Frontrunner Transformation Programme

Update – June 2023

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Agenda

About Croydon

Diverse population, with a high level of deprivation

Croydon ~400,000 residents

- 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

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

Programme objectives

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

Overview of our progress so far and next steps

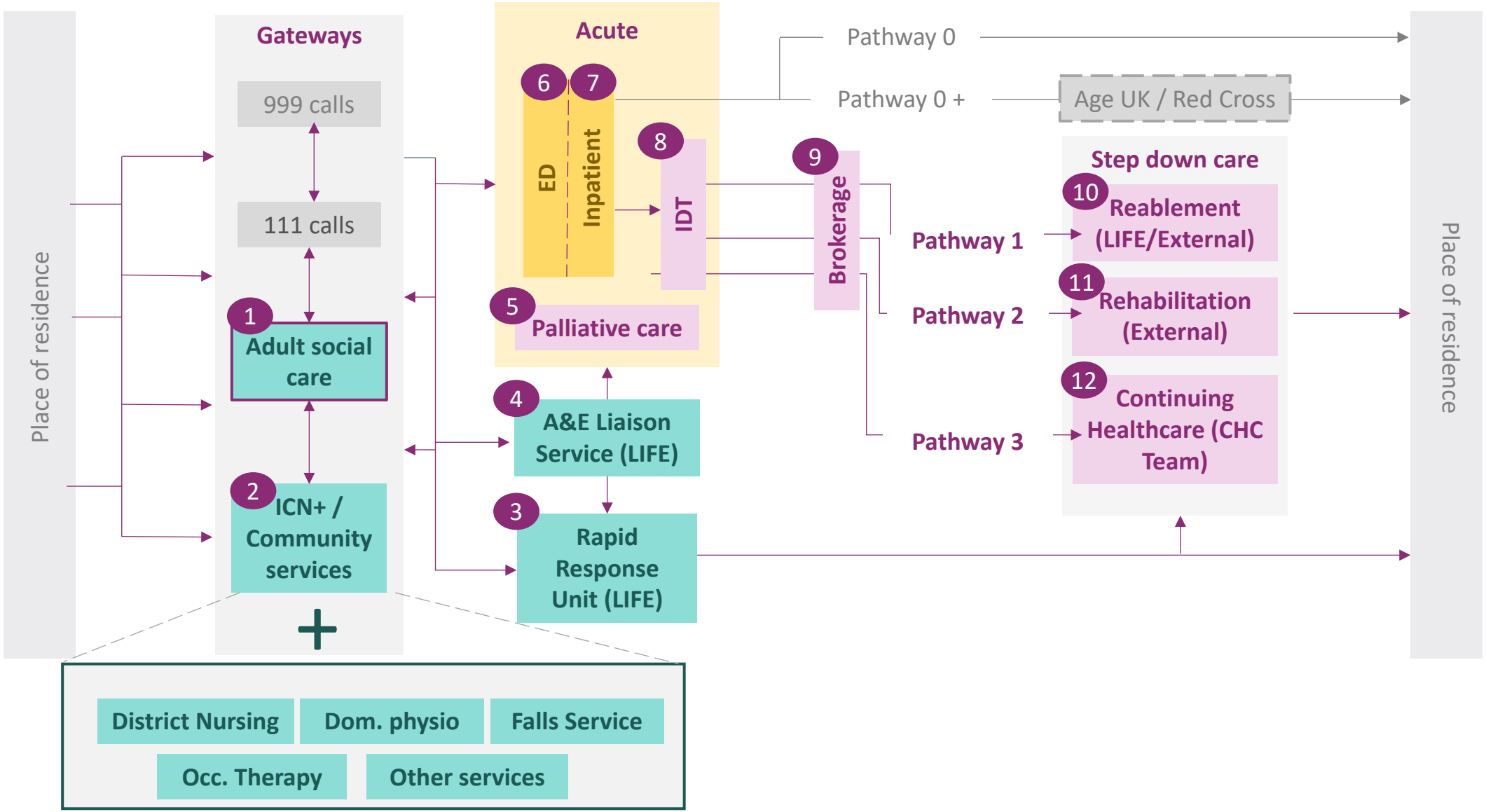
One Croydon
Your Health and Care partnership

