A&E WINTER PLAN: CROYDON CCG UPDATE

INTRODUCTION

The attached checklist document provides information on the state of readiness that the Croydon system is currently at, in preparation for the coming winter. This document was originally submitted in September 2017 via the CCG to NHSE but produced in collaboration with key partners. The checklist continues to be updated as we approach the winter period so that all ambers are converted to green. The checklist by its nature contains a large number of technical terms and therefore a glossary is provided at Appendix One.

SURGE ARRANGEMENTS

Additionally "surge" processes exist to ensure that peaks in activity are managed across the system as follows:

1. Daily surge calls take place which include representation from the Trust, the CCG and its Commissioning Support Unit and over winter will include SLaM, LAS and the Local Authority.

2. There is also a Director on call during OOHs that can be contacted either by the Trust, NHSE or other agencies that can deal with any surge issues that occur during that time.

3. Any surge issues identified at the morning calls or requests from the Trust at any other time, can be dealt with as follows:

    a. Reducing Pressure at the Front Door: A media and marketing programme has been in place encouraging patients to "phone before you go" and contact 111. The CCG (as part of SWL) has funded a GP based at 111 who can give clinical advice to callers. In addition, 111 can direct patients who do not need to go to A&E to more appropriate services such as the GP Hubs, Rapid Response (RRT) team and the Roving GP service. LAS also operate a "see & treat service", a Croydon dedicated Motor Cycle (MRU) unit, and have an ACP to direct refer into the GP Hubs.

    b. Notification of Support to Surgeries: At times of surge, GPs are notified of the Alternative Care Pathways and services. In addition, services in the "LIFE" programme are notified to do additional support which will include Rapid Response Team, Roving GP and reablement teams.

    c. Reducing Pressure at the Back Door: Discharge to Assess pathways in place. Continuing Healthcare Care, social care and voluntary sector support to help reduce the level of issues that can prevent or delay discharges especially for complex care patients. Liaison through the Commissioning Support Unit surge hub if required, to help with out of borough Delayed Transfers of Care and patients needing Repatriation.

TRAINING

1. There will also be a whole system training session for key personnel, on the winter plans and preparation to ensure that all departments are fully prepared going into this period

A&E Delivery Board 217/18 Winter Readiness Checklist

A&E Delivery Board (AEDB) name: Croydon AEDB

Name and contact details to where initial queries regarding this return should be directed: Rachael Colley Rachael.colley@croydonccg.nhs.uk

Please confirm that this submission has been agreed jointly (electronically is acceptable) by the membership of the AEDB…Yes……..

Individual/s signing off the return on behalf of the AEDB…Stephen Warren & Jayne Black……

This checklist is intended to support AEDBs with winter readiness and planning for 2017/18 winter period - 1 October 2017 to Easter 2018 - as outlined in the winter planning letter. Please return this checklist by 8 September 2017, to england.london-winterhub@nhs.net

	Readiness Checklist Area	A&E Delivery Board commentary to support readiness assessment	RAG rating based on current status	RAG rating based on status by 1 Nov
1	**Wider System Preparation**			
1.1	• Please assess your current compliance with the embedding of good practice on patient flow across the organisations within your AEDB – provide an update on current plan to improve this where necessary, and your expected status by winter	Trajectory in the AEDB demonstrates how the top 11 solutions will help achieve the 4 hour target and maintain good patient flow. Further pages demonstrate the collaboration between all providers. The governance for the AEDB is included in the AEDB plan.		

	2017/18			
1.2	• Please outline the processes in place to receive weather related warning information (Met Office alerts / NHS England daily winter briefings) and the actions taken as a result to consider the likely impact on activity levels and mitigating activities (e.g. hot clinics, reduced electives, increased speciality staffing etc)	CHS plan for adverse weather conditions and include these within the Operational Resilience plans attached. CCG get updates on Monday and Friday from the Met Office. Croydon Resilience and EPR Team also provide local intelligence around weather. On a Friday the CCG receive the London Resilience briefing for the coming week including weather updates. All these documents are received by CHS.		
1.3	• Please confirm you have updated the Directory of Services and MiDoS are up to date with the most appropriate services especially those services providing alternative care pathways to support the London Ambulance Service crews	NEL CSU London DoS Team working on South London liaise closely with the CCGs to ensure appropriate services are profiled for NHS 111/ IUC referrals. HLP has funded a full time person to work on the Directory of Services in relation to healthcare professional access (via MIDOS) Services are added for HCP access. We also contact services periodically to ensure service/referral details are correct. All services are contacted before every public holiday and we liaise directly with NHS England for independent contractors (pharmacies opticians and dentist). An audit trail is kept to ensure all services are validated. CCGs across SWL are kept informed of the validation process through the monthly DoS reports. Services in addition, third party applications such as the patient website My Health London. We also carry out scenario testing to ensure that all pathways mapped within the DoS are returning appropriately for IUC/NHS111. This testing is carried out following every NHS Pathways upgrade (which usually occurs in June and December each year) The NEL London DoS Team has been based at the LAS Clinical Hub (CHUB) in Bow and Waterloo every Thursday since January 2017 to increase usage of MiDoS. The use of MiDoS allows the LAS CHUB to locate suitable services that can accept a referral from LAS, rather than sending the patient to A&E. The usage has increased rapidly over the past few months, on average 900 hits a month. Going into winter this will increase as MiDoS is rolled out to crews to support reduction in conveyances to A&E.		

