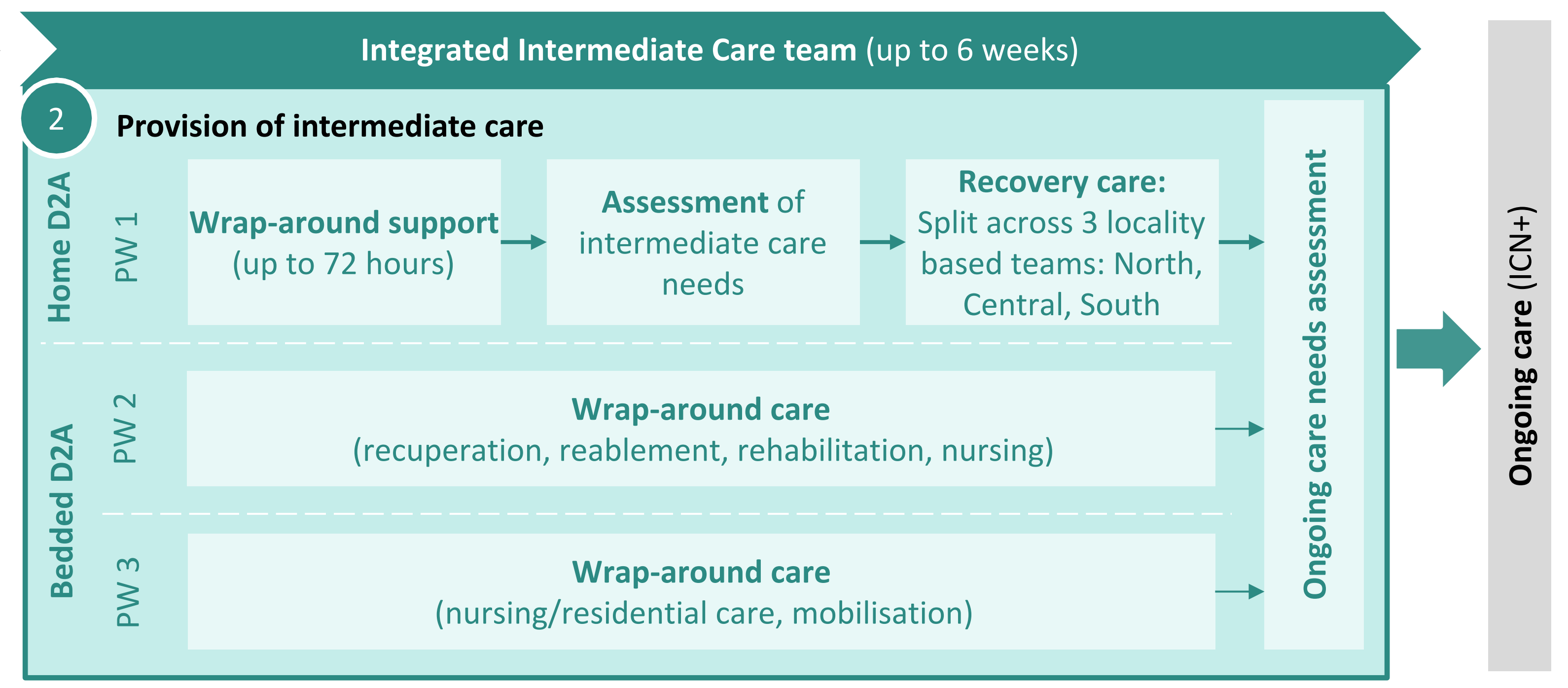
- Integrate teams
- Introduce new ways of working and SOPs
- Iteratively improve SOPs

We have created a comprehensive baseline of our system

Overview of current ambition

= TOCH





Ongoing care (ICN+)

3 **Central coordination function**

- **Demand and capacity matching** to optimise use of resources and the 'Croydon pound' – i.e., eliminating overprovision of unnecessary placements and ongoing DOM care
- **Placement** of patients into D2A settings and ongoing care

4 **Supporting pillars**

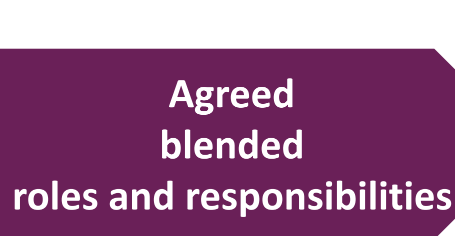
Ownership, responsibility and operational delivery	Funding	Joint commissioning