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

	Baseline (diagnostic)	Design (TOCH blueprint)	Finalising the blueprint	Implementation
What we have done	▪ Developed a multi-dimensional baseline of the system including activity, workforce, and bottlenecks ▪ Aligned stakeholders on 'one version of the truth' baseline and agree priorities	▪ Principles of system design ▪ Functions and teams of the TOCH (E.g., assessment, coordination, placement) ▪ Architecture and SOPs of patient journeys ▪ Capacity required to deliver	**Answering the 3 support pillars** (difficult questions): ▪ Define clinical responsibility, oversight, and ownership for a truly integrated care offering ▪ Agree operational delivery by a single blended team with everyone managed under one collective ▪ Develop a permanent integrated health and social commissioning team	▪ Integrate teams ▪ Introduce new ways of working and SOPs ▪ Iteratively improve SOPs
How we involved our people	**2 workshops with key stakeholders:** Hospital MDT, IDT, LIFE, VCS, LA brokerage, CHC, primary care, commissioners (health and social), system leaders	**Weekly blueprint design working groups** ▪ Including operational leaders from health and social **Pilot** ▪ Test emerging thinking on IDT ways of working ▪ Capture learnings to guide development of TOCH blueprint	**Weekly blueprint design working groups** ▪ Including operational leaders from health and social **Continuing engagement sessions** ▪ Hospital doctors, community geriatricians, primary care ▪ Adult social services ▪ Patient representatives	

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

We have created a comprehensive baseline of our system



Overview of current ambition

= TOCH

Hospital

1a In-hospital assessment
- Determine care needs
- Complete assessments
- Support discharge of complex cases

1b Ward ways of working
- Nursing, medical staff, therapy

Integrated Intermediate Care team (up to 6 weeks)

2 Provision of intermediate care

Home D2A – PW 1
- **Wrap-around support** (up to 72 hours)
- **Assessment** of intermediate care needs
- **Recovery care:** Split across 3 locality based teams: North, Central, South

Bedded D2A – PW 2
- **Wrap-around care** (recuperation, reablement, rehabilitation, nursing)

Bedded D2A – PW 3
- **Wrap-around care** (nursing/residential care, mobilisation)

Ongoing care needs assessment

Ongoing care (ICN+)

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

4 Supporting pillars
- Ownership, responsibility and operational delivery
- Funding
- Joint commissioning

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

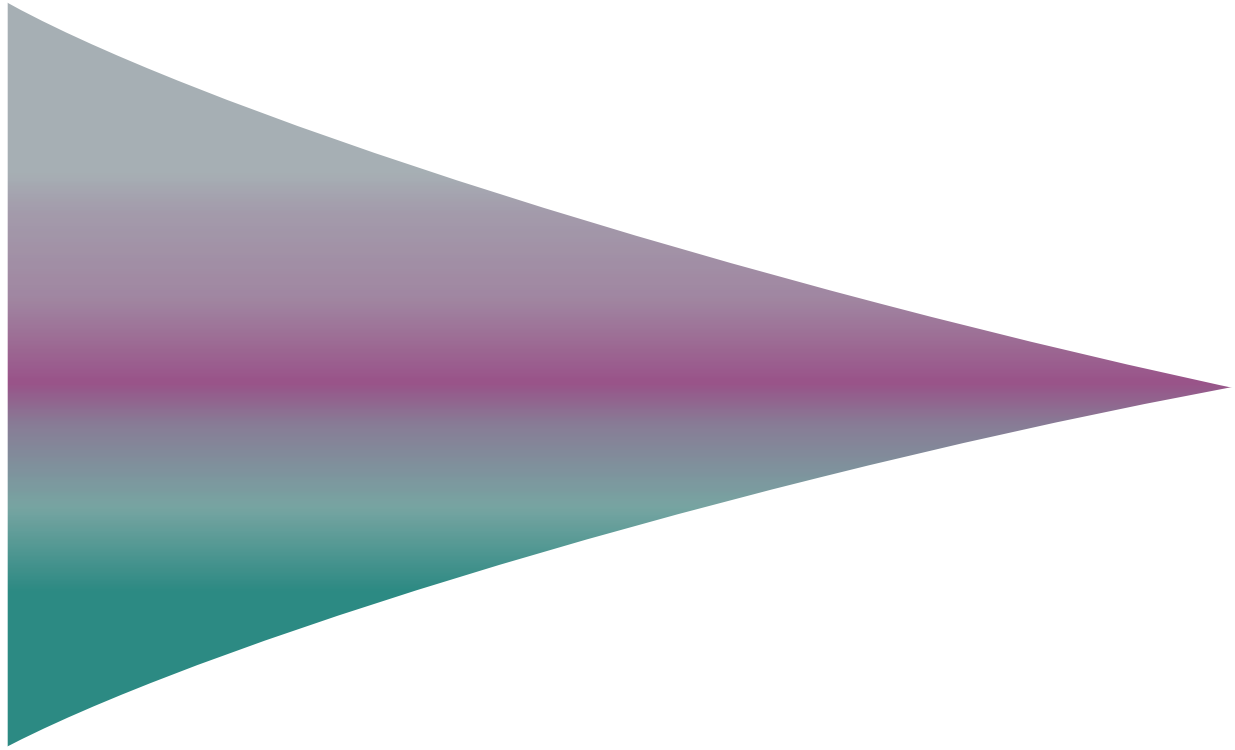
One Croydon
Your Health and Care partnership