1.4	• Please assess your ability across organisations within the AEDB to access Mental Health crisis Plans, GP Care Plans, End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services across the Emergency Department (ED) and Urgent Care Centre (UCC)	The LA currently has limited access to any of the Health systems recording databases. Social Services staff currently uses a separate case recording system of their own. The issue of information sharing across the whole system is being reviewed as part of the Croydon Alliance arrangements. In the interim local communication and processes are well embedded, ensuring information is shared in a timely and responsive manner. MH patient records cannot be accessed but there is a 24/7 PLN team that can be contacted for information, advice and support. CMC for those patients that a record has been uploaded for is available.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
2	**NHS 111 / primary care**			
2.1	• Is the AEDB assured that there are robust plans for GP OOH providers to deal with known activity peaks in demand across the winter period?	Workforce is reviewed weekly and adjusted according to demand. OOH - Assurance is through the contractual meetings, Integrated Urgent Care (IUC) Clinical Quality Review Group, IUC Contract meetings and submissions to HLP. These meetings provide assurance in managing capacity and demand activity peaks. Monthly contract and CQRG meetings assure performance of the provider and the clinical quality of the service and contribute to the on-going redesign of the service to meet the new IUC specification.		
2.2	• **Primary Care Access (100% coverage 7 day 8am-8pm)** • What is the current and projected coverage of extended access to primary care in evenings and weekends? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if	Currently we have three GP Hubs providing same day appointments for urgent primary care problems. This service is open between the hours of 08:00 and 20:00 pm, 7 day a week which meets national specifications. These hubs are located at: • Central Croydon • Purley • Parkway (New Addington) In addition, we have under development three further top-up hubs which will be located at:		

	planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	• Shirley area, Croydon • Thornton Heath • Mayday They will provide extended access to routine GP appointments with pre-bookable access, extending the time of availability or routine primary care services to 8-8pm Monday – Friday. In the first phase of the pilot there will be Saturday morning opening too. Additional weekend opening will be trialled as the pilot develops to determine demand/need around existing services. The hub in the Shirley area will be based at Shirley Medical Centre and will be open by early December 2017. The Thornton Heath Hub is still in development and the start date for this site is still to be confirmed but there is an expectation that this will open before the end of this year. The proposed hub in Mayday is under discussion and at a similar stage as Thornton Heath. All three top-up hubs will provide 8-8pm Monday-Friday and some provision will be made for Saturdays. At present Sunday opening is being discussed and will implemented as soon as possible.		
2.3	• **111 Capacity (51% threshold)** • What is the current and projected percentage of 111 calls with clinical contact? • What plans are in place to ensure performance to deliver the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall*	We currently meet 30% of 111 calls with clinical contact. We have piloted a GP in the contact centre to manage "star lines" along with the rest of London since Jan17. This has now been agreed as Business as Usual and will be funded for a further year. This additional clinical capacity alongside our enhanced pathways for young, elderly and vulnerable patients, and Low-Acuity Ambulance and A&E re-triage will ensure that patients requiring contact with a clinician will have access to the right clinical skillset to meet their needs. We will reach the 51% target by the end of 17/18 by continuing to support care homes and ambulance crews through the star lines into the GP in the CAS and by moving from c.65% re-triage of Low-Acuity ambulances to 85%. As at Oct, this is now at 77.7%. We plan to run a GP in the Clinical Assessment Service (CAS) and Mental Health Warm Transfers for the rest of the year and we will focus the additional senior clinician capacity on callers from care homes, complex and elderly patients and children, particularly where there		

	below the threshold	is a suspicion of sepsis.		
2.4	• Does NHS 111 have access to Mental Health crisis Plans, GP Care Plans and End of Life Care plans and to extended patient data either through the Summary Care Record or local care record sharing services?	NHS 111 has access to summary care records via adastra and EoLC plans via Coordinate my Care and SPNs. Plans are underway but at this stage there are still technical, operational and governance barriers. We will continue to work with software vendors and HLP to deliver this functionality when it becomes widely available. NHS111 will be able to send patients to the UCC but it is unlikely that booking fully operational		
2.5	• Can NHS 111 book into UCCs?	NHS 111 cannot book into UCCs. They can send via DoS – the receiving UCC will usually receive an nhs.net email from 111. There is an expectation that once the IT issues have been resolved then the ability to book directly into the UCCs will be available – HLP are currently working on this issue		
2.6	• Can NHS 111 book into primary care?	NHS 111 can book into OOH services across SWL but not into extended access hubs or primary care in hours. Plans are underway with pilot practices in a number of areas supported by the continuation of GP in the CAS. Practices will come online as and when a software vendor and HLP expertise become available to support us. A pilot for booking is expected to go live in Dec 17 in some practices with roll out following.		
2.7	• What are the AEDB's plans to seamlessly route electronic prescriptions from NHS 111 and GP out of hours to pharmacies via the Electronic Prescription Service (EPS)?	We are developing a SWL approach and the expectation is that EPS will be in place in place by Nov 2017.		
2.8	• What are the AEDB's plans to develop and test new specialist modules of clinical triage through NHS 111 for paediatrics, mental health and frailty?	We run modified pathways for paediatrics, mental health crisis, patients over the age of 85 and any patient with an end of life or care plan.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			

