

Frontrunner Transformation Programme

Update – June 2023

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

- 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)

Diverse population, with a high level of deprivation

52%

made up of non-white residents

40%

are in the "Core20" population

This population has a 6 year lower health life expectancy

12.6

Care home beds per 100 people aged 75+

Highest rate in London

3065

Care home beds

Highest number in London

Croydon
~400,000
residents

Page 3

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

One Croydon Alliance

Health and Care Board

Local authority

SLaM





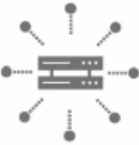
Health Services

Age UK

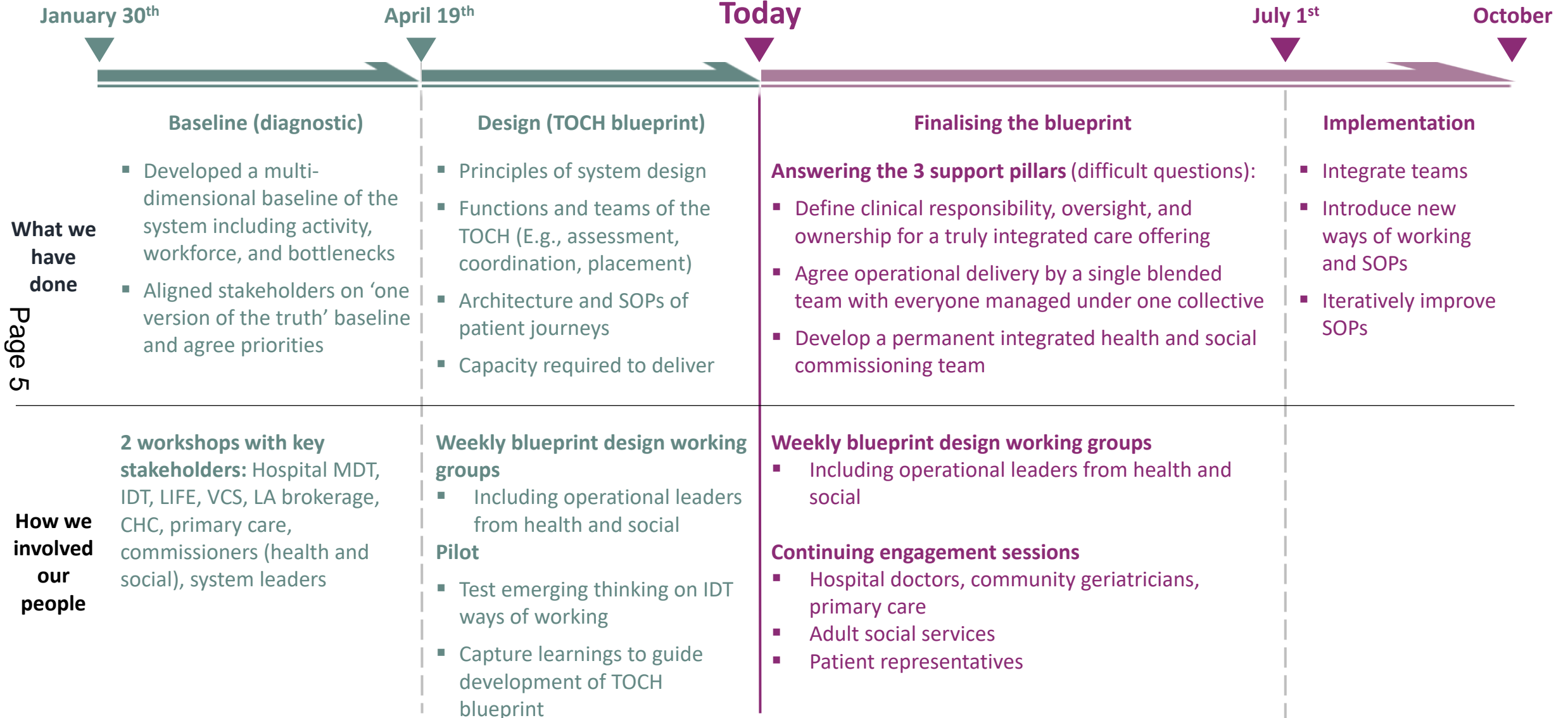
GP collaborative

Other providers e.g.
care homes, GP,
private sector, VCS

- 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

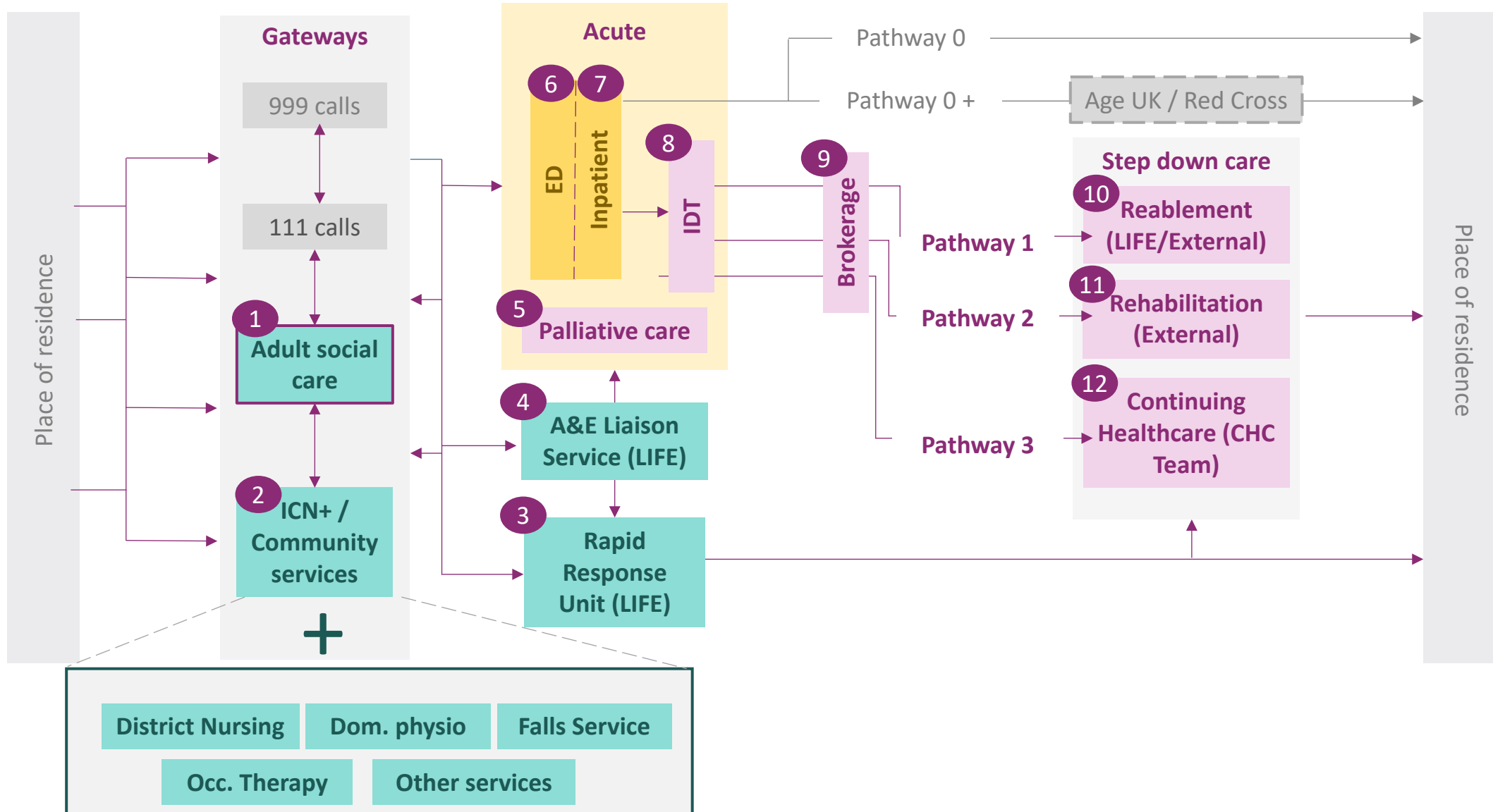
Areas	Objectives
 <p>How do we deliver integrated care, including best architecture for our discharge process?</p>	<ul style="list-style-type: none"> ▪ Simplify processes and SOPs and minimise steps to transfer of care ▪ Establish a true single point of access for hospital discharges and community step-ups ▪ Offer Discharge to Assess as default for all patients
 <p>What integration / team structure / workforce?</p>	<ul style="list-style-type: none"> ▪ Deliver a truly integrated discharge team ▪ Introduce blended roles ▪ Define the workforce and skill mix required