Objective

FROM:
Two distinct roles

Social worker

Health band 6 discharge coordinator



TO:
Single blended role

Blended assessor with joint assessment responsibilities

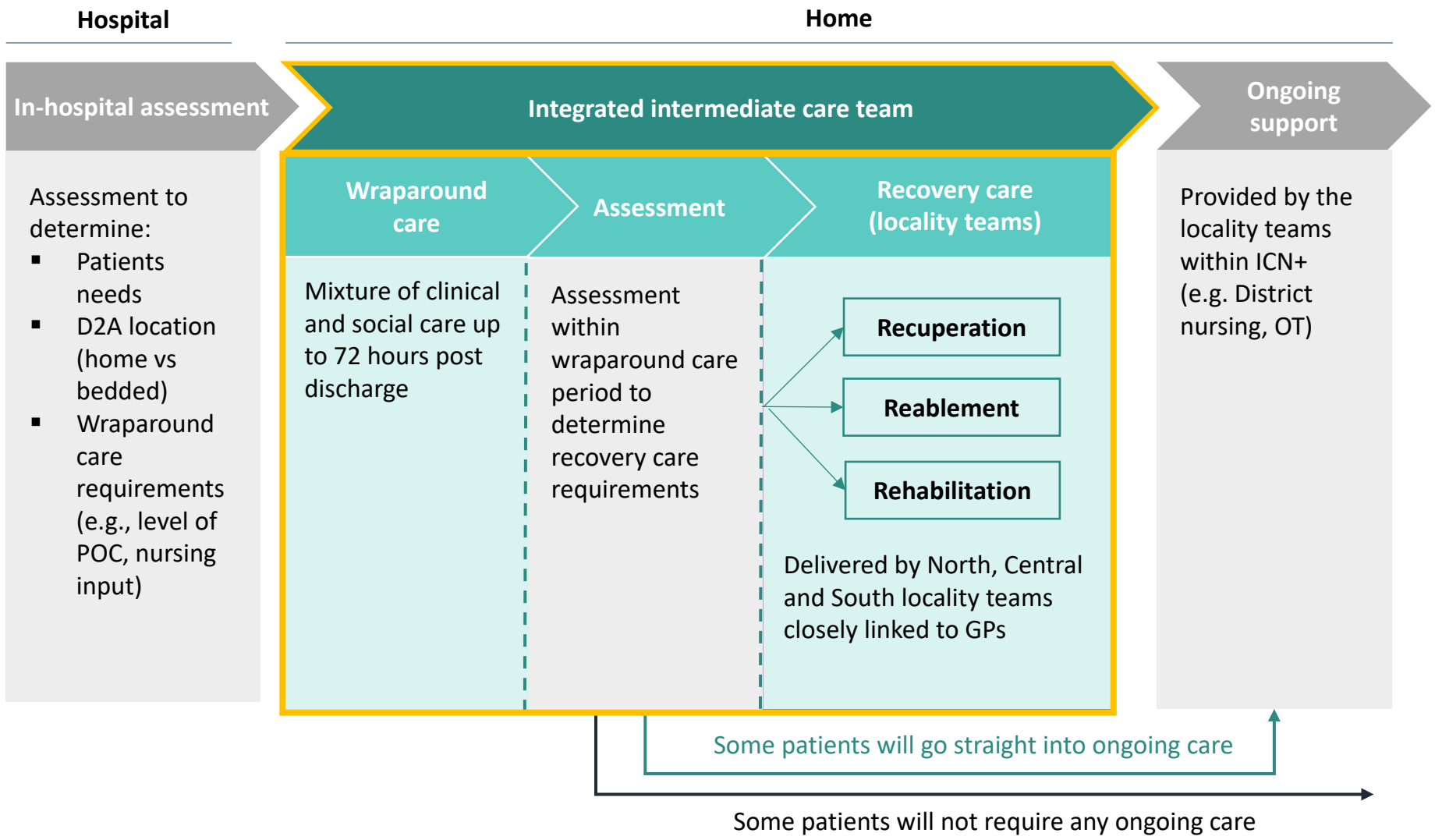
Outputs

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

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

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

One Croydon
Your Health and Care partnership



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

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

One Croydon
Your Health and Care partnership

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

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

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

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

?

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

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

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

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