Through the Integrated Discharge Team pilot our teams have developed the blueprint for a blended assessor role

Objective

FROM:
Two distinct roles

Social worker



TO:
Single blended role

Blended assessor with joint assessment responsibilities

Outputs

- Agreed blended roles and responsibilities
- Agreed required IDT training
- Agreed staffing model and numbers
- Agreed segmentation of IDT caseloads

NHS

Patients discharged home on Pathway 1 will be referred into a single 'integrated intermediate care team' that provides wraparound care (up to 72 hours) followed by recovery care

Hospital

In-hospital assessment

Assessment to determine:

- Patients needs
- D2A location (home vs bedded)
- Wraparound care requirements (e.g., level of POC, nursing input)

Home

Integrated intermediate care team

Wraparound care

Mixture of clinical and social care up to 72 hours post discharge

Assessment

Assessment within wraparound care period to determine recovery care requirements

Recovery care (locality teams)

- **Recuperation**
- **Reablement**
- **Rehabilitation**

Delivered by North, Central and South locality teams closely linked to GPs

Ongoing support

Provided by the locality teams within ICN+ (e.g. District nursing, OT)

Some patients will go straight into ongoing care

Some patients will not require any ongoing care

Case study: How our integrated care offering (TOCH) will transform patient care and experience

Context

- Irene was a fiercely independent 83-year-old, living alone and managing to perform all activities – use of public transport, no mobility aid etc.
- She was admitted due to shortness of breath and a fall and stayed in hospital for 3 weeks where she was diagnosed with a heart condition that required inpatient treatment
- In hospital, Irene became quite frail and required a Zimmer frame to mobilise

FROM

- Irene was assessed by a Physiotherapist and an Occupational Therapist prior to discharge from hospital
- She was sent home with a reablement package of care - 3 calls a day for various tasks.
- Final observations showed a problem with her heart rate and BP failing a discharge. The Doctor investigated and Irene's medications were adjusted.
- The reablement provider was informed of the change and Irene stayed one night longer, she was discharged home the next day

TO

- **Irene is well known to the entire discharge team,** who assess her need for support at home and submit a D2A
- **Irene is well informed on what to expect:** A member of the integrated discharge team (IDT) will discuss her discharge plan, including explaining the purpose of reablement. This will be supported by a booklet on what to expect including all relevant contact number in case she needs to contact someone once home
- **The IDT makes sure everything is in place for discharge:** MDT have completed all discharge tasks, wraparound care provider will visit on the day of discharge
- **A member of the LIFE service will visit her at her home within 24 hours** to ensure she is settled and agree her reablement goals, creating a reablement plan

Overview of the functions provided by the integrated care team – Pathway 1 example

	Wraparound care (up to 72 hours)	Recovery care (up to 6 weeks)
Case management	▪ **What:** Own the recovery care journey of patient, adjusting balance of services and escalating to clinical staff as required ▪ **Who:** Health and wellbeing assessors	
Assessment	▪ **What:** Holistic assessment of patient's intermediate care needs, and identification of clinical deterioration ▪ **Who:** Upskilled health and wellbeing assessors	
Clinical input	▪ **What:** Reviewing escalated patients and providing clinical care where necessary e.g. taking bloods ▪ **Who:** Virtual wards, LIFE nurses, Rapid Response (outside of TOCH)	
Recuperation (Home-based care)	▪ **What:** Personal care, Home and settle, Assistance with domestic tasks, social contact goals ▪ **Who:** Voluntary sector, personal care provider (internal or external)	
Reablement		▪ **What:** personal care centred around getting people to do things for themselves rather than doing it for them ▪ **Who:** Internal/external reablement workers
Rehabilitation		▪ **What:** Time limited, goal orientated therapy exercises ▪ **Who:** LIFE therapy, Falls, Domi physio, OT

How do care providers (home-based and reablement) work together with the assessment function?

Will it be the same provider of recuperation for wraparound and recovery care?

For residents receiving reablement, will they also receive an element of recuperation? If yes, how will providers work together?

We are in the process of addressing these 3 supporting pillars (difficult questions)

Ownership, responsibility and operational delivery

We are developing integrated care which will replace unnecessary hospital LoS. This will be an enhanced model of 'home-based' care / "enhanced model of domiciliary care" which includes nursing, therapy, virtual wards, etc

- Is this predominantly a **health responsibility?** And therefore **owned by health?**
- Therefore, who owns **operational delivery**? What does that include?
- Specifically, would the **reablement team** be separate from the council reablement team? Does this impact on our **vision for integration**?