 <p>How can we maximise the impact of the 'Croydon pound'?</p>	<ul style="list-style-type: none"> ▪ 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
 <p>How do we achieve alignment and coordination?</p>	<ul style="list-style-type: none"> ▪ 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
 <p>How can we optimise data capture and information flow?</p>	<ul style="list-style-type: none"> ▪ 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



Page 5

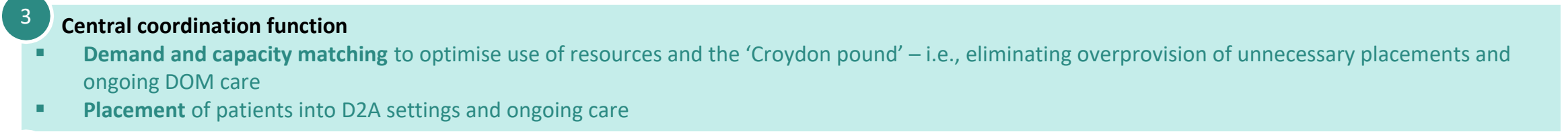
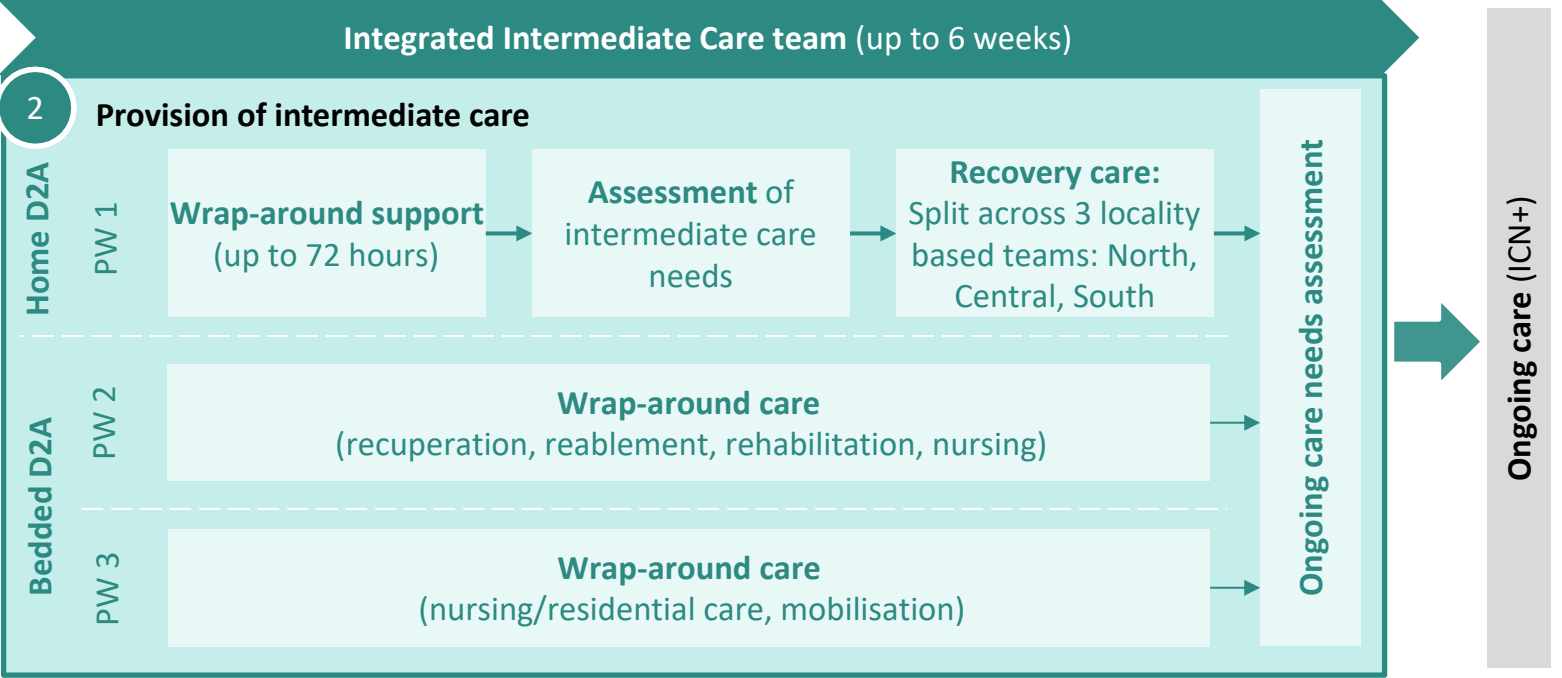
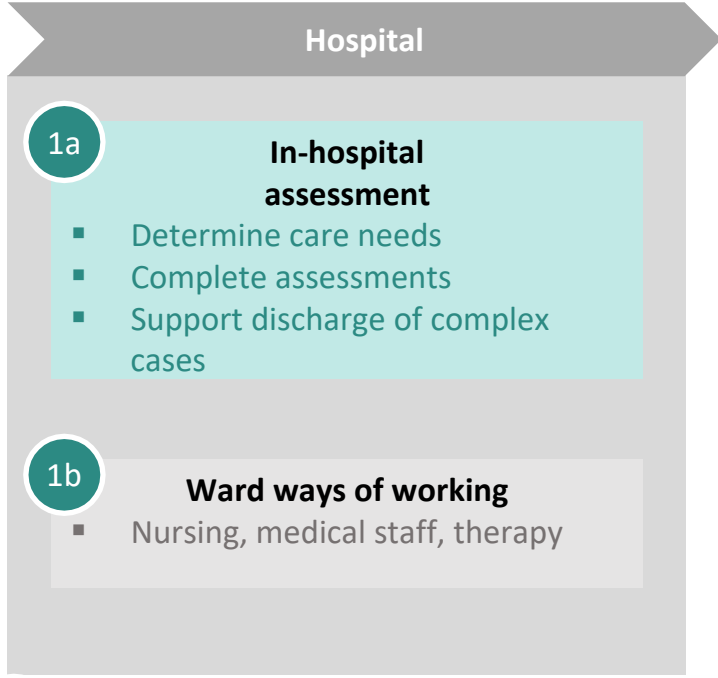
We have created a comprehensive baseline of our system