Ownership, responsibility and operational delivery

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

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

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

Funding

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

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

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

Joint commissioning

Our Frontrunner bid included the proposal for integrated commissioning:

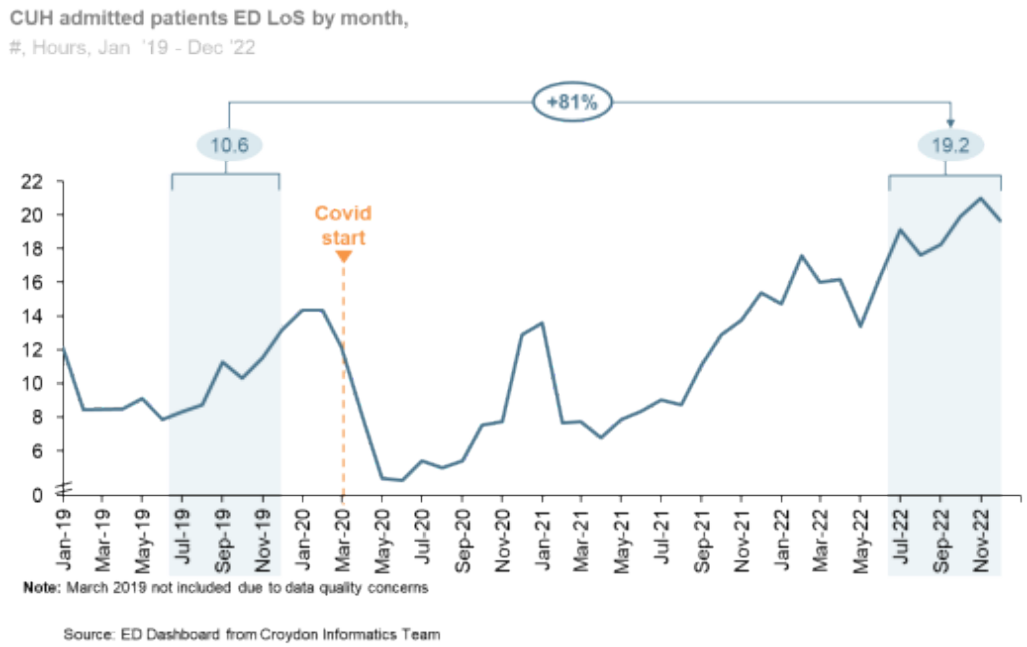
- What do we mean by that?
- What are our options to deliver it?
    1. **Integrated commissioning team** (Croydon previously had this model)
    2. **Temporary collaboration** for the TOCH/ICN+ supported by a Section 75
    3. Formal request for **social to commission on behalf of health**

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

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

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

July - November 2019 shows and 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.