What is the right solution? We have pushed the blueprint significantly, but we can't continue any further until we answer the above questions

Funding

We have agreed this would be **jointly funded**, but we need to specify:

- What do **health and social** each bring to the table?
- What **existing funding** can we use?
- What **additional funding** can we access?
- Can we create a **dedicated single pooled fund** for integrated care / TOCH?

Do we need to add an **economic evaluation** workstream to enable these agreements?

Joint commissioning

Our Frontrunner bid included the proposal for integrated commissioning:

- What do we mean by that?
- What are our options to deliver it?
    1. **Integrated commissioning team** (Croydon previously had this model)
    2. **Temporary collaboration** for the TOCH/ICN+ supported by a Section 75
    3. Formal request for **social to commission on behalf of health**

It is the right time to answer these questions as a system to provide clarity and unblock progress

Hospital ED length of stays have risen – particularly for admitted patients

CUH's aLoS for admitted patients has steadily risen since mid 2020 - Increasing by ~80% when compared to pre-pandemic

CUH admitted patients ED LoS by month,

#, Hours, Jan '19 - Dec '22

+81%

10.6

19.2

Covid start

22
20
18
16
14
12
10
8
6
0

Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22

Note: March 2019 not included due to data quality concerns

Source: ED Dashboard from Croydon Informatics Team

NHS Croydon age UK Croydon GP Collaborative

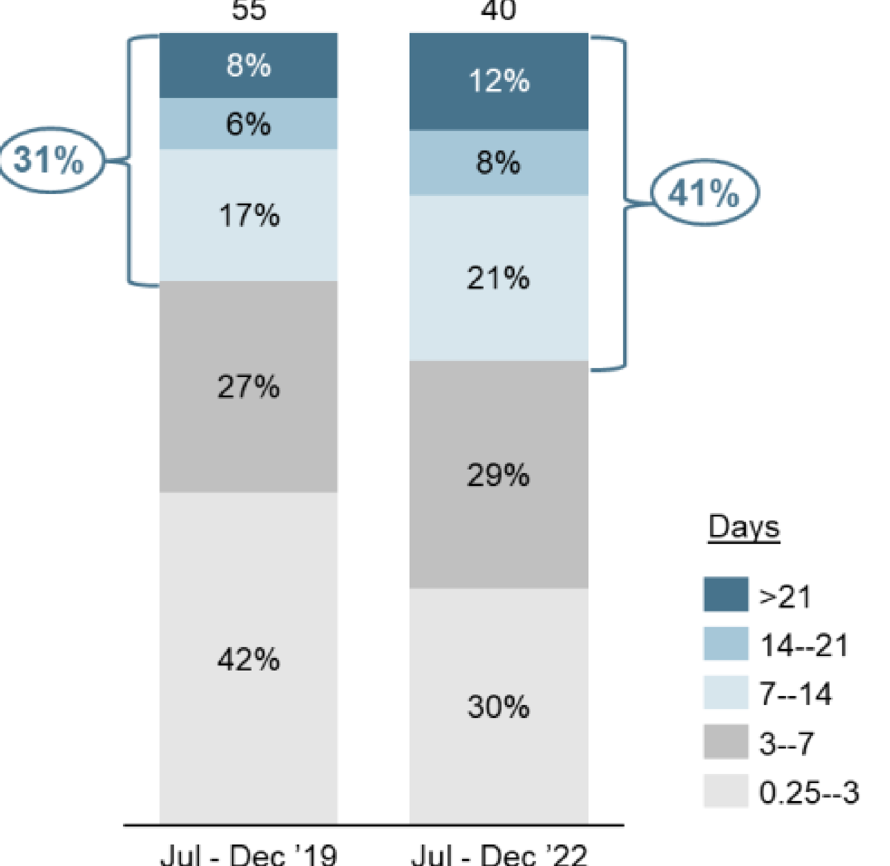
Transformation Nous

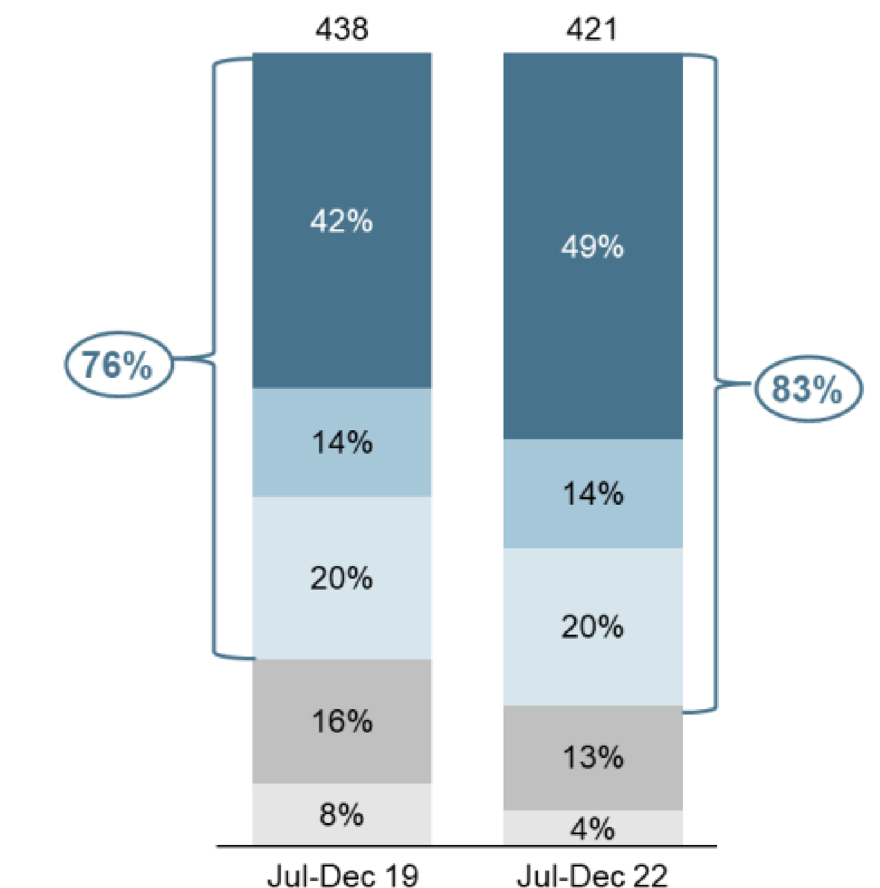
Source: Croydon ED dataset

Patients staying >7 days now occupy 82% of hospital bed days

The percentage of patients staying >7 days has increased by 12pp since 2019

These patients now occupy 85% of in-patient beds





Source: CUH inpatient dataset

*Excluding short stayers (<0.25 days), Paeds, Maternity, Elective and Dental patients, day units, ICU and Purley 3