3	**Care home support:**			
3.1	• Please assess your AEDB's compliance against the British Geriatrics Society Guide on Care Home Medicine	A Joint policy was ratified in July 2017 between LA and CCG around medication management and administration in domicillary care settings.		
3.2	• Please outline the AEDB's risks around care home capacity this winter e.g. closures, plans to open or commission new care home beds	Current capacity will be reviewed. New block contract arrangements reablement and CICs beds are being commissioned and the added resilience is the OBC alliance programme No plans for any homes to be closed or to close in the borough.		
3.3	• Are there any CQC issues affecting care homes in the AEDB's geography e.g. self-embargos, local authority embargos?	There are around 18 care homes in Croydon who are rated as requires improvement. However at present there is no suspension on new services/placements with any care home in Croydon.		
3.4	• How many care homes in the AEDB's geography are receiving support from your quality and safety team?	We have around 150 care homes in Croydon. At any one time we are speaking to around 20-30 of them in quality discussions between quality monitoring, commissioning and safeguarding as well as the CCG. At present 6 are in a Provider Concerns process. The Care Support Team works with 15-20 care homes at any time.		
3.5	• Is there sufficient therapy and specialist nursing capacity in the community to offer in reach support to care homes in AEDB's geography?	There are specialist nursing and therapies available to visit care homes including CICS & Rapid Response. The care homes are able to make direct referrals to the Rapid Response Service 24hrs per day 7 days per week. Currently there is sufficient capacity to meet the demands on this service.		
3.6	• Please confirm you are providing the *567 access to a GP through NHS 111 for care homes and crews. Please confirm what marketing you have provided to care homes on the service offer available	The CCG provides regular notification to the care homes via emails regarding the *567 access. The next one will be sent on Friday, 24th November. From the data supplied on the monthly Care Home LAS activity reports generated by LAS, we are able to target those care homes and the managers to discuss reasons behind their high usage. This helps to ensure that the issues are dealt with quickly. Care Home managers are also encouraged to attend the Care Home steering group to discuss issues with a view to solving problems. The purple guide which is a training guide for care home staff is being updated to reflect the		

		*567 access numbers and latest developments around care homes. There is an expectation that the updated version will be circulated prior to the end of the year.		
3.7	• Is there a tele-health service to reduce 999 calls and ED attendance? Please provide explanatory commentary	There is currently limited provision of telehealth on a case managed basis for individual patients with Chronic disease (COPD, HF). Limited provision within some selected care homes. However this is set to expand within the ICN and the LIFE initiatives. In respect of Adult Social Care, the Council operates a Tele Care and care Line system which helps reduce unnecessary ED attendance and maximise people's independence and their ability to remain in their own homes.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
4	**Front Door**			
4.1	• Is the AEDB assured that the acute provider has a rapid assessment service in place? If so, is the rapid assessment service aligned with social care? • How has the AEDB ensured that there is a clear process for primary care referrals (including OOH) to acute specialities to bypass ED? • What alternatives to immediate referrals are available, including 'hot' clinics?	CHS have a variety of Rapid Assessment Areas: • ACE • RAMU • SAU • GAU • PAU Ambulatory clinics run alongside a variety of specialty hot clinics. GP referral directly to AMU, ACE and RAMU are well established, including LAS referrals directly to RAMU which came on line May 2017. In the community, Rapid Response provides an admission avoidance service with access to the Consultant Geriatrician, the Roving GP and Step-Up beds.		
4.2	• How is the AEDB ensuring that EDs have sufficient clinical input from surgical and clinical specialties? • Does the ED have access to Records (EOL/GP Care Plans / Mental Health)	CHS have produced an updated Streaming and Re—Direction policy that will support patients being re-directed to other services within the CUCA system. Going forward being able to book directly to Primary Care services will be dependent on IT intra-operability. The IT issues are being looked into by HLP and there are no timings available when this will be resolved. MH patient records cannot be accessed but there is a 24/7 PLN team that can be contacted		

