One Croydon Alliance

Presentation to Adult Social Service Review Panel
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16 October 2017

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OBC Alliance Vision

'Working together to help you live the life you want'

The Alliance ambition is to shift health activity from an acute setting which is reactive in nature to proactive and preventative health and care in the community.

Our Ambition is articulated in 3 main ways:

- **Personal Outcome Improvements**
- **Improved financial sustainability**
- **Activity Shift – right place, right time**

Health and care partners are committed to an ambitious programme of innovation and change to transform the way we support the people in Croydon to be independent and healthy for longer and be able to access high quality care when necessary.

We will work holistically to use our resources wisely supported by developments in digital technology, training and development of our workforce and improved communication and engagement to communities to empowering individuals to manage their physical, psychological and social care.

Our Ambition

Personal Outcomes Improvement

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Personal Outcomes

The 5 outcome domain "I-Statements" set with us by residents of Croydon provide the centre of our shared ambition

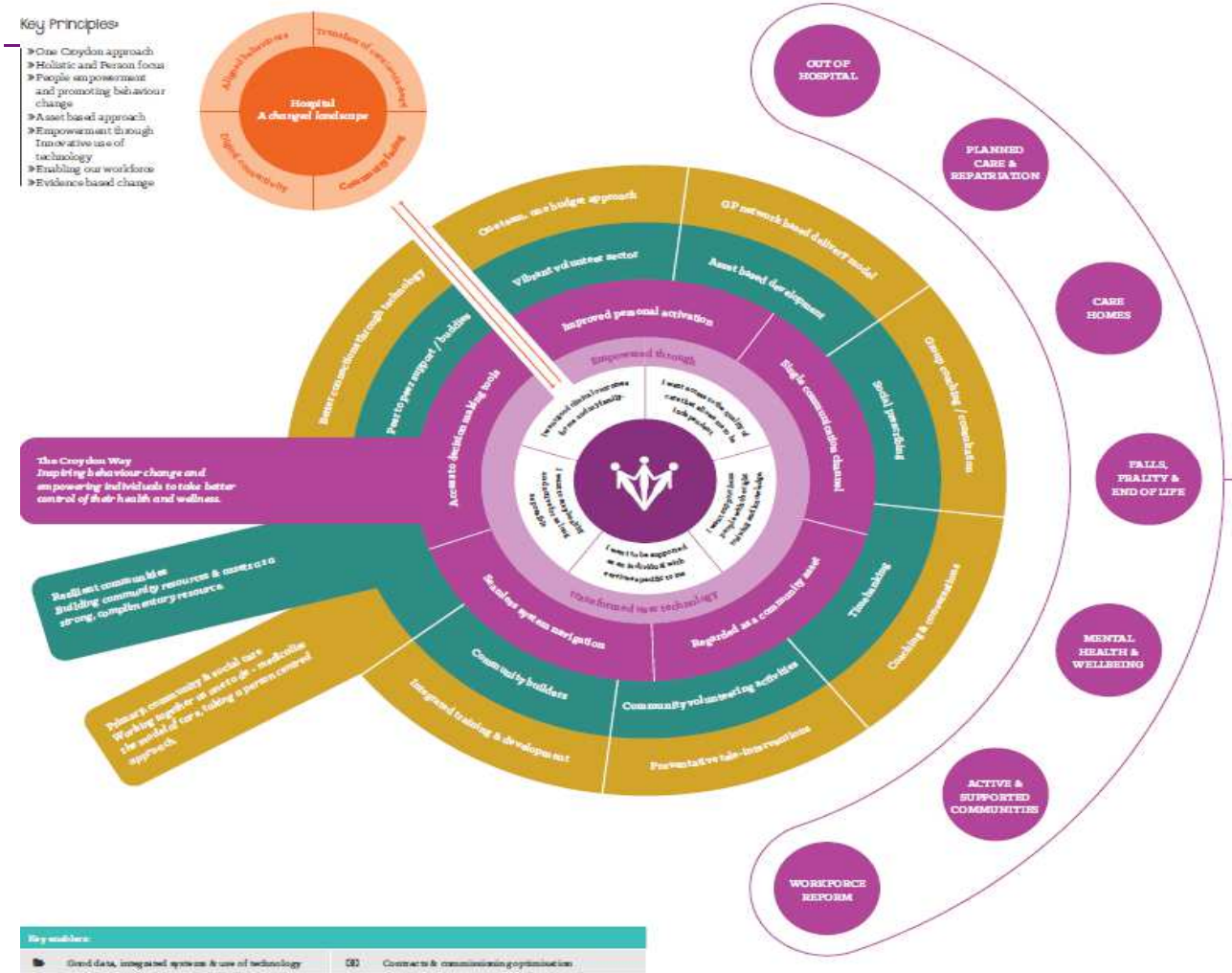
We aim to achieve the top quartile/decile status on the key outcomes as identified in the OBC outcomes framework during the term. We expect to achieve the outcomes that allows our people to achieve the best out of life.