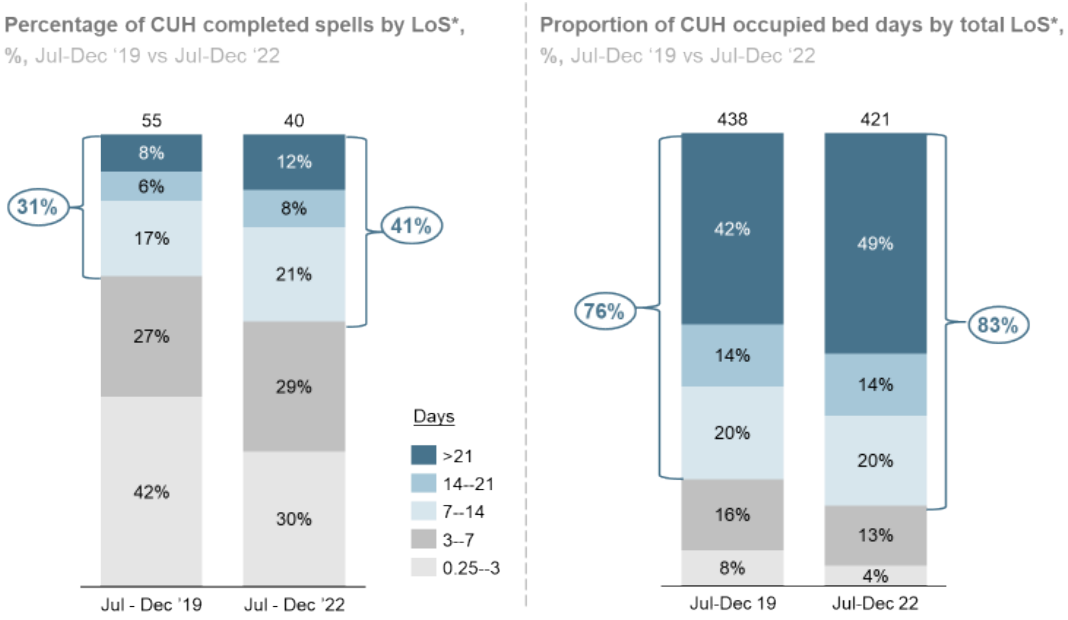
Source: Croydon ED dataset

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

One Croydon
Your Health and Care partnership

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.