Transformation Nous

Hospital discharge planning: There are opportunities to improve SOPs and processes

Key opportunities for improvement in supported discharge planning across the UEC pathway,

ED / AMU → Admission to medical optimisation → Medical optimisation to discharge

ED / AMU

(!) Incomplete gathering of patient information:
- Functional baseline
- Existing POCs
- Family details
- Keysafe

(!) MDT does not proactively identify issues that will delay discharge:
- Social issues (e.g., safeguarding)
- Equipment needs
- Staying put referrals
- Home assessments

Admission to medical optimisation

(!) Limited proactive engagement with family to set expectations and understand needs

(!) Duplication of tasks e.g., liaising with NOK, referrals between therapists, nurses and IDT

Medical optimisation to discharge

(!) No consistent use of agreed MO and 'therapy fit' criteria .

(!) No 'trusted assessor' model to avoid duplication of assessment & paperwork

Actions required:
- Create checklist for patient information in ED/on admission
- Create agreed MO and therapy fit definitions and criteria
- Set guidelines for NOK engagement
- Implement Trusted Assessor model

Transformation Nous

Pathway 1 supported discharges: The facts

The process for Pathway 1 is complex: involving 10 steps, 7 teams, 4 assessments and 6 decision points

Patients stay 17 days in hospital on average

27% of Pathway 1 referrals do not start – largely due to 'failed discharges' from hospital

10 Steps

7 Teams: Ward MDT, IDT, brokerage, LIFE (social workers, community reablement, therapists), domiciliary care agencies

4 Assessments: Mental Capacity Act assessment (MCA), and Parts A, B, & C Assessments

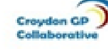
6 Decision points

27% D2A referrals do not begin reablement

17 days aLoS in-hospital for all Pathway 1 patients

39 days aLoS in-hospital for ~30% of Pathway 1 patients with MO timestamps **(20 days post-MO)**