1. I want to stay healthy and active for as long as possible	a) Injuries due to falls in people aged 65 and over b) Social care-related quality of life in people in the target population
2. I want access to the best quality care available in order to live as I choose and as independent a life as possible	a) Proportion of people who use services who have control over their daily life b) Proportion of people who use services who say that those services have made them feel safe and secure c) Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over. d) - Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.
3. I want to be helped by a team/person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me	a) Proportion of patients and carers who report that they felt those involved in treating and caring for them worked well together to give them the best possible care and support b) Proportion of patients and carers who report that they have a named health or social care professional who co-ordinates their care and support c) Proportion of people who feel that the person acting as their first point of contact understands them and their condition d) Placeholder: Health equity audit is undertaken and published on at least an annual basis, with subsequent outcome aims identified and used as target indicators
4. I want to be supported as an individual with services specific to me	a) Proportion of people who said they were involved as much as they wanted to be in decisions about their care and support b) The proportion of carers who report that they have been included or consulted in discussion about the person they care for
5. I want good clinical outcomes	a) Rate of unplanned hospitalisations per 100,000 population aged 65 and over for chronic ambulatory care sensitive conditions b) Health-related Quality of life for people aged 65 and over c) Emergency admissions of people aged 65 and over for acute conditions that should not usually require hospital admission

Year 2-10 Transformation Plan

Key Principles:

- One Croydon approach
- Holistic and Person focus
- People empowerment and promoting behaviour change
- Asset based approach
- Empowerment through Innovative use of technology
- Enabling our workforce
- Evidence based change



Key enablers:	
Good data, integrated systems & use of technology	Contracts & commissioning optimisation
Estates rationalisation	Primary care development
Stakeholder engagement & comms	Living conditions / housing
Workforce reform & organisational development	

Transformation scope & summary of key whole system changes:

Out of Hospital

Joined up proactive care in community where a person's wellbeing is managed holistically, caring for them physically, psychologically and socially.

- Development of Integrated Community Networks (ICN)
- Personal Independence Coordinators (PIC)
- Development of person centred 'My Life Plan'
- Community based points of access
- Integrated teams: Living independently for everyone (LIFE)

Planned Care & Repatriation

Delivering a holistic model of care, empowering people and promoting behaviour change.

- One website, one app
- Awareness and social marketing for both people & health/care workers
- Health coaching and lifestyle management
- Group consultation and group coaching
- Digital connectivity
- Enhanced primary care

Care Homes

A clear strategic approach to delivering holistic care to people in care homes.

- Commissioning and Pricing Strategy
- Contract Management Alignment
- Coordination of Support Services
- GP Alignment
- Technology
- Communications Strategy
- End of Life
- Shared Care Planning – Summary Care Plan
- Coordinated Workforce Development
- Pharmacy and Drug Strategy

Falls, Frailty & End of life

Promoting healthy living in over 65s: promotion, prevention and early intervention.

- Early Identification of Falls Patients
- Promoting Healthy Living in Over 65s
- Centralised and comprehensive Falls service and community bone health
- Proactive case management and Osteoporosis Advice and Management in the Community
- Medication Reviews
- Other Service Scope (e.g. Carelina, Telehealth, LAS, Counselling, Link with Care homes).