TOCH =

Overview of current ambition

Page 7



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

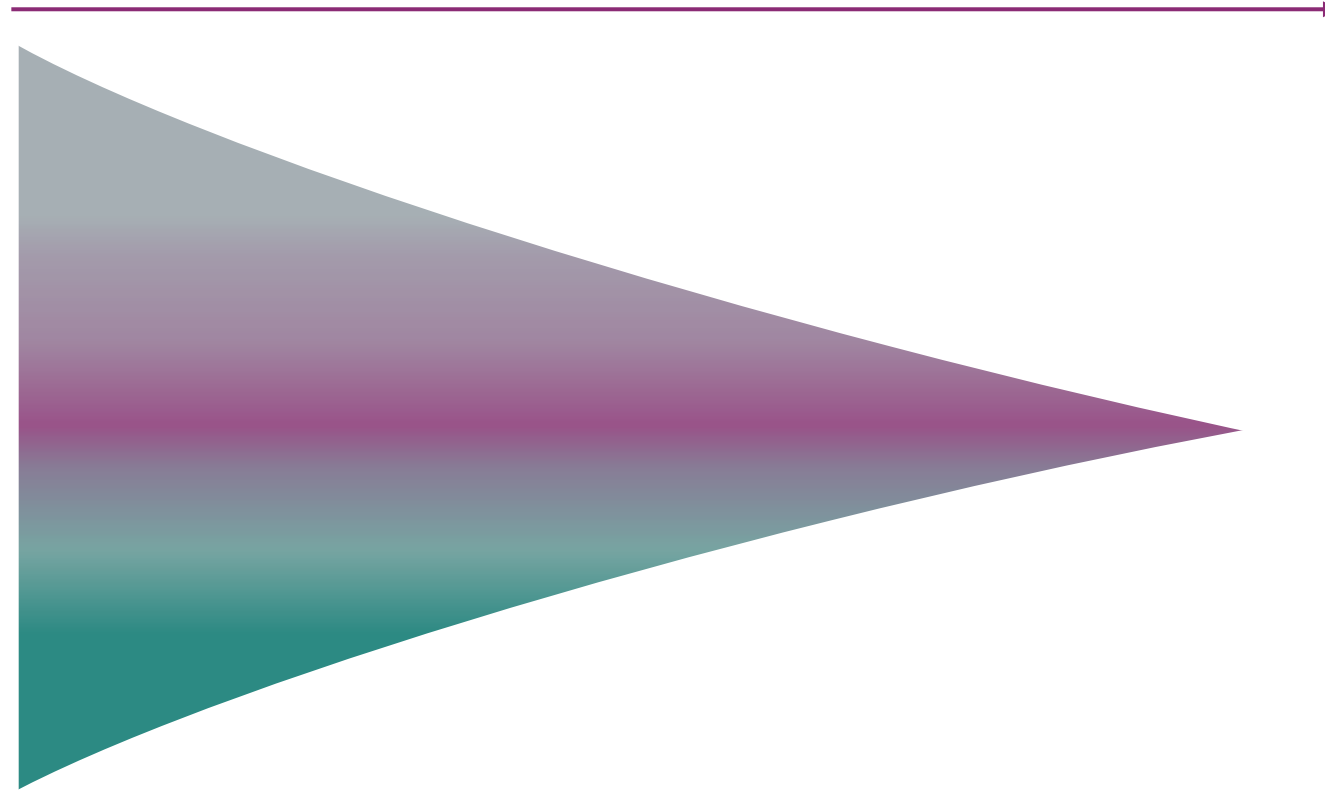
FROM:
Two distinct roles



Social
worker



Health band 6
discharge
coordinator



TO:
Single blended role



Blended assessor
with joint
assessment
responsibilities

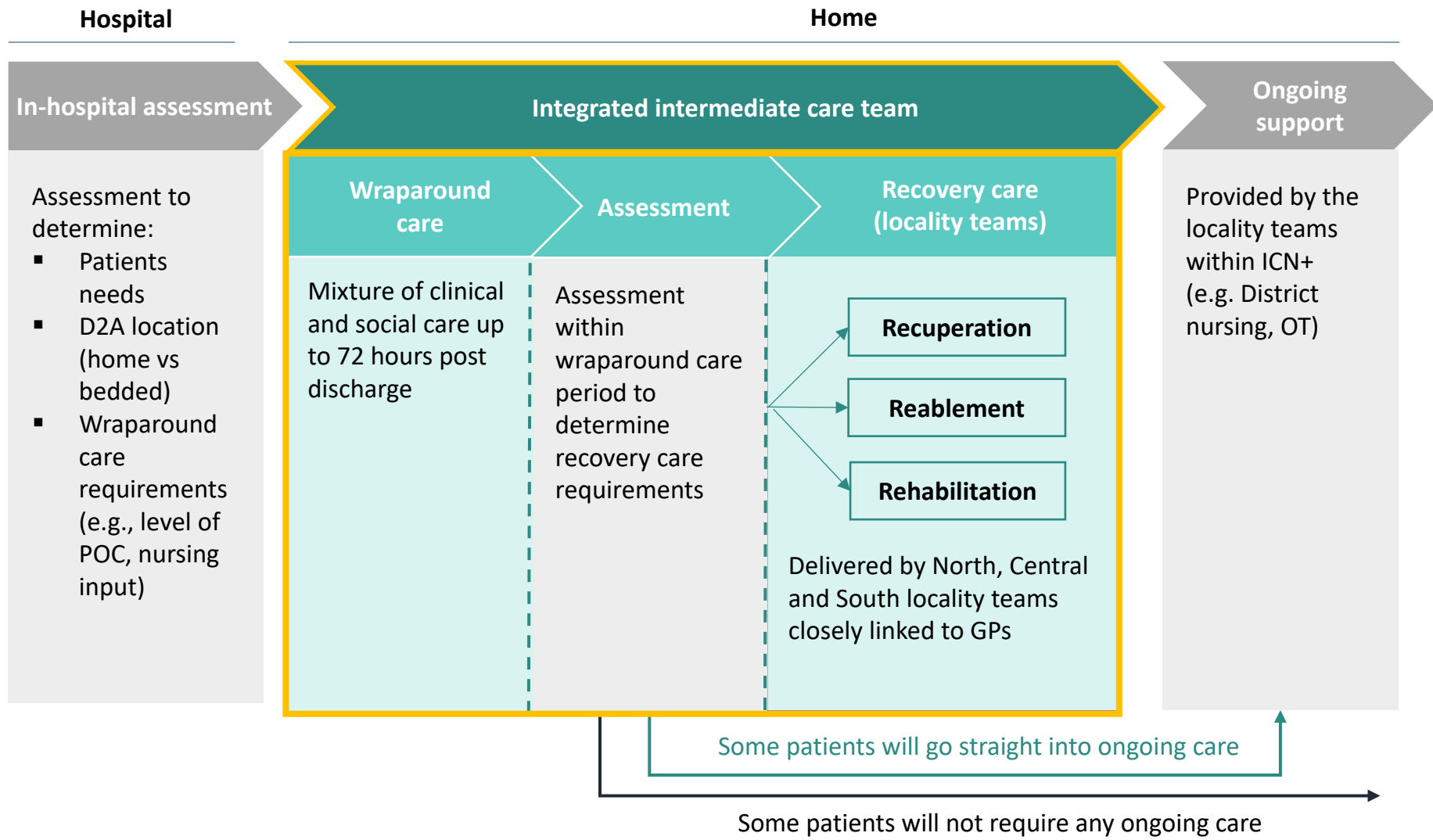
Agreed
blended
roles and responsibilities