	• Are there plans in place for winter for UCCs and EDs to book into primary care?	for information, advice and support. CMC for those patients that a record has been uploaded for is available.		
4.3	• What actions are in hand or planned to ensure that LAS handover delays are reduced to a minimum?	We use an escalation process to avoid delays in handovers, this alongside direct referral to RAMU for those appropriate patients reduces hand over delays. Some LAS delays are due to the temporary location of the ED which results in delay from arrival of LAS into the hospital grounds to arrival in the department. This is being reviewed as part of the LAS AEDB Sub Group.		
4.4	**Streaming (50% threshold)** • What is the current and projected trajectory for percentage of patients streamed at the front door? • What plans are in place to ensure that streaming performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	All patients are streamed on arrival. There is a KPI within the CUCA contract that stipulates % of patients' walk-in/any mode of arrival are to be streamed to UCC. This is monitored in the monthly CUCA CMG meeting. A SOP has been developed to support streaming and re-direction of patients away from the ED into UCC or GP Hubs		
4.5	**Ambulatory Care** • What proportion of patients presenting at the ED are for ambulatory care sensitive conditions? • What plans are in place to increase service provision for these patients?	We are currently achieving 24% of patients converted to an ambulatory pathway and whilst not achieving the required 33% we are on an improving trajectory. There is an expectation the new Streaming and Re-Direction policy (see 4.2) will help to deliver the trajectory. The provision is being extended from Q3 to support increasing hours of service at weekends		
	Is additional support required in this area? If so please specify the nature			

	of, and where, support is needed			
5	**Mental Health**			
5.1	• Is the AEDB assured that there is a 24/7 liaison psychiatry service available. Does the service include a consultant psychiatrist?	There is a 24 hour Liaison Psychiatry team based in CUH, Woodecote House, the team consists of 5 nurses with 4 vacancies, 1 team administrator 1 team leader, 1 consultant psychiatrist with 1 vacancy and 4 junior doctors. There is an on-call core trainee Doctor covering CUH based at the Bethlem site out of hours. The team also have access to a Specialist Registrar and Consultant on call out of hours. With increased investment as part of NHSE Core24 funding we will be recruiting into 12 month fixed term posts, to date the following posts are filled: • 0.2wte Consultant MHOA Liaison Psychiatrist Croydon University Hospital • 1.0wte b7 MHOA Specialist Psychiatric Liaison Nurse Croydon University Hospital • 0.5wte Consultant Liaison Psychiatrist King's College Hospital Pending Recruitment by the end of 2017: • 0.6wte Consultant Liaison Psychiatrist • 0.6wte Psychologist • 1.0wte Occupational Therapist • 2.0wte b6 Psychiatric Liaison Nurse		
5.2	• What training/competencies do staff, including doctors have against the Mental Health Act and the Mental Health Act Code of Practice? Have the upcoming (Autumn) MHA legislation changes been considered?	All staff are required to attend mandatory training including MHA and MCA training yearly. Doctors are required to renew their section 12 / Approved Clinician status on 5 yearly basis. The team have a dedicated MHA and MCA Lead.		
5.3	• Is the AEDB assured that the provider is compliant with NICE guidance on short-term management and prevention of recurrence of self-harm?	An initial informal audit had identified a need for consistency in this area. The team leader has met and recently reminded all staff of the NICE Guidelines for the short term management of self-harm and ensured that psychosocial assessments were in place for every attendance. We are currently re-auditing to ensure adherence to this with the		

		results presented to the SRG when complete.		
5.4	• To support the timely delivery of care for individuals detained under s136 and requiring physical health input has consideration be given to a parallel and concurrent mental health assessment and treatment by medical staff?	The team follow the key principles of the PAN London Section 136 pathway. People subject to Section 136 attending for medical treatment are discussed with the MHLT to ensure parallel working protocols are adhered to. If there is a need for prolonged medical treatment the MHAA can be completed by the MHLT both in and out of hours.		
5.5	• In line with the pan-London s136 pathway, what protocols are in place for patients arriving under s136? Are these protocols recognised by the police and ambulance service?	The team follow the PAN London sec 136 pathway – this will be added to the operational policy for CUH currently in draft for ratification and the Health Based Place of Safety operational procedures		
5.6	• What arrangements are in place between the acute and mental health trust to ensure robust clinical pathways and reduce the number of patient transfers between sites?	There is a Mental Health Act Service Level Agreement in progress for CUH. SLAM also follow the medical fitness for transfer protocol where each CUH patient is assessed as medically fit for transfer to a MH bed before transfer and this is documented in EPJs by a SLAM Doctor. There is currently no formal protocol for the transfer of patients to CUH from the Bethlem site in place. It is accepted that when a patient is admitted to CUH from the Bethlem that the SLAM transfer of patients policy be adhered to : **Transfer of a Service User to Another Hospital/Unit/Service** *All transfers should be well planned with the service users and carers being given adequate and timely information as to why the transfer is taking place. There also needs to be good communication between the Trust and the receiving hospital/unit, with photocopies of the relevant records being provided and a formal documented handover of care between the Trust and receiving service.*		
5.7	• What area is provided for patients to wait in until transport for admission to a psychiatric service or other follow-up action is arranged?	Assessment room in ED is available for patients waiting for admission when not in use for assessments. If this option is not available patients will wait in the general ED area.		
5.8	• What arrangements are in place	LAS are currently reviewing the monthly high callers to their service and working with GPs,		