Mental Health & Wellbeing

Focus on improving quality of life, ambition and hope, not on illness and deficiency.

- Improving mental health urgent and crisis care
- Integrated delivery of care, frontline training and development
- Digital connectivity
- Transformed dementia diagnosis and holistic management
- Other areas: care homes and specialist care

Active & Supported Communities

Changing the way people consume, not just changing supply.

- Communication, engagement, information & advice
- Education & Workforce Development or Cultural Change
- Technologies
- Social Investment

Workforce Reform & OD

Enabling transformation and development of the local workforce to achieve the ambition of transformed delivery of health and care in Croydon.

- Training and development
- Role development
- Recruitment and retention
- Organisational culture and values
- Communication and engagement
- Croydon as a place to work

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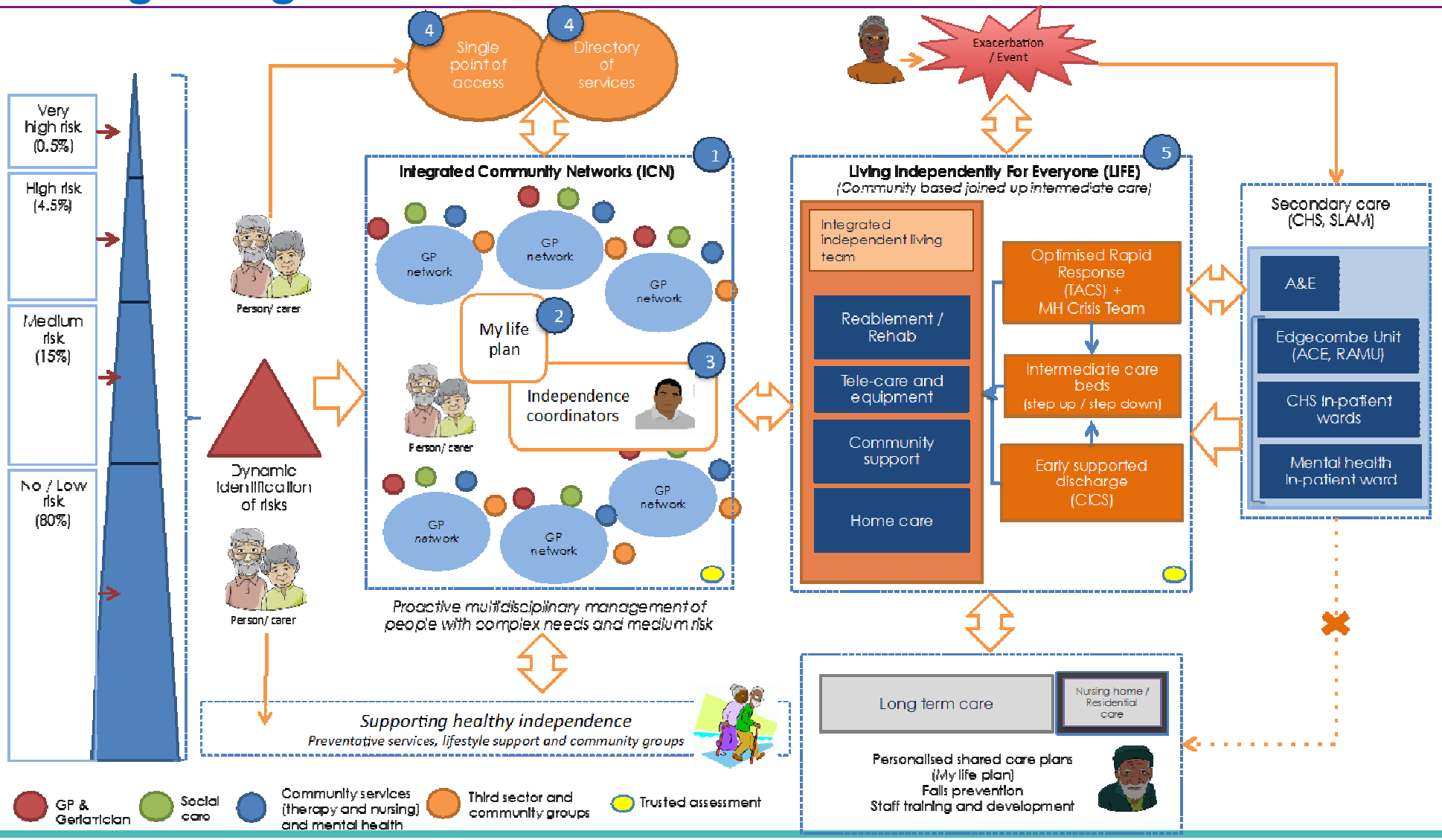
Out of Hospital