NHS



Transformation Nous

Pathway 1

One Croydon
Your Health and Care partnership

Currently, the entire pathway 1 (LIFE) process is complex

It involves up to 6 teams, 10 steps and 4 assessment

Legend: Other service; LIFE service*; Assessment; Data source

Admit — 19 days — MO — 20 days — Discharge — 1 day — Assessment — 4 weeks — Ongoing care

Hospital aLoS: 39 days**

CERNER

- **Mental Capacity Assessment (MCA)** and **Part A assessment** done and sent by ward MDT
  - → Brokerage team
    - Restart existing POC → Refer to care agency and locality team
    - New POC → Triaged by LIFE staff, & discharges allocated to social workers**
  - No POC → Refer to voluntary support (e.g., Age UK, Red Cross)

Triaged by LIFE staff, & discharges allocated to social workers**:

- POC → **EMIS & LAS**: **Part B assessment** by duty social worker/ HWA
  - POC → Refer to domiciliary care agency; Refer to community reablement team
  - POC & therapy → Refer to community reablement team; Refer to domiciliary care agency; Refer to therapy team (**EMIS**)
  - No POC, but requires ongoing care → Financial assessment by locality team for ongoing care needs
- No POC (therapy only) → Refer to therapy team
- No POC (inappropriate for LIFE) → Refer to IDT → Financial assessment by locality team for ongoing care needs

LAS: **Part C assessment** by social worker/ HWA

Transformation Nous

Pathway 1 outcomes

Of those who start a POC, around ~30% are classified as 'fully reabled'

Average daily Pathway 1 referrals with assigned outcomes (LIFE Tracker),
#, Apr – Aug '22

Category	Value
Begin a POC	5
Deceased	0.1
Readmitted to hospital	0.8
Step up care (e.g., care home transfer, increased DOM care)	0.4
Transfer to private POC or DOM care (no change)	1.2
Step down care (e.g., reduced DOM care, family support)	0.6
Fully reabled (no ongoing POC)/ reabled	1.3
Other (e.g., declined ongoing support)	0.3

- **20%** Readmitted or deceased
- **46%** Ongoing care needs
- **18%** Stepped down
- **28%** Fully reabled

The proportion of patients who are fully reabled is likely an **under-estimate** – for instance, patients may be reabled but receive family support with ongoing care and are therefore not classified as fully reabled

Source: LIFE Tracker

Transformation Nous

The LA brokerage and placement teams currently spend 60% of their time on hospital discharge

This is 19pp more time than they should spend on discharge

Time spent by LA brokerage & placement teams on hospital discharge by role, %,

Role	Current time spent	Time that should be spent
Support Officer	65%	45%
Placement & Brokerage Officer	65%	45%
Placements & Brokerage Manager	70%	45%
Service Manager	50%	35%
Department Head	50%	35%
Average	60%	41%

-19pp

NHS Croydon age UK Croydon GP Collaborative CROYDON www.croydon.gov.uk Delivering for Croydon

* Council brokerage workforce information via Steve Hopkins

Transformation Nous

Hospital inpatient discharges have fallen by ~25% since 2019

The average number of patients discharged each day has dropped by ~25% compared to pre-pandemic

CUH average daily adult NEL discharges of inpatients by month*,
#, Jan '19 – Dec '22

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	56	59	55	57	56	58	57	56	56	55	54	53
2020	50	53	53	43	41	47	49	48	48	48	47	48
2021	49	50	51	53	51	50	50	48	48	45	46	45
2022	41	41	47	46	45	44	40	41	40	39	41	42

Jul–Dec 2019 average: 55 → Jul–Dec 2022 average: 40 (-26%)

Source: CUH inpatient dataset

*Excluding short stayers (<0.25 days), Paeds, Maternity, Elective and Dental patients, day units, ICU and Purley 3

Transformation Nous

Data Insights - Workshop 1

Workshop 1: Focused on baselining hospital operations and supported discharge pathways 1-3

Areas of focus in Workshop 1	Summary of insights
Hospital ▪ Inpatient ▪ ED	▪ **Hospital discharges are down ~25%** from pre-pandemic levels ▪ **Inpatient average length of stays have increased by ~30%** since pre-pandemic – more than other London hospitals ▪ The medical assessment model is currently not working – with average length of stays on AMU at 3 days
Supported discharge pathways ▪ P1: Reablement ▪ P2: Rehabilitation ▪ P3: 24 hour bed based care / CHC	▪ **Supported discharge pathways are complex** with multiple assessments and handovers between different teams − E.g., Pathway 1 has 7 teams, 10 steps and 4 assessments ▪ **No true D2A pathways** meaning many assessments are performed in hospital rather than in the community ▪ **Misalignment on the purpose of Pathway 1 (reablement)** between health and social colleagues ▪ **No integrated data systems** means each team has their own manual trackers with different purposes