Agreed required
IDT training

Agreed staffing
model and
numbers

Agreed
segmentation of IDT
caseloads

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



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

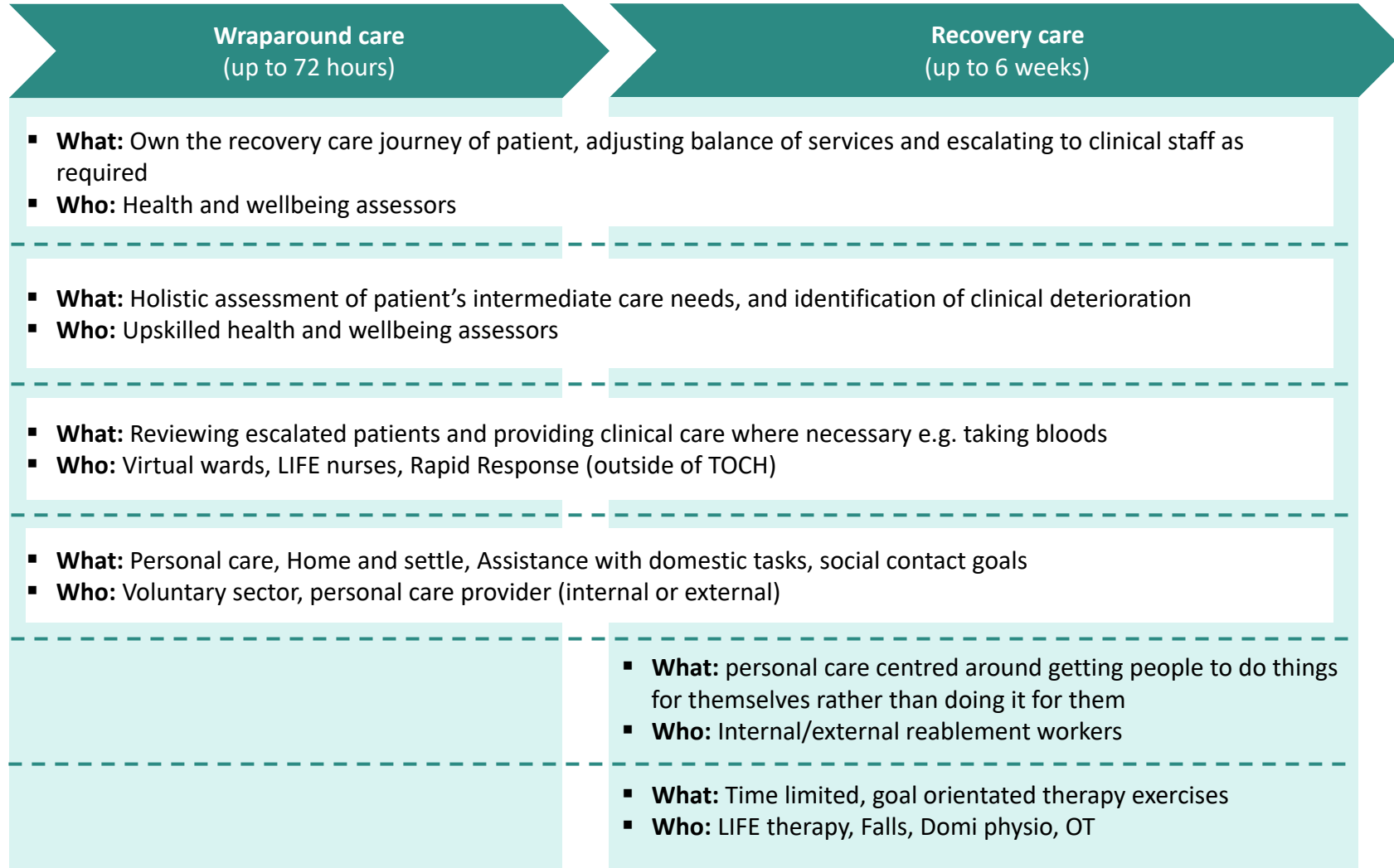
FROM

- 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



Page 11

?

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?

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**

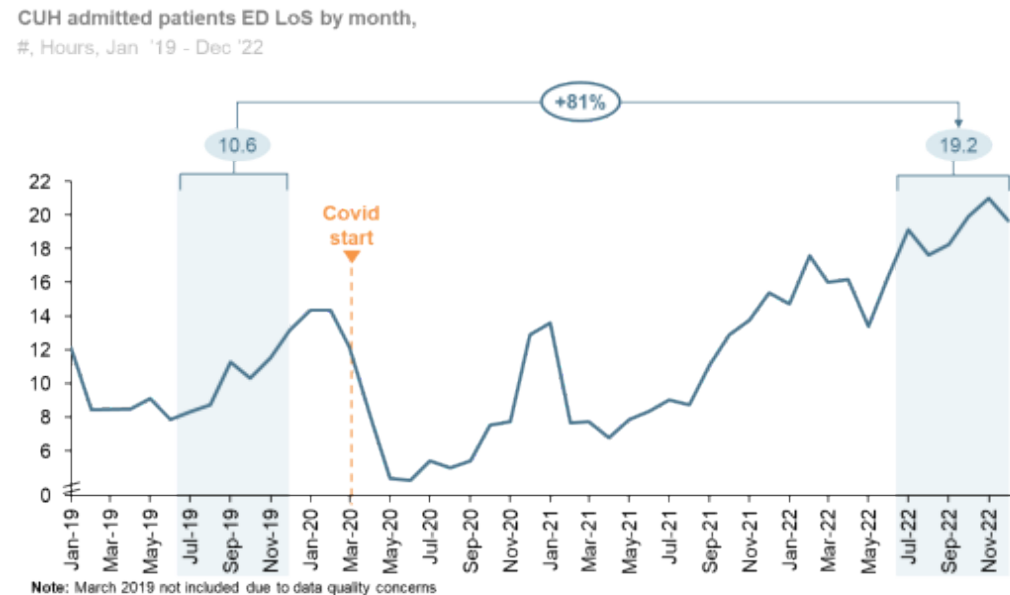
It is the right time to answer these questions as a system to provide clarity and unblock progress

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

This graph shows that the average length of stay in ED for patients has steadily increased since pre-pandemic.

July - November 2019 shows an average length of stay in ED - 10.6 hours. Compared with July - November 2022 shows the average length of stay in ED - 19.2 hours.

Page 13



Source: ED Dashboard from Croydon Informatics Team

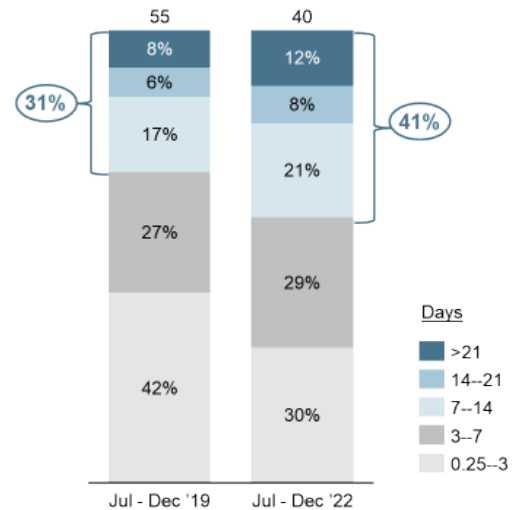
Patients staying >7 days now occupy 82% of hospital bed days

This image shows that the percentage of patients staying more than 7 days has increased by 12 percentage points since 2019

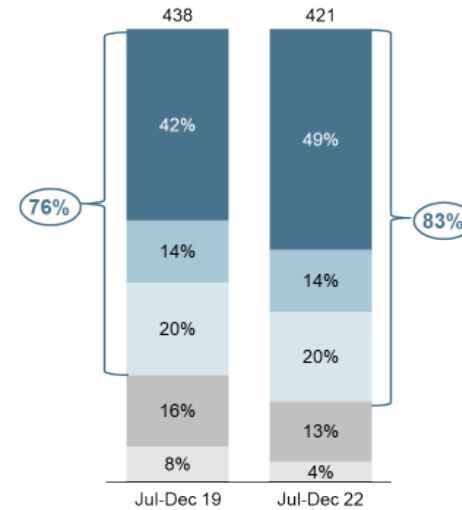
These patients now occupy 85% of in-patient beds.