The beginning: *The New Model of Care*



Out of Hospital

Integrated Community Network Overview

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Integrated Community Network

1

Multi-Agency Working (MAW) and Huddles

1. Huddles held weekly for 30 minutes
2. Consist of Core ICN Team – GP, PIC, SCW, Community Nurse, pharmacist, VCS, & Network Facilitator.
3. Discusses, and case manages top 3 tiers of people in the Kaiser Triangle; v. complex, complex and medium risks

2

Complex Care Support Team (CCST)

1. Provides advice (9 – 5) and Case Management (one a month) of very complex people
2. Two CCST Hubs in the Croydon Network
3. Includes psychiatric nurse, frailty GP, geriatrician, community nurses.

3

Personal Independence Coordinators (PICs)

1. A member of the core ICN team, bringing together the voluntary sector and health and care organisations to support people over 55.
2. Independent of social services and the NHS, and not part of the person's family.
3. Works intensively with people with long term conditions,

Key Dependencies

Points Of Access and Information (POA&I) – prior to the start of each Huddle, a virtual or physical POA&I solution should be made both available and accessible to the Huddle and the Core ICN Team therein. Communications on the POA&I's scope and how to access should be made readily available.

My Life Plan MLP (MLP) – prior to the start of each Huddle, a MLP solution should be made both available and accessible to the Huddle and the Core ICN Team therein. Communications and training on how to access, create and update MLPs should be made readily available.

Galvanising Community Networks (GCN) – strengthening the formal and informal social networks, by encouraging the voluntary and community organisations who are commissioned to provide preventative services to Croydon residents to work together to find new ways of developing services and/or activities that meet the growing and changing needs of a diverse population within each of the ICNs

6. Transition Workstream Update

6.2.1 Y1 Transformation Delivery - ICNs

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WORKSTREAM STATUS SUMMARY	Executive Lead: John Chan	Workstream Lead: Rachel Soni

a) Progress Against Plan

RAG:

The overall ICN programme is Green. The Re-sequenced & Accelerated Multi-Agency Working (MAW) & Huddle Delivery Plan was created and agreed in August 2017. Delivery of this plan within the timelines will realise financial savings as indicated in the agreed Business Case. 8 Huddles have now implemented with another 4 scheduled week commencing 16th October, and each subsequent week thereafter. Pilot evaluation completed. Carrying out activities to reaffirm Organisational Development (OD) and operational best practice with the Core ICN Teams and the ICN PMO, via GP Network, Practice and workforce meetings. POA and Complex support work is progressing well but slightly behind schedule.

Deliverable/Milestone Status & Progress Summary

MILESTONE	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
MAW & Huddles: GP Comms, Facilities, & Tech Audit	4th						
MAW & Huddles – Implementation **START**		2nd					
MAW & Huddles – Implementation **ENDS**							5th
Complex Care Support Team (CCST) – Model Requirements	13th						
Complex Care Support Team – Detailed Design						28th	
My Life Plan (MLP) – Implementation	11th						
PICs – Recruitment Ends					15th		
Points of Access & Information					22nd		
POA&I – Mayday and Thornton Heath Implementation		30th					
Active & Supportive Communities – Detailed design	4th						