	with the community and ambulance service to reduce the number of frequent attenders?	acute providers and MH colleagues to implement care plans where appropriate to support community support. There are ACP in place for LAS to RAMU and to GP Hubs. There are plans to develop an ACP for LAS to Rapid Response and the Roving GP service. There is a National CQUIN to reduce the number of attendances and bed days to CUH. This is jointly owned by SLAM and the acute trust. A frequent attender's forum is being facilitated and is designed to include all clinicians involved in the persons care and can include, but not exclusively, CUH, community staff, LAS and Local Authority staff. The forum is designed to ensure robust safety and recovery plans are in place alongside onward referrals if appropriate. We have achieved Q1 and are on track for Q2. Frequent callers are managed through an integrated process involving a multi-disciplinary group that meet monthly. This group includes representatives from the LAS, Croydon Hospital, Community Health Services, Social Care, MPS and Mental Health teams. It looks to review identified frequent callers and frequent attenders to ED and put in place appropriate care plans that are visible to all agencies in order to appropriately manage a reduction in attendance.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
6	**Flow**			
6.1	• What is the current status on the implementation of the SAFER Patient Flow Bundle • Implementing SAFER reduces stranded patient numbers and reduces deconditioning that results from prolonged hospital stays. If not implementation is not 100%, please describe the plans to drive full implementation,	CHS have provided a number of implementation weeks, and is currently promoting SORT to support a consistent approach to ward rounds. EDD's are being promoted by using mixed media and we are seeing an improvement across the Trust. We monitor our compliance monthly and have a programme of work to improve the application of SAFER.		

	including AEDB oversight.			
6.2	• How is the AEDB area monitoring and managing 'stranded patients'? • Are you making use of 'mini-MADE' (Multi-agency discharge events) early when stranded patient numbers rise, rather than as an urgent measure during escalation. It is essential to identify the number of stranded patient that should trigger the mini-MADE • Please describe the local arrangements which address this	Weekly reviews of all inpatients, escalation within the trust preceding system wide escalation. Weekly review of all DTOC's and shared across social and health providers to minimise length of stay. Reviewed monthly at AEDB within the Dashboard and monthly reports shared with CCG and Social services colleagues. As from the end of October, "stranded patient numbers" are being reported daily as part of the morning surge call.		
6.3	• Is the AEDB assured that the trust has a Full Capacity Protocol (FCP) in place? • If it does not, please confirm that this is either because the trust has sufficient capacity available not to require one, or, that the trust wards have been surveyed and judged unsuitable to support the use of a FCP. • If this is the case, please articulate the trusts plan to manage a crowded ED safely, without recourse to an ED redirect or closure *NB The use of FCPs is supported by the Royal College, but their use should be kept to an absolute minimum, and they must be*	CHS escalation policy and Operational Resilience shared and support de-escalation. To be reviewed at AEDB		

	introduced with suitable governance, in a planned manner.			
6.4	• If there were 12 hour trolley breaches within your AEDB geography last year, what were the causes, and what actions have been put in place to prevent them occurring this year?	Only 1 recorded, lessons learnt regarding Mental Health support and place of safety		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
7	**Capacity**			
7.1	**Bed Occupancy (92% threshold)** • What is the current and projected non-elective bed occupancy? • What plans are in place to ensure performance is within the threshold level? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation*	**Please refer to Appendix 2 – Bed audit/ occupancy exercise**		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
8	**Discharge**			

8.1	• Describe the current status of implementing the Eight High Impact Changes for Managing Transfers of Care locally across your AEDB	The 8 High Impact Changes Steering Group is leading on the implementation of the 8 High impact changes. The next big milestone is the rollout of the Discharge to Assess model developed for Croydon. A detailed status report is embedded below. Discharge to Assess pilot to has been in place for 4 weeks and has had 40 patients through the D2A(2) pathway. Starting work on the D2A(3) pathway before end of December 2017		
8.2	• Has the AEDB modelled discharge capacity (workforce, beds, equipment, funding) to ensure that health and social care can meet daily demand, including variation, across the whole of winter? • Please provide supporting narrative regarding any gaps or issues which are of concern and where further work is required, including timescales for completion	Bed modelling has been completed by CHS and submitted to NHSE this alongside the winter planning to support operational resilience gives assurance plans are in place. The draft winter plan takes into account staffing, demand and capacity. Croydon Council have highlighted the risk regarding market forces and the impact on placement and care package provision within AEDB and mitigation is being prepared to support the system over the winter period		
8.3	• How many additional home-care packages have been commissioned to support 'discharge to assess'. Systems that have done this find that Continuing Health Care (CHC) delays and social care delayed transfers of care (DToCs) are reduced. This additional capacity can be realised before winter and	From September 2017, a six-week pilot will be introduced at Croydon Health Services NHS Foundation Trust to test the local Discharge to Assess (Home First) process in three hospital wards (Purley 1 & 2 and Wandle) with the expectation of a full rollout by March 2018. The Council has commissioned 38,000 hours for D2A homecare packages, which will double by the end of the year. This will reduce social care delays for care packages. Work looking at the Discharge to Assess for Pathway 3 will start October 2017. Currently 15-20% of the CHC assessments are done in CHS.		