Source: CUH inpatient dataset

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

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

Transformation Nous

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

One Croydon
Your Health and Care partnership

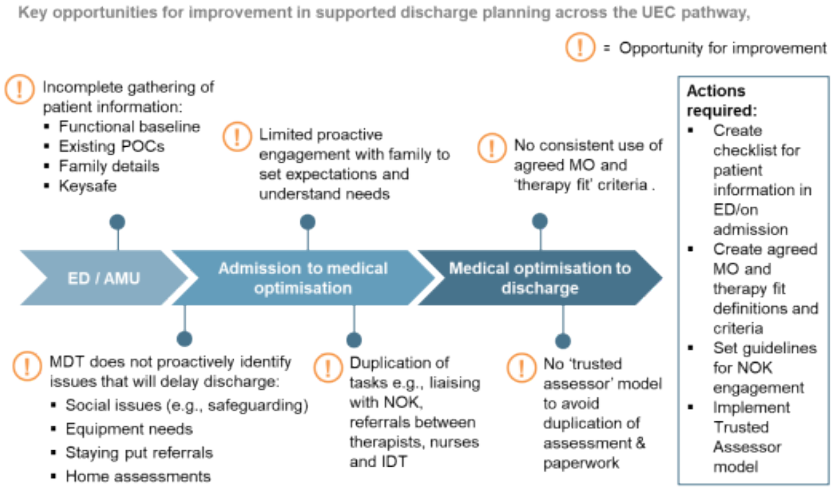
Key opportunities for improvement

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



Pathway 1 supported discharges: The facts

One Croydon
Your Health and Care partnership

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

Patients stay 17 days in hospital on average

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

10 Steps

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

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

6 Decision points

27% D2A referrals do not begin reablement

17 days aLoS in-hospital for all Pathway 1 patients

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

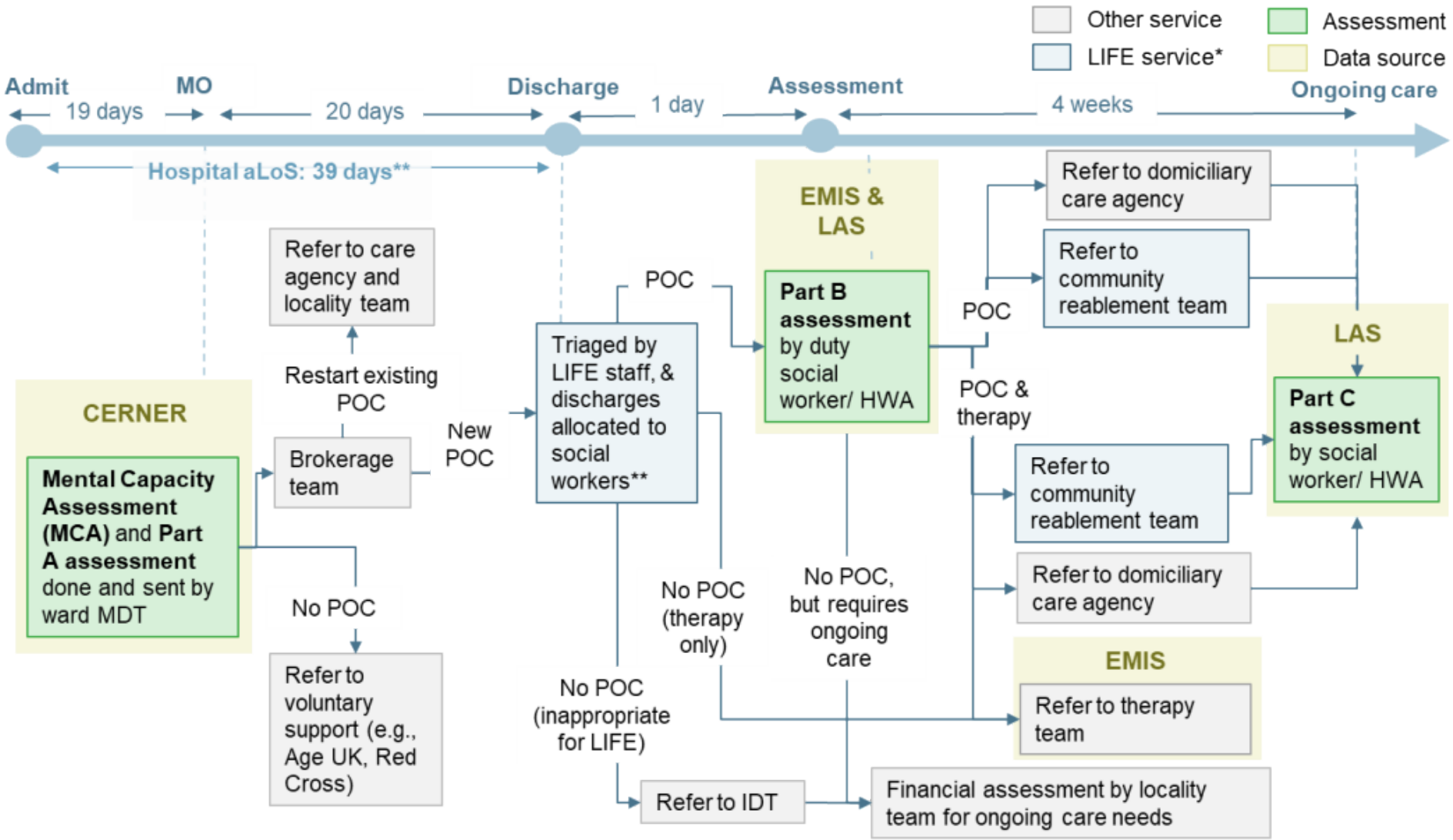
NHS | Croydon Age UK | Croydon GP Collaborative | CROYDON www.croydon.gov.uk | Delivering for Croydon