Insights - Workshop 2

Workshop 2: Focused on community services and further discharge processes (MDT / IDT, ICN+)

Areas of focus in Workshop 2	Summary of insights
Community services ▪ Rapid Response ▪ A&E liaison ▪ ICN+ and wider community	▪ The Rapid Response team provides effective care to reduce potential acute admissions ▪ A&E Liaison only receives ~4 referrals a day ▪ The ICN+ needs to improve integration with primary care services and create joined up working with GP huddles
Further discharge processes ▪ Palliative care ▪ Brokerage/placement ▪ MDT/IDT ways of working − Integrated discharge team (IDT) − Therapy	▪ The MDT has several overarching challenges: − **Roles and responsibilities** within the MDT are unclear − Limited **early discharge planning** − **Poor communication** and recording of actions ▪ A high proportion of **therapist's time is spent on non-therapy tasks**, meaning medically optimised patients are prioritised ▪ Fast Track patients appear to be delayed in their discharge **waiting ~7 days on average for the issuance of funding** ▪ Challenges with communication and criteria understanding can lead to duplicate work for brokerage / placement teams

www.croydon.gov.uk

Collaborating with our voluntary sector

Provider	What do they currently do?	What could they do?
Red Cross (National contract)	**Facilitating discharge** ▪ Welfare checks ▪ Key cutting ▪ Provide clothes ▪ Provide access to patients' property for: equipment delivery, pest control, keysafe and Careline installation	▪ Which of these services are currently provided under Pathway 0+? ▪ How could Pathway 0+ be expanded? ▪ How can these services fit into the TOCH?
	Support after discharge ▪ Help around the home: e.g. food preparation, housework ▪ Transport: e.g. assisting with shopping, accompanying to appointments, prescription collection ▪ Keep patients in good health: e.g. medication reminder, liaising and linking users with primary and voluntary services ▪ Provide friendly company	
AGE UK Croydon (PIC & Personal Safety Project)	**Admission avoidance** ▪ Personal safety and falls prevention	
	Support after discharge ▪ Exercise groups ▪ Groups to provide company e.g. knit and natter ▪ Personal independence coordinators ▪ Advice on: social care, health, transport etc. ▪ Equipment adaptation & recommendation ▪ Ensuring people's safety at home	
Croydon Neighbourhood Care Association (CNCA)	**Support people in the community reducing risks of social isolation** ▪ Group walks ▪ Support with hearing / eye tests ▪ Organised community activities for older people ▪ Work closely with other voluntary services and can make referrals	

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LONDON BOROUGH OF CROYDON

REPORT:		**HEALTH AND SOCIAL CARE SUB-COMMITTEE**
DATE OF DECISION		**20 June 2023**
REPORT TITLE:		**Health & Social Care Sub-Committee Work Programme 2023-24**
CORPORATE DIRECTOR / DIRECTOR:		**Stephen Lawrence-Orumwense, Director of Legal Services**
LEAD OFFICER:		**Simon Trevaskis, Senior Democratic Services & Governance Officer Email: simon.trevaskis@croydon.gov.uk Telephone: Extn:27207**
LEAD MEMBER:		**Cllr Eunice O'Dame, Chair of Health and Social Care Sub-Committee**
AUTHORITY TO TAKE DECISION:		The Health & Social Care Sub-Committee is able to review and suggest updates to its work programme.
KEY DECISION?	**No**	REASON: Not applicable
CONTAINS EXEMPT INFORMATION?	**No**	**Grounds for the exemption: Not Applicable**
WARDS AFFECTED:		**ALL**

1 HEALTH & SOCIAL CARE SUB-COMMITTEE WORK PROGRAMME 2023-24

1.1 This agenda item has been included on the agenda to give the Health & Social Care Sub-Committee the opportunity to consider its work programme for the 2023/24 municipal year.

1.2 Set out in Appendix 1 is a copy of the work programme for 2023-24, which at this time, has only be provisionally planned until the next meeting. Following this meeting, further work can be undertaken to scope the areas suggested to allow the further development of the work programme.