	used for surge			
8.4	• In previous winters, acute trusts have reported difficulties in discharging patients because non acute providers cannot provide the level of care that the acuity of the patients demand. Has this been an issue for your AEDB area? If so, what action has been taken to provide additional services to non-acute care settings, in order for them to be able to support acutely unwell, but medically fit patients?	Several steps have taken place to prepare for any challenges due to reduced discharge profiles: Out of Hospital transformation with D2A and increased intermediate care provision will be implemented during September and October 2017 to prepare for increased winter demands. Integrated working with Health and Social care to support our complex patients who cross funding barriers support innovative approaches and joint care provision to support the patient pathway. Acute trust has escalation routes to partner organisations to address any key issues. Increase support for admission avoidance for those who can be cared for in the community Rapid Response, ICT, Reablement and step up/down bed provision		
8.5	• What work has been undertaken to promote maximising earlier in the day discharges? • Do you have targets for the numbers of patients to be discharged before 9/ 10am? • Are they being achieved, how is this monitored, who at board level is responsible?	This work stream is within our Right Patient, Right Bed programme of work chaired by the Medical Director and we have already seen a reduction in LOS from April to June of 0.6 days and whilst our discharges before 13:00 are still recorded at an average of 15% we acknowledge in real terms this is often the recording of the discharge on EPR rather than real time when a patient leaves the ward. We have recently implemented SORT which is impacting our discharge profile operationally and we anticipate seeing this within our data over the next month's monitoring		
8.6	• Is a 'placement without prejudice' process in place? *This ensures that when a patient has been identified as potentially requiring CHC, he/she is discharged to an appropriate environment out of hospital while the assessment and decision is made. A local agreement should exist between the CCG and Local Authority specifying which party will initially pay for the care or*	Funding without prejudice will be taken on a case by case basis as in previous years.		

	placement. If CHC is agreed, the costs should be met by the CCG backdated to the date of discharge.			
8.7	• Are plans in place to use the trusted assessor guide, designed to support hospitals, primary and community care and local councils deliver trusted assessment as a key part of the High Impact Change Model described in Chapter 2 of *the Five Year Forward View Next Steps*?	The trusted assessors used to support the discharge to assess model are compliant with the guide. Pilot Sept 2017 Roll-Out October 2017 Working with Respiratory colleagues in their Facilitated Discharge initiative also.		
8.8	• What specific trusted assessments are happening in the AEDB geography? • Does the Local Authority have trusted assessor models of working? If so, what kind? • Does your CHC team follow a trusted assessor model? • Does the AEDB have plans in place for non-prejudice funding agreements with the Local Authority for patients not eligible for CHC but do have health needs. For example: patient with grade four pressure sore	The local Authority and Croydon University Hospital have created a trusted assessor model. A single trusted assessment has been created for people going through Pathway 2 D2A. The short assessment takes place in hospital. A full functional assessment takes place in the community, which follow the trusted assessor model. Funding without prejudice will be taken on a case by case basis as in previous years.		
8.9	• What specific work is being undertaken to support capacity at the end of the festive period? • Please outline current work with internal teams around re-ablement and external teams re community support / social services etc., so that options are	The LA requires its staff to work consistently across the festive period and is currently engaging with staff in respect of extended working hours under new models of delivery (LIFE). Staff will be deployed equitably to ensure an even spread across peak times. At times of pressure, staff will be deployed to cover different parts of the service to ensure social services are fully responsive to support pressures in the whole system.		

	not exhausted straight after the return after the New Year, increasing the risk of long ED delays, ambulance handover delays and 12 hour breaches.			
8.10	**Medically Optimised (3% threshold)** • What is the current and projected MOs performance during winter? • What plans are in place to ensure that the percentage of patients that remain within the threshold level? • Do you have sufficient community therapy and domiciliary care capacity to manage the medically optimised patients who are discharged form hospital sooner? • Please provide justification if planned trajectory is below threshold levels *N.B. this metric will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	The trust is predicting a MO of 2% over the winter period; our current average is 1.5%. We are confident that with the implementation of D2A from October, the winter effect will not increase the MO beyond the 3% threshold The Plan is to introduce a new service called The LIFE Service (Living Independently for Everyone). The service will be an integrated community based single team of staff drawn from across reablement, rehabilitation, intermediate care, health and social care professionals, clinicians and colleagues from related community organisations within the 3rd Sector. The new service will start in October and will work on a home-first principle, but will incorporate bedded facilities for people who cannot be safely care for at home, but do not require acute hospital care. Extra investment has been given to the service to staff nurses, physiotherapists, occupational therapists, health and wellbeing assessors and reablement workers		
8.11	**Continuing Health Care (threshold 75% by end Oct-17, 85% by end Jan-18)** • What is the current and planned trajectory for CHC assessments taking place outside of an acute setting? What plans are in place to ensure performance is within	Croydon CCG has assessed their position regarding the numbers of CHC assessments outside of the acute setting. Our current trajectory is 75-80% of all CHC assessments are taking place outside of the acute setting. We are currently working with our acute colleagues to develop plans to increase this number by reviewing existing pathways and processes and to ensure that over 80% are completed during the winter months outside of the acute setting.		