Transformation Nous

Pathway 1

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

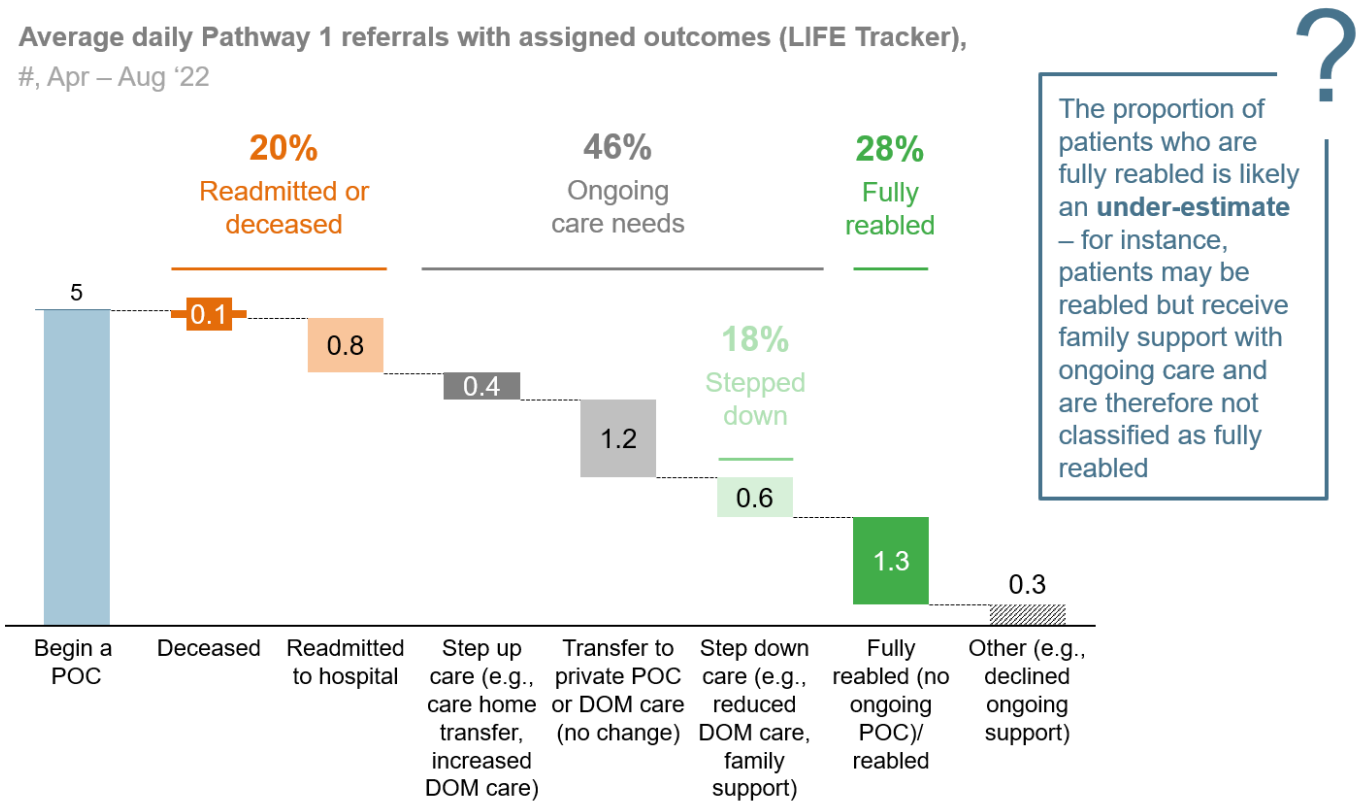
It involves up to 6 teams, 10 steps and 4 assessment