1. **Re-sequenced and Accelerated implementation plan agreed - savings and investment tracking plan developed**
2. **ICN & Huddle roll-out proof-of-concept evaluation & readiness assessment complete and reported with ongoing work on patient feedback with Healthwatch. Included IT and facilities audit – completed.**
3. **IT and facilities Requirements and Business Case Completed, 25/08 and 26/09 respectively. Sent to CSU for CSU Project Support and costing 27/09**
4. **PIC's Recruitment – 1 PIC Service Manager engaged, ex front line PIC. 6 PIC' (Inc. 1 backfill PIC) & 1 support worker recruited. AgeUK Croydon's continuing recruitment advert for the remaining 6 PICs for January 2018.**
5. **Network Facilitators Recruitment – 3 recruited (now totalling 4). Continuing recruitment advert for the remaining 2 Network Facilitators for January 2018**
6. **CN pharmacists – 3 people recruited starting late Nov '17. Additional 3 to start Jan '18**
7. **Community Nurses recruitment - successfully completed**
8. **CCSS - modelling & referral process re-work meetings taking place with specialist teams**
9. **Active and Supportive Communities engagement with voluntary and community sector ongoing**

b) Decisions, Interdependencies, Risks & Issues

1. Decision/ Discussion/Noting required by Programme Delivery Board (PDB)

None required.

2. Workstream interdependencies:

a) **IT and Facilities requirements in place in time to support delivery of huddles**

b) **All core huddle staff member recruited and in place in time for huddle rollout**

3. Risks to the critical path of this Workstream:

a) **Technology & Facilities - There is a risk that the Practice meeting rooms may not meet the minimum requirements to facilitate face-to-face and remote Huddles . | Mitigation: the project team has completed an audit of the practices. Business case to be prepared for additional equipment. Workaround : Core ICN Team to continue to have face-to-face meeting and working from hard copy worksheets.**

b) **There is a risk that the Huddles may not be fully resourced by the ICN Core Team. | Mitigation: Network Facilitators to be supported in the interim by OBC PMO. Medical Optimisation Team to support face-to-face in Mayday ICN & support by Best Endeavours until fully resourced in November 2017.**

4. Issues impacting critical path of this Workstream:

a. **There is a Issue that that the reviewed and agreed IG documents between the GP Collaborative, practices & the Alliance will not be in place before the launch of the huddle rollout. | Mitigation: CSU IG specialist has advised that the explicit patient consent on who data is being shared with is appropriate as a work around if all info & legal documents are not in place. IG Documents currently in review by Legal Department for compliance, prior to distribution to practices for sign off.**

b. **There is an issue that the Point of Access and Information hub for Mayday and Thornton Heath Networks and the** Active & Supportive Communities detailed design solution **will not be in place until March. | Mitigation: Meeting held on 28/09. Discussed proposed process and model re: six Locally Trusted Organisations (LTOs) aligned to each of the networks. The design will include how the physical points of access will support LTOs. Develop the LTOs to a certain standard. Define the development role, agree standards and costs. This is a key enabler workstream for ICNs, so new plan timescales need to be met.**

Out of Hospital

Living Independently for Everyone - LIFE Overview

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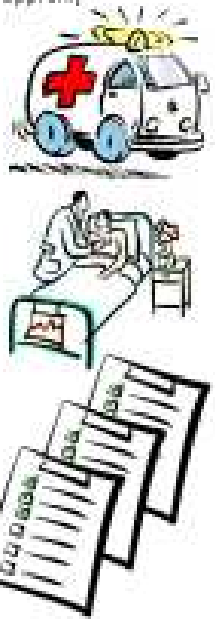
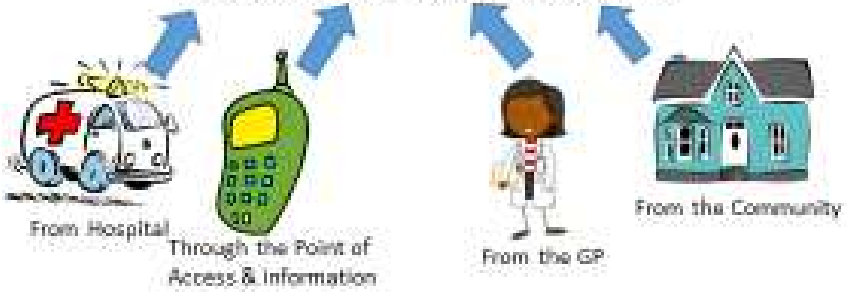
'As Is':

- Limited referral pathways;
- High hospital admissions (non-elective);
- High use of bed days;
- Delayed discharge;
- Multiple assessment and referral points (case studies suggest up to 20)
- Large domiciliary care packages which are not always reviewed (overall cost of £13m approx.)