Page 14

Percentage of CUH completed spells by LoS*, % Jul-Dec '19 vs Jul-Dec '22



Proportion of CUH occupied bed days by total LoS*, % Jul-Dec '19 vs Jul-Dec '22



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

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

Key opportunities for improvement

ED/ AMU - Incomplete gathering of patient information

- Functional baseline
- Existing Packages of Care
- Family details
- Keysafe

Admission to hospital - Limited proactive engagement with family to set expectations and understand needs

MDT does not proactively identify issues that will delay discharge

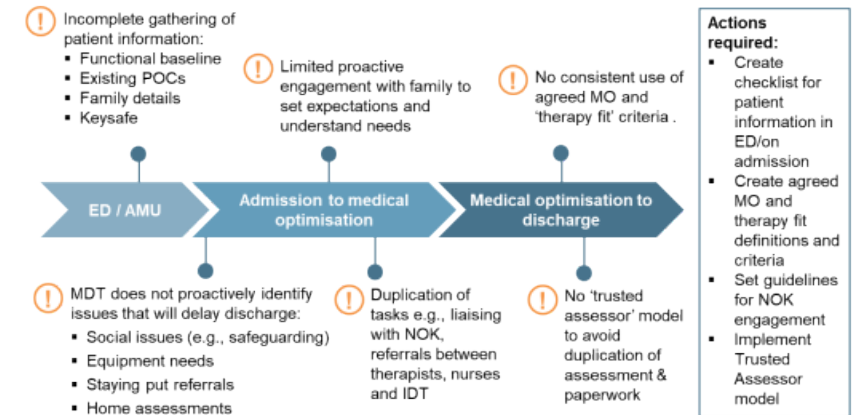
- social issues
- equipment needs
- staying put referrals
- home assessments

Duplication of tasks (not liaising with next of kin, referrals between therapists 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 and paperwork

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

! = Opportunity for improvement



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

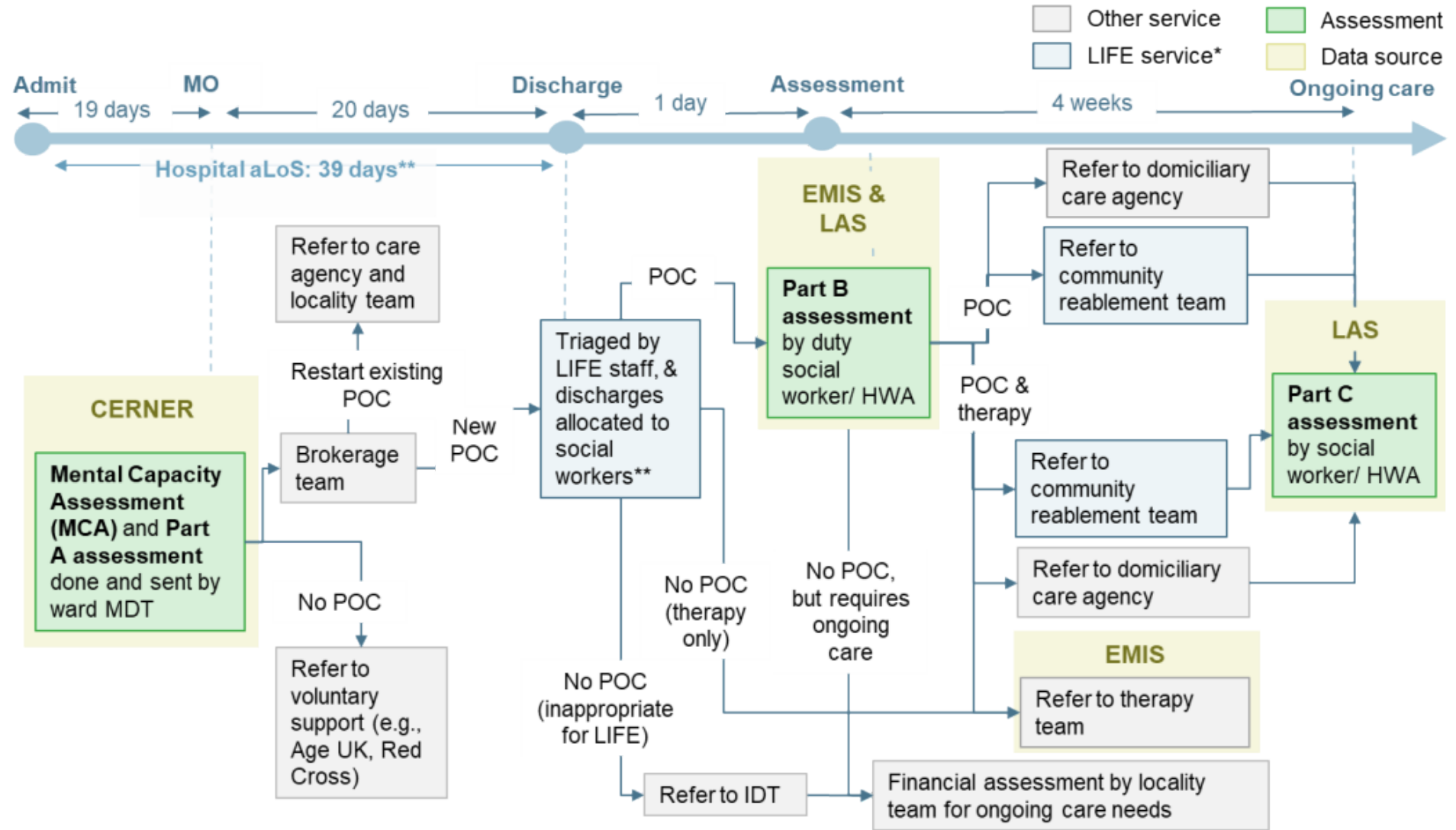
for ~30% of Pathway 1 patients with MO timestamps **(20 days post-MO)**