Transformation Nous

Pathway 1 outcomes

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



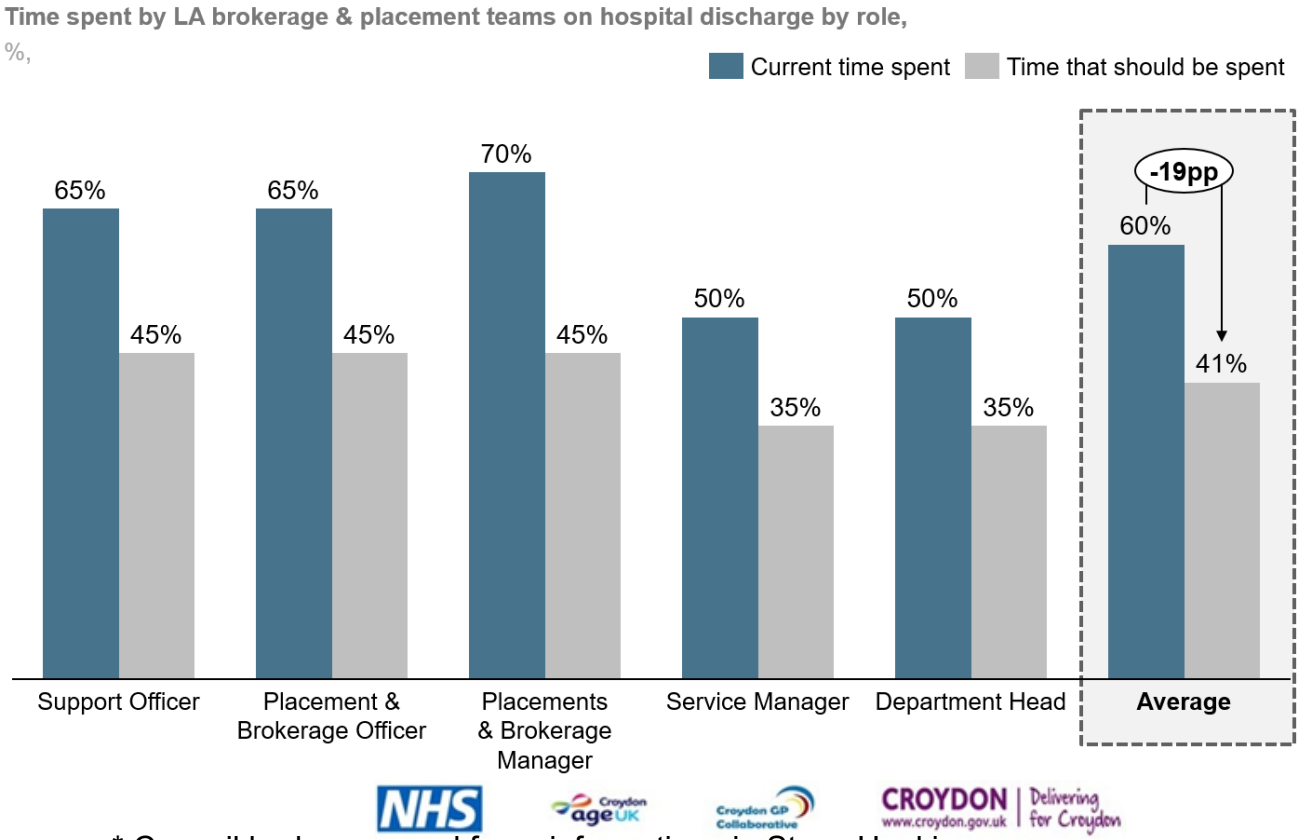
The proportion of patients who are fully reabled is likely an **under-estimate** – for instance, patients may be reabled but receive family support with ongoing care and are therefore not classified as fully reabled

Source: LIFE Tracker

Transformation Nous

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

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



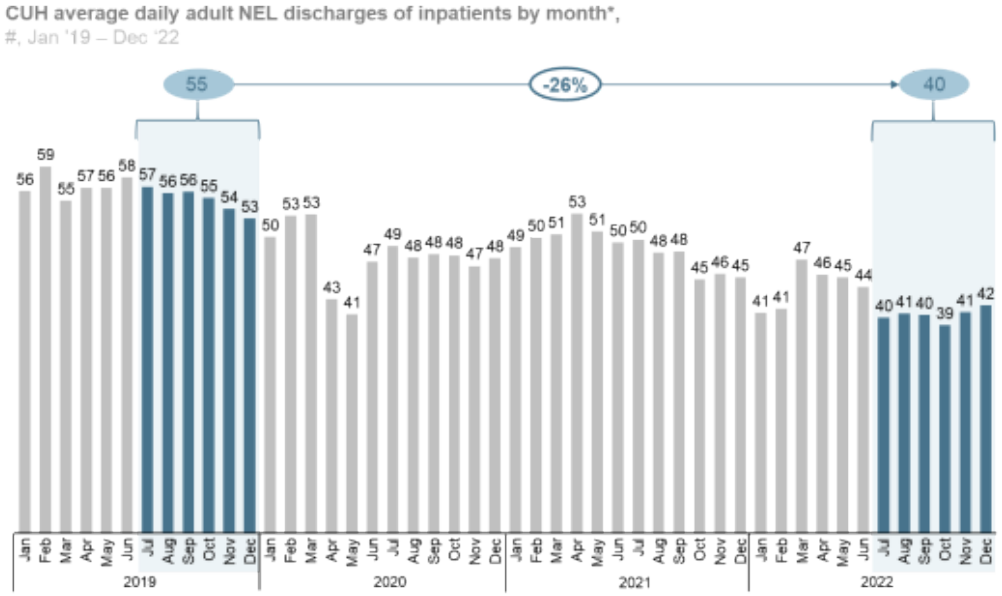
* Council brokerage workforce information via Steve Hopkins

Hospital inpatient discharges have fallen by ~25% since 2019

One Croydon
Your Health and Care partnership

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.



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

Transformation Nous

Data Insights - Workshop 1

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

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

Insights - Workshop 2

One Croydon
Your Health and Care partnership

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

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

Collaborating with our voluntary sector

One Croydon
Your Health and Care partnership

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