	this threshold level? • What plans in place to ensure that the 80% threshold of CHC assessments taking place within 28 days during winter is met? • Please provide justification if planned trajectory is below threshold levels • How will the AEDB assist acute trusts with choice issues related to CHC placements and care offers? • How will the AEDB work with the Local Authority to ensure residential home patients are regularly reviewed to ensure cross over from residential to nursing care is seamless to avoid admissions for re-banding to Funded Nursing Care or CHC *N.B. CHC assessments will be monitored daily/weekly depending on AEDB categorisation. Recovery plans will be requested should performance fall below the threshold*	Within the Discharge Policy choice is included, and the brokerage team also support and enable families to make informed decisions regarding making the appropriate decision for their relative. The CCG is currently working with all stakeholders including our LA colleagues to ensure that processes are in place to ensure that there is a seamless transfer from FNC to CHC.		
8.12	**DTOCs** • What plans are in place to ensure performance is aligned with the expectations set out in London DTOC Expectations – Winter 2017/18 (Appendix 4)? • Please provide justification if planned trajectory is below threshold levels	We have reviewed our processes and implemented a weekly review of all inpatients and DTOC review with our Social Services colleagues. This has led to an increase in the % of DTOC as we have a complete picture and transparency across providers. The implementation of D2A provides the assurance we will achieve 3.5% consistently from October. DTOC are currently 4.1% and this is felt to be due to improved reporting of the process. This is part of the 8-HICs programme and is under review to ensure DTOCs are reduced to under the 3.5% national target.		

	N.B. this metric will be monitored daily/weekly depending on Delivery Board categorisation. Recovery plans will be requested should performance fall below the threshold			
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
9	**Public Health including managing flu and Infection control**			
9.1	• Is the AEDB assured that public health and prevention measures are a comprehensive part of system-wide winter resilience plans which include all providers? This should include the local plans for responding to Influenza or Influenza-like illnesses	The CCG has a flu planning task and finish group, which includes representatives from public health and other key providers that is convened during the summer months to review performance and key lessons from the preceding year and to update the system-wide plan accordingly. The group then meets regularly (at least monthly) throughout the seasonal influenza period to review progress against the system-wide plan and monitor local flu surveillance data and necessary actions that may need to be put in place if early indicators suggest an outbreak, either isolated or more widespread.		
9.2	• Is the AEDB assured that local leadership from public health commissioners and providers are involved as part of winter resilience planning? *N.B. The main commissioners are Local Authorities and NHSE for certain immunisation programmes. In partnership with Local Authorities, London Pharmacies are offering influenza vaccines to LA Care Home staff to build resilience in these care*	Croydon's system wide flu planning group includes public health commissioning representatives and plans are underway to update their flu vaccination plans for front line social workers in light of the uncertainty regarding uptake during 2016/17.		

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<td>homes and hopefully affect delayed discharges.
Providers include general practice and pharmacy.</td>
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Does the AEDB have assurance around compliance with hand washing levels in trusts?
What is the target level and what is your achievement of that to date?
What is being done pre-winter to re-enforce the messages around good infection control?

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Hand Hygiene is audited on a monthly basis and both our CCG and PHE attend our monthly ICC meetings where our compliance is monitored. Please see table below demonstrating our training compliance.

There is a rolling programme of Infection Control measures and prevention promotion and increased vigilance is supported with trust wide promotion as we plan for winter
<table>
<tr><th></th><th>Nurse/ midwife</th><th>Doctor</th><th>Therapist</th><th>HCA/ Phlebotomist</th><th>Student</th><th>Non Clinical Staff</th></tr>
<tr><td>June 2017</td><td>95%</td><td>88%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>July 2017</td><td>95%</td><td>77%</td><td>100%</td><td>100%</td><td>92%</td><td>100%</td></tr>
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Is there a comprehensive local flu strategy in place?
Is the AEDB assured that plans are in place for the delivery of seasonal flu immunisation across all population groups and that monitoring of these plans will be part of your routine reporting?
Do those plans include the at risk groups in your population?
Are plans in place to routinely review and act on the PHE weekly flu surveillance reports in order to understand the indicators on flu in circulation amongst the population as well as support the

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<td>The Croydon-wide System-wide flu plan is in the process of being updated to include an enhanced focus on flu surveillance.</td>
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	management of the health and care system?			
9.5	• How is the AEDB using data from the sepsis CQUIN, the PHE Fingertips AMR dashboard and RX-Info to assure itself that all patients are receiving effective 3 day antibiotic reviews?			
9.6	• Is the AEDB assured that the targets for staff immunisation will be exceeded? How will this form part of your routine reporting? It is important that this includes all providers of NHS Services across acute, community, mental health and primary care. • Did organisations meet their targets for staff vaccination rates last year? • Is your staff vaccination rate target sufficiently stretching? • If targets were not met, what is the strategy to do better this year? • How will this be monitored?	CHS is our main provider of acute and community services achieved a target of 78% by January 2017. They have submitted their flu plan for 2017/18 and are on track to achieve the national target for this year. SLAM is our main Mental Health Trust (MHT) and provider of our MH services and had the lowest flu performance across all London's MHTs during 2016/17. We have requested details of their plans and are awaiting their response.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
10	**Workforce**			
10.1	• What review of workforce plans has been undertaken within the winter planning process? How has this been overlaid to fragile services, including identification of	We continually review our workforce and manage the mitigation as business as usual. Wider system workforce planning acknowledges the concerns regarding community care provision and this has been highlighted within AEDB. CHS is looking at the skill mix and other AHPs (Pharmacists, Paramedic Practitioners, ENPs		