Pathway 1

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

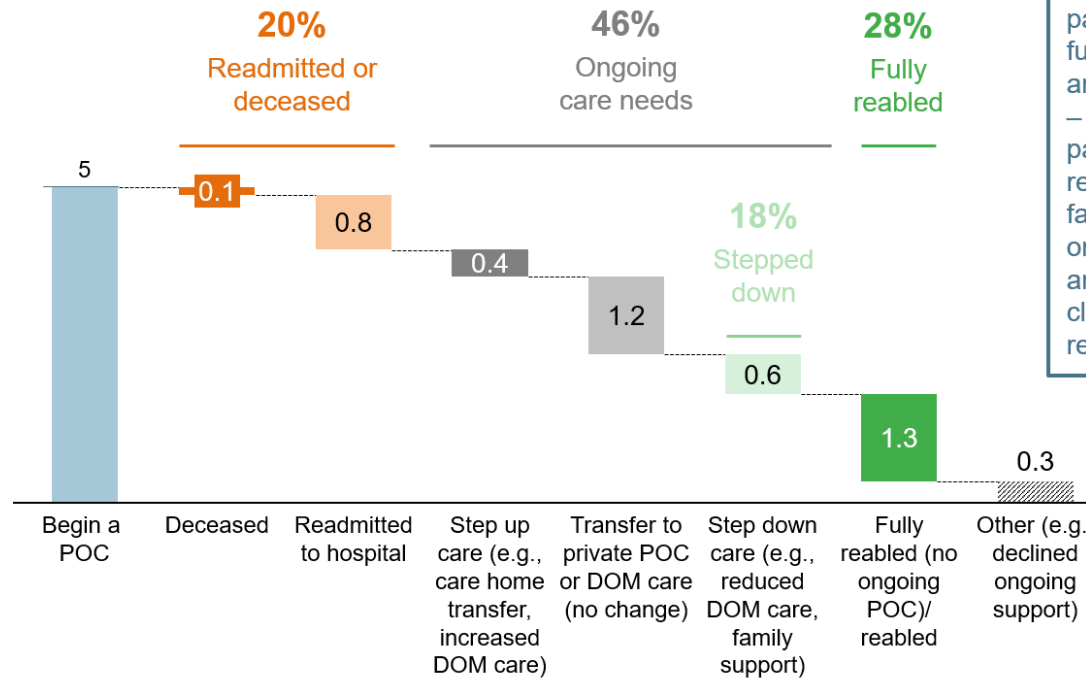
It involves up to 6 teams, 10 steps and 4 assessment

Page 17



This graph shows that of patients who start a package of care, approximately 30% are classified as fully reabled.

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



?

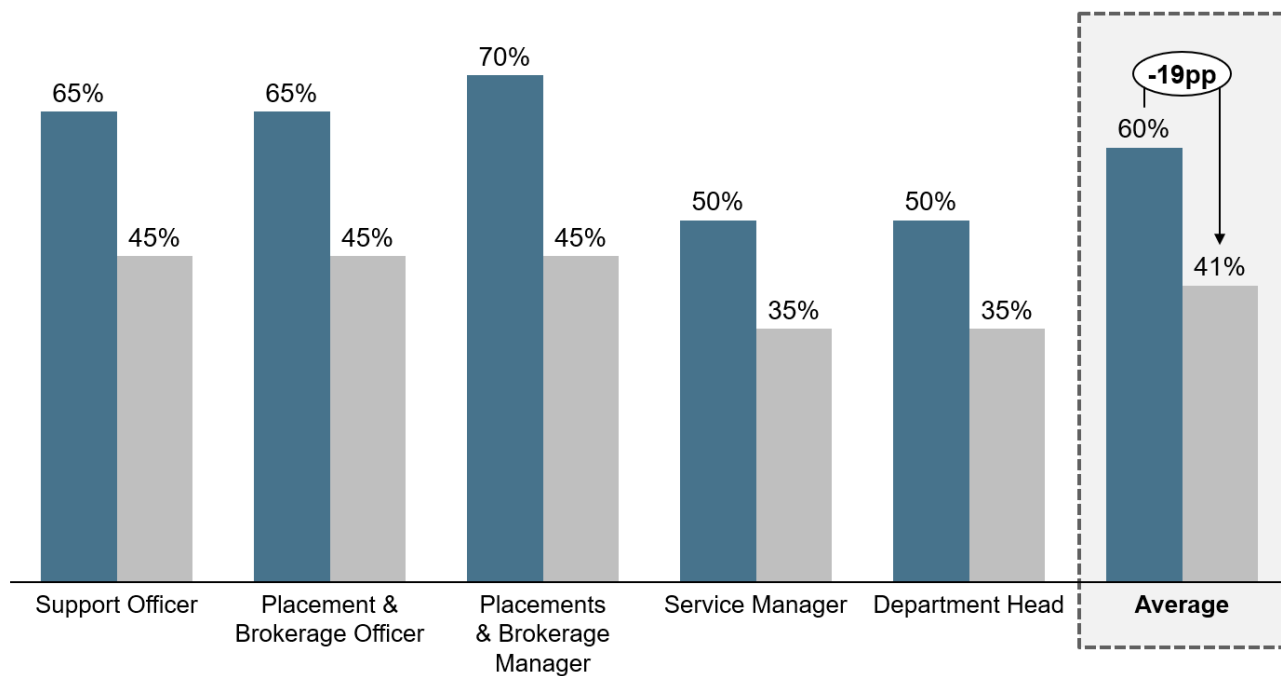
The proportion of patients who are fully reabled is likely an **under-estimate** – for instance, patients may be reabled but receive family support with ongoing care and are therefore not classified as fully reabled