- **'One Name, One Budget, One Team':** A team providing intermediate care and reablement services plus other reintegration support to the over 65s of Croydon;
- **One core eligibility criteria:** to 'unblock' pathways and minimise assessments and referrals;
- **All services working to the same key outcomes;**
- **Making sure the correct services are being used most efficiently**
- **Creating more opportunities for client outreach**

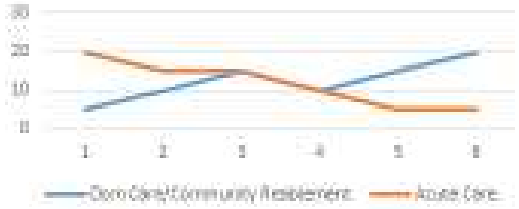
Multiple points of entry (examples below)



'To Be':

- Decrease in non-elective hospital admissions;
- Decrease in bed days;
- Increase in smaller domiciliary care packages; (increase in larger) and community reablement
- Increase in wider community interventions;
- A cultural change around the need for domiciliary care;
- A sustainable single system;
- Increased range of entry pathways;
- Unblocking of community and environmental barriers

Changing the Profile of Acute and Community Care



Best case saving of 15.00 bed days (approx.) and 44 beds by year 10*

*Figures from MoC overarching document

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6. Transition Workstream Update

6.2.2 Y1 Transformation Delivery - LIFE

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WORKSTREAM STATUS SUMMARY	Executive Lead: John Chan	Workstream Lead: Rachel Soni

a) Progress Against Plan

RAG:	Workstream Green 60% completed. Discharge to assess started on 3 wards on 25/09/17. 21 referrals have successfully been supported within 2 hours of discharge Roll out plan being developed

Deliverable/Milestone Status & Progress Summary

MILESTONE	AUG	SEPT	OCT	NOV	DEC
Community Reablement	1st				
Reablement Procurement North		25th			
Service/Process Mapping		5th			
LIFE Team recruitment				16th	
Single Assessment Form		5th			
Single Accommodation for LIFE team			1st	1st	
Telehealth, Telecare and equipment Business Case		30th			
OT Review		1st			
Staff consultation			13th		
Performance and Savings Tracker	14th				
D2A pilot three wards		25th			
D2A full rollout (April)					

1. Part B assessment completed 100%
2. Reablement Procurement North – 100% (monitoring dashboard still to be developed)
3. OT review to start October
4. Telehealth, Telecare review competed
5. Agreed banding for the joint LIFE manager, advert out 16th October
6. 5 health and wellbeing post advertised, 1 admin 16th October

b) Decisions, Interdependencies, Risks & Issues

1. Decision/ Discussion/Noting required by Programme Delivery Board (PDB)

a) PDB are asked to note the updated LIFE Implementation Plan [see slide 7]
b) Lack of project support, due to recruitment of a Change Manager

2. Workstream interdependencies:

a) IT and Facilities - Lennard Road has been identified as the LIFE office however staff needed to be moved to make space for LIFE Team. Develop Mobilisation plan. Planned move 1st November
b) Staff consultation requires sign off from the Transforming Out of Hospital delivery group
c) Service baseline to be agreed

3. Risks to the critical path of this Workstream:

a) Technology and facilities - the service will have to use both AIS and EMIS double entry) recruiting an admin person to upload the health assessments on AIS.
b) Allocations and understanding demand
c) Roles of the staff still to be defined
d) Delay with the staff consultation, due to agreement over staff weekend working
e) Health & Well being Assessors recruitment
f) That the Community Reablement Service, when located with the LIFE service, will lose it's preventative focus and instead be used to take on more people upon discharge from hospital
g) Social workers accessing equipment