	key operational/staffing gaps via profession/service/speciality and plans to address and the confidence levels of this within the winter timeframe?	and ANPs)		
10.2	• Has an impact assessment and risk mitigation of Brexit been undertaken and how this plays into winter and operational plans?	We have considered Brexit and will prepare this for winter 18-19 when we believe the impact will be realised		
10.3	• Is the AEDB assured that the Trust holding firm on agency use and caps across all workforce groups, in particular medics, and staying within authorised frameworks – how is this being assured over the winter period?	CHS shares its workforce overview with CCG colleagues including vacancy factors, agency usage.		
10.4	• Describe the wider links to Flu planning and exception planning in terms of workforce and impacts and risk management associated with this including outstanding risks	CHS had successful workforce vaccination plans in 2016/17 and intend to roll these forward for 2017/18. During 2016/17, the Local Authority came across different interpretations within teams as to what constitutes a front line social care worker and what was the uptake of the vaccination within this cohort. Therefore action is underway to update their plans for front line social workers in light of the above. Awaiting confirmation of actions SLAM have planned for 2017/18 for their workforce. CHS has a flu plan and includes workforce absence within its operational resilience planning		
10.5	• Have you identified any high risk workforce issues? What are these and what is the impact of not mitigating? Are they being addressed and managed within the trust or do they depend on a wider solution across STP/speciality etc?	Currently working with NHSI to review our nursing workforce requirements including risk assessments		

10.6	• Are your trust plans on workforce risk assessment and mitigations going to Trust Board for review and when is this scheduled for? Are these plans drawn together by clinical, medical and speciality managers and senior staff working in an integrated way to provide assurance across all services?	This is a continual process and these are submitted every 6 months to the Trust Board		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
11	**Escalation arrangements**			
11.1	• Is the AEDB assured that the Trust has remedied and tested escalation arrangements internally and with system partners if there were issues last year?	These have been tested a number of times over the previous 12 months both in Major alerts and due to demand management triggers		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
12	**Business continuity**			
12.1	• Have business continuity plans been reviewed recently, in particular, regarding those elements geared to coping with cold weather? • Do all parts of the organisation know what to do in the event of receiving cold weather alerts? • Does the trust have adequate	CHS reviews all BCP annually Yes CHS is prepared and plans in advance for adverse weather both in summer and winter. Yes our estates and facilities team provide Salt/Grit and maintain all exits and entrances when required		

	stocks of salt and grit, and is it assured regarding the BC arrangements of its suppliers?			
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
13	**Communications**			
13.1	• Has the AEDB reviewed the communications plans used last year, both internally with staff, but also externally with patients and partners, to ensure that it remains up to date and fit for purpose? • Does the plan focus on high risk groups and attendance avoidance best practice through self-care, pharmacy and NHS 111? • Have you made any changes as a result of learning?	Communications plan is currently under review with recognition that a system wide plan needs to be implemented and supported by all organisations within the AEDB, whilst aligning to the national comms strategy.		
	Is additional support required in this area? If so please specify the nature of, and where, support is needed			
14	**Summary Statement**			
14.1	Please provide a summary statement regarding your AEDB preparations for winter, demonstrating (if not clearly captured above) the lessons learned from last winter and where you have actioned these.	Please find the acute trusts draft winter plan and operational resilience report which both include the overarching AEDB winter planning		
Overall RAG status				

NB. Assurance of ambulance service planning will be undertaken once across London by the Ambulance Commissioners in NW London and results shared with Delivery Boards

Appendix One

GLOSSARY OF TERMS

ACE - Acute Care of the Elderly
ACP – Alternative/Approved Care Pathway
BCP – Business Continuity Plan
CHC – Continual Health Care
CHS – Croydon Hospital Service
COPD - Chronic Obstructive Pulmonary Disease
CQUIN – Commissioning for Quality and Innovation
CUCA – Croydon Urgent Care Alliance
CUH – Croydon University Hospital
DoC – Director on Call
DoS – Directory of Services
DTOC – Delayed transfer of care
D2A(2) – Discharge to Assess (Pathway 2)
EPR Team – Emergency Planning, Resilience
EPS - Electronic Prescription Service
GAU - Gynaecology Assessment Unit
HCP – Health Care Professional
HF – Heart Failure
HICs – High Impact Changes
HLP – Healthy London Partnership
IUC – Integrated Urgent Care
LA – Local Authority
LAS – London Ambulance Service
LIFE – Living Independently For Everyone
MCA – Mental Capacity Act
MHA – Mental Health Act
MHOA - Mental Health Older Adult
NELCSU – North East London Commissioning Support Unit
OOH – Out of Hours

PAU - Paediatric Assessment Unit
PLN - Psychiatric Liaison Nurse
RAMU - Rapid Assessment Medical Unit .
UCC – Urgent Care Centre
SAU - Surgical Assessment Unit
SLAM – South London and Maudsley
Wte - Whole time equivalent