1.3 A provisional draft of the work programme will need to be submitted to the next meeting of the Scrutiny and Overview Committee on 25 July 2023 for sign off. The reason for this is to accord with Section 6 of the Scrutiny & Overview Procedure Rules in the Council's Constitution, which specifies that the Committee is responsible for setting both its and its sub-committee's work programmes.

1.4 At its meeting on the 6 June 2023, the Scrutiny & Overview Committee set the following principles as a guide for setting work programmes in the

year ahead. The three principles are:-

1. **The Public's Money.** Scrutiny wants reassurance that taxpayers' money is put to best use. At a time when the Council is making cuts to balance the books, it has no money to waste. In the middle of a cost-of-living crisis, every pound of public money should be valued. Scrutiny will aim to look at the impact of any financial decisions on the public and the Council's finances, including knock-on effects. We will aim to research best practice and to provide suggestions as well as criticism.

2. **The Public's Services.** Scrutiny wants reassurance that services are improving. This is about leadership, culture and organisation as much as it is about budgets. We will seek reassurance that even in difficult financial circumstances, we are still meeting our duty of care to the most vulnerable. Scrutiny will listen and learn from the public's experiences of service performance to guide its work on Croydon's transformation.

3. **The Public's Voice**. Scrutiny wants to make sure that the Council is transparent, open and engaging with the people it exists to serve. Scrutiny will monitor the planned improvements in governance for Croydon's local democracy, as well as inviting public voices into the Scrutiny process itself. The Mayor was elected on a mandate to "listen to Croydon" and Scrutiny will hold the executive to account for this pledge.

1.5 From an initial discussion with the Corporate Director for Adult Social Care & Health, The Chair and Vice-Chair, were advised that the key priority areas for the service were:-

- Delivering the required savings, while making sure they did not have a detrimental impact on residents.
- Delivering the Transformation Programme.
- Preparing for the CQC Assurance process.
- Croydon Adult Safeguarding Board – Annual Report.

1.6 In the appended work programme, it is proposed that the agenda for the next meeting of the Sub-Committee in October will include the Croydon Safeguarding Adults Board Annual Report and an update on the transformation programme.

1.7 The Sub-Committee has the opportunity to discuss any other items that it wishes to may wish to add to its work programme related to either health or social care.

1.8 The Sub-Committee is able to propose changes to its work programme at any time during the year, but in line with Constitution, the final decision on any changes to any of the Committee/Sub-Committee work programmes rests with the Chairs & Vice-Chairs Group, following consultation with officers.

2 RECOMMENDATIONS

2.1 The Health and Social Care Sub-Committee is recommended:

1 Note the most draft version of its Work Programme, as presented in the report.

2 Consider whether there are any other items that should be provisionally added to the work programme for scoping as a result of the discussions held during the meeting.

3 REASONS FOR RECOMMENDATIONS

3.1 Setting a work programme provides an opportunity for the Sub-Committee to ensure it is focussed on high priority issues affecting the services provided to residents.