Page 18

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

This is 19 percentage points more time than they should spend on discharge

Time spent by LA brokerage & placement teams on hospital discharge by role,
%,
■ Current time spent ■ Time that should be spent



Page 19

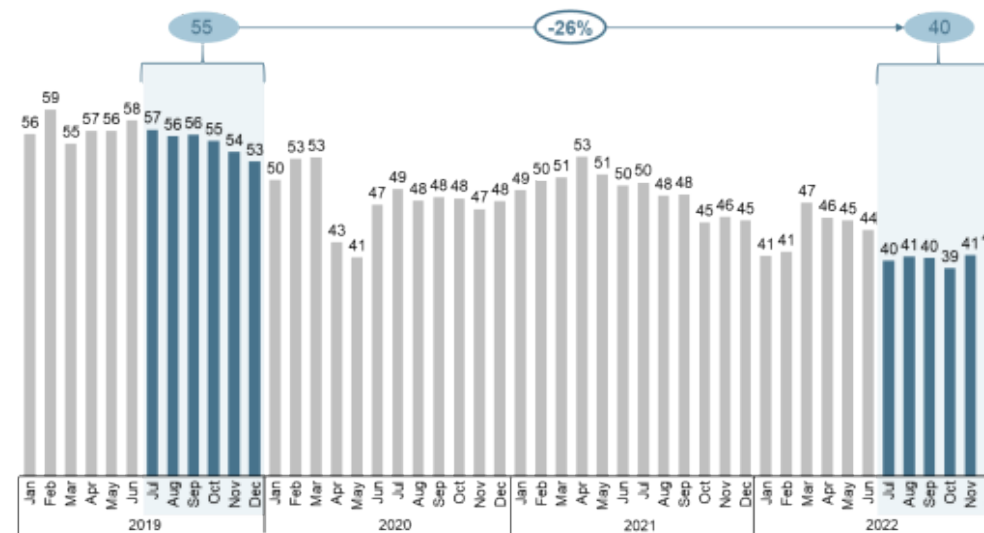
Hospital inpatient discharges have fallen by ~25% since 2019

This graph shows a decrease in the average number of patients discharged from hospital in from July to December 2019 compared with July to December 2022.

The monthly average number of patients discharged from hospital between July and December 2019 was 55; compared with The monthly average number of patients discharged from hospital between July and December 2022 was 40 patients per month.

Page 20

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



Source: CUH inpatient dataset

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

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

Areas of focus in Workshop 1 | Summary of insights

<p>Hospital</p> <ul style="list-style-type: none">▪ Inpatient▪ ED	<ul style="list-style-type: none">▪ 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
<p>Supported discharge pathways</p> <ul style="list-style-type: none">▪ P1: Reablement▪ P2: Rehabilitation▪ P3: 24 hour bed based care / CHC	<ul style="list-style-type: none">▪ Supported discharge pathways are complex with multiple assessments and handovers between different teams<ul style="list-style-type: none">– 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

Page 21

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
<p data-bbox="38 611 81 768">Page 22</p> <p data-bbox="63 396 512 439">Community services</p> <ul data-bbox="63 468 479 701" style="list-style-type: none"><li data-bbox="63 468 479 511">▪ Rapid Response<li data-bbox="63 539 377 582">▪ A&E liaison<li data-bbox="63 611 479 701">▪ ICN+ and wider community	<ul data-bbox="700 401 2423 696" style="list-style-type: none"><li data-bbox="700 401 2262 501">▪ The Rapid Response team provides effective care to reduce potential acute admissions<li data-bbox="700 529 1633 572">▪ A&E Liaison only receives ~4 referrals a day<li data-bbox="700 601 2423 696">▪ The ICN+ needs to improve integration with primary care services and create joined up working with GP huddles
<p data-bbox="63 796 453 886">Further discharge processes</p> <ul data-bbox="63 915 657 1310" style="list-style-type: none"><li data-bbox="63 915 428 958">▪ Palliative care<li data-bbox="63 986 580 1029">▪ Brokerage/placement<li data-bbox="63 1058 657 1310">▪ MDT/IDT ways of working<ul data-bbox="165 1168 657 1310" style="list-style-type: none"><li data-bbox="165 1168 657 1258">– Integrated discharge team (IDT)<li data-bbox="165 1272 402 1310">– Therapy	<ul data-bbox="700 782 2466 1353" style="list-style-type: none"><li data-bbox="700 782 1956 982">▪ The MDT has several overarching challenges:<ul data-bbox="784 829 1956 982" style="list-style-type: none"><li data-bbox="784 829 1956 872">– Roles and responsibilities within the MDT are unclear<li data-bbox="784 886 1531 929">– Limited early discharge planning<li data-bbox="784 943 1786 982">– Poor communication and recording of actions<li data-bbox="700 1011 2339 1110">▪ A high proportion of therapist's time is spent on non-therapy tasks, meaning medically optimised patients are prioritised<li data-bbox="700 1139 2339 1239">▪ Fast Track patients appear to be delayed in their discharge waiting ~7 days on average for the issuance of funding<li data-bbox="700 1268 2466 1353">▪ Challenges with communication and criteria understanding can lead to duplicate work for brokerage / placement teams

Collaborating with our voluntary sector

Provider	What do they currently do?	What could they do?
Red Cross (National contract)	Facilitating discharge <ul style="list-style-type: none"> Welfare checks Key cutting Provide clothes Provide access to patients' property for: equipment delivery, pest control, keysafe and Careline installation 	<ul style="list-style-type: none"> Which of these services are currently provided under Pathway 0+?
	Support after discharge <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Personal safety and falls prevention 	<ul style="list-style-type: none"> How could Pathway 0+ be expanded? How can these services fit into the TOCH?
	Support after discharge <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Group walks Support with hearing / eye tests Organised community activities for older people Work closely with other voluntary services and can make referrals 	

This page is intentionally left blank