4. Issues impacting critical path of this Workstream:

a) IT – accessibility to WIFI and internet at Lennard Road, may delay staff co-location specifically for Croydon Council staff

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Out of Hospital

Discharge to Assess (D2A) Pathways

LIFE Services are playing a key role the delivery of D2A

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D2A Model

Hospital Discharge (Pathways)

1

People who require no further input. Further needs can be met at individuals home setting

- Advice and Information needed
- Equipment telecare / telehealth needed

2

People will return home with Reablement / Intermediate care

- Intermediate care beds or step down beds — Up to 6 weeks
- Reablement/ LIFE team — Up to 6 weeks

3

People with complex care needs which may need continuing care, Step down beds
Residential nursing Care, including specialist placements

Complex situations / CHC Long term

Escalation

People with complex needs difficult to place within funding allocation
Could include; Clients with no access to funding, Homeless, Out of area

Escalation for Bespoke solution or leverage

Funding Sources

Self Fund / Self Care at home	LA Funded home care	LA Funded or Health	LA Funded & Health	CHC Funded Care or LA Funded care/ assessment for self funding or combination	Can be unclear/ undefined

SAFER Bundle

Scope of LIFE Services
£1.2m for reduced LoS

Pathway 3 in development

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6. Transition Workstream Update

6.2.2a Y1 Transformation Delivery – LIFE: Update Implementation Plan

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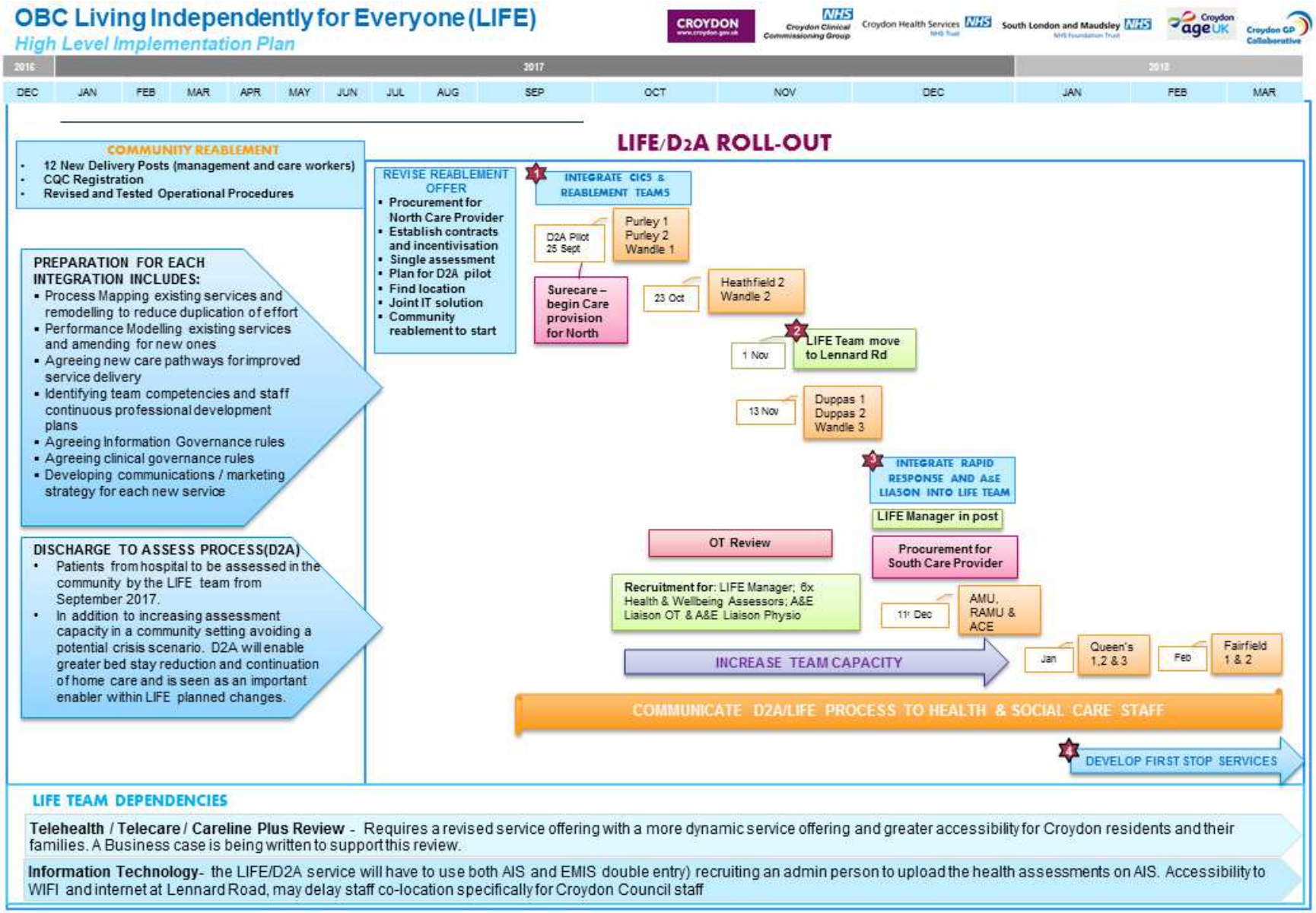
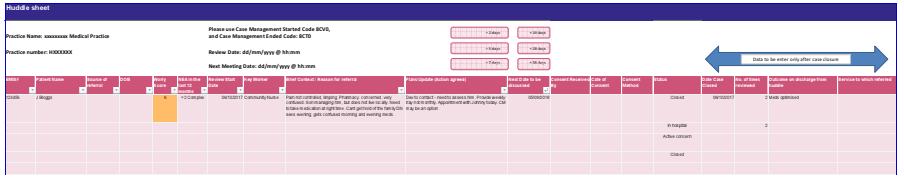