2. WORK PROGRAMME

2.1 The proposed work programme is attached at Appendix 1.

Additional Scrutiny Topics

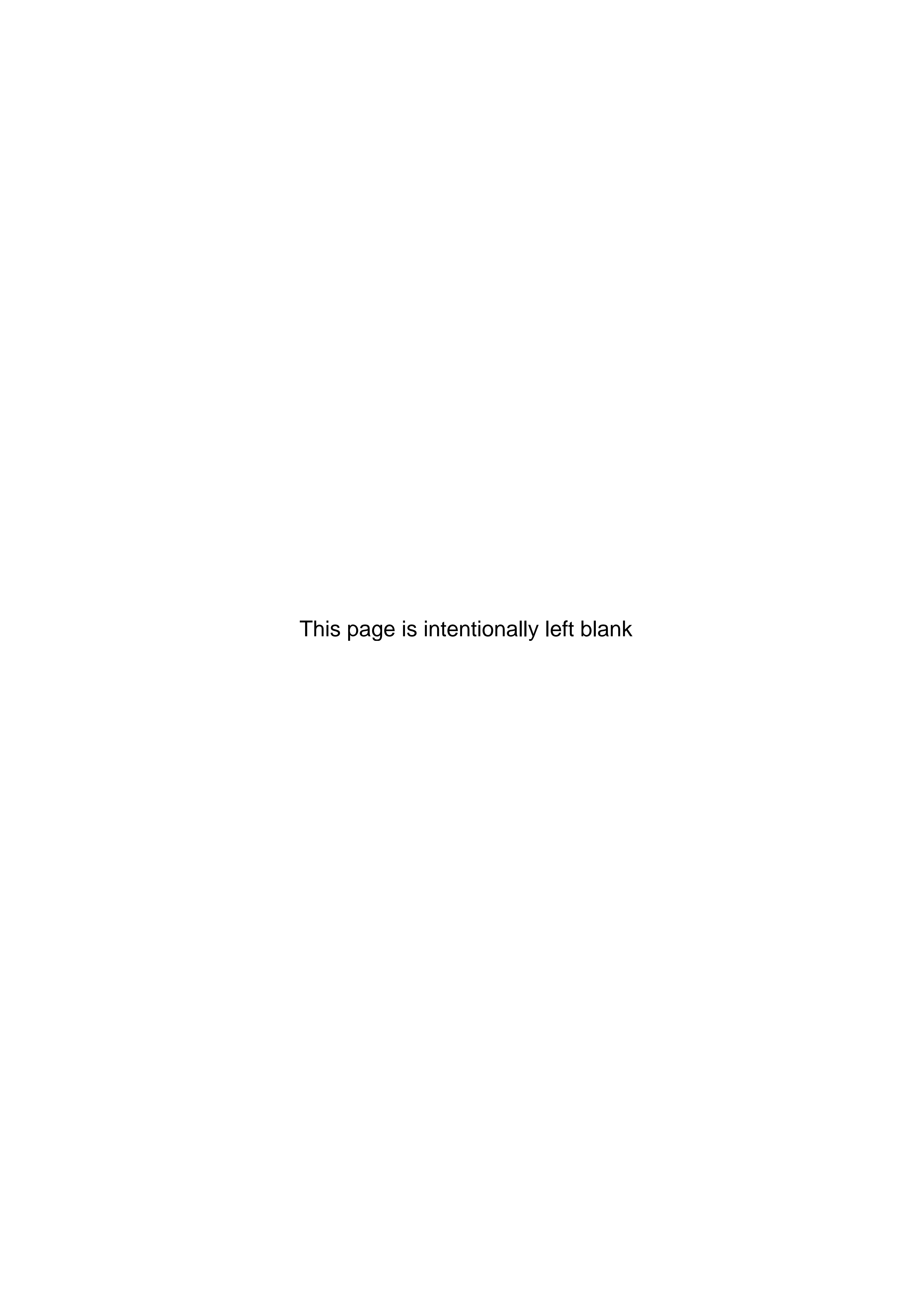
2.3 Members of the Sub-Committee are invited to suggest any other items that they consider appropriate for the Work Programme. However, due to the time limitations at Committee meetings, it is suggested that no proposed agenda contain more than two items of substantive business in order to allow effective scrutiny of items already listed.

Participation in Scrutiny

2.4 Members of the Sub-Committee are also requested to give consideration to any persons that it wishes to attend future meetings to assist in the consideration of agenda items. This may include Cabinet Members, Council or other public agency officers or representatives of relevant communities.

Appendices

APPENDIX 1: Work Programme 2023/24 for the Health & Social Care Sub-Committee**.**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Health & Social Care Sub-Committee

The below table sets out the working version of the Health & Social Care Sub-Committee work programme. The items have been scheduled following discussion with officers and may be subject to change depending on any new emerging priorities taking precedent.

Meeting Date	Item	Scope	Directorate & Lead Officer
20 June 2023	Front Runner Pilot Scheme	The Health & Social Care Sub-Committee is presented with a report on the Discharge Integration Frontrunner programme, which aims to bring together transformation efforts from across Croydon to develop an effective, integrated system across hospital, social and community care.	Adults Richard Eyre
	HSC Work Programme	To discuss areas of scrutiny for inclusion in the Sub-Committee work programme in 2023-24	
24 October 2023*	Croydon Safeguarding Adults Board – Annual Report	To review and comment upon the Croydon Safeguarding Adults Board annual report ahead of its consideration by the Mayor in Cabinet	Adult Safeguarding Denise Snow
	Transformation Update	To receive an update on the transformation of Adult Social Care.	Adults Richard Eyre
30 January 2024			

12 March 2024			

*Date may be subject to change to late September/early October.

Areas to schedule

The following items haven't been scheduled into the work programme but have been previously identified as areas of scrutiny to be scheduled during the year ahead.

Unallocated Items	Notes
A review of the cost of out of borough placements	Arising from the discussion on mental health provision in the borough
Commissioning for Community Sexual Health Services	To feed into the commissioning process of community sexual health services by the Public Health team.