Snapshots of the trackers being rolled out for performance and activity tracking

Huddles activities and outcomes trackers

		ICN Core Team Attendance (if more than 1 member of a discipline attends, only enter the number 1)												
Wk	Huddle Date enter dd/mm/yyyy	Total Cases	GP:	Community Nurse:	Social Worker:	PIC:	Pharmacist:	Network Facilitator:	Total	Percentage Attendance	Admission Avoided	New Cases	F/U Cases	Cases Closed	Cases Open
1	06/10/2017	1	1	1	1	1	1	1	6	100%		1	0	1	0
2	13/10/2017	0	1	1	1	1	1	0	6	100%		0	0	0	0
3	20/10/2017	0							0	0%		0	0	0	0
4	28/11/2017	0							0	0%		0	0	0	0
5	05/12/2017	0							0	0%		0	0	0	0



LIFE activities and outcomes trackers

Client - identification & channel							Activities			Savings drivers - Reduced Activities			
							LIFE	Rapid Response	A& E Liaison				
Service User ID	AIS number	NHS Number	Age	Source of referral Community/ CICS/Rapid/A&E+Q1:Y 1	GP Practise	Discharge to Assess	Episode Start Date	Diagnosis 1	Date of referral	Package reduction (No. of Hours/week)	Admissions avoided	Prevention going to Res /Nursing	Early Discharge
	2244954			Community									

Huddles Performance monitoring tracker

		Activities			Outcomes -Monthly guidances			
Practise	Network	Huddles per month (1 Huddle -30 minutes)	Cases monthly	Persons supported monthly	No cases reviewed monthly	No. of admissions avoided	No. of new cases	Huddles person who appear for NE Admissions
Brigstock and South Norwood Partnership	Mayday	4	32.8	10.8		7	26	
Eversley Medical Centre	Mayday	4	32.8	10.8		5	16	
London Road Medical Practice	Mayday	4	32.8	10.8		2	9	

Person journey tracker – cuts across LIFE & ICN

Client identification													Sources of referral		Gateways of Care	Pathways /Services		
Identifiers						Age & Demographics			Health			Social Care						
Service User ID	AIS number	ICD /Reed code	Network	GP Practise	NHS Number	Age	Gender	Network Location	Long Term condition	Risk Level	No. of hospital admissions /year	SALT codes	Level 1	Level 2		Team	Level 1	Level 2

Comments, Suggestions and Questions