One Croydon Alliance

Frontrunner programme: Delivering integrated care in Croydon

Transformation Nous

Agenda

- **What we set out to deliver**
- What we've delivered so far
- What's next
- Appendix

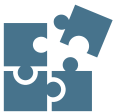
Croydon's aim for the Frontrunner programme was to bring together system wide transformation efforts to provide integrated care in Croydon and get people the right care, at right time, in the right place

Aims

Defining effective pathways architecture
Delivering integrated care across our discharge processes by simplifying processes, removing steps, aligning ways of working

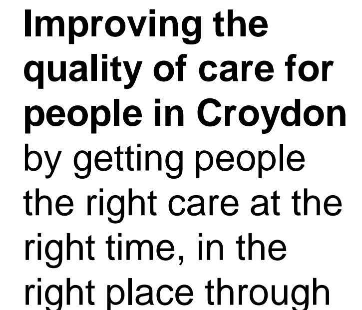
Getting the right teams and workforce
Introducing truly integrated teams, blended roles, and providing appropriate capacity and capability

Maximising the impact of the 'Croydon pound'
Treating people in the right setting, reducing overprovision of care, joint fundings and budgets

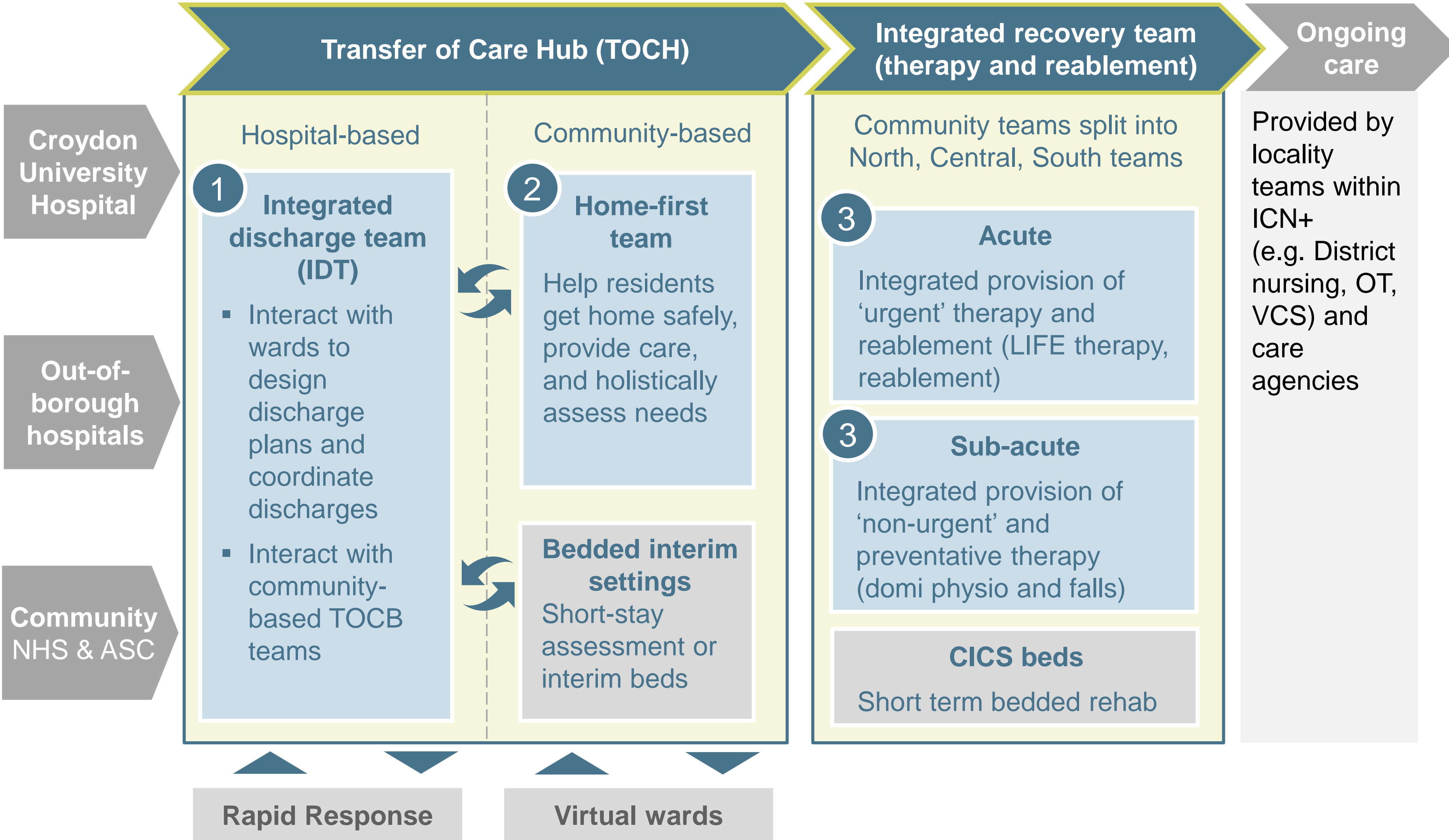


Alignment and coordination across the system
Creating clear oversight, clinical responsibility, ownership and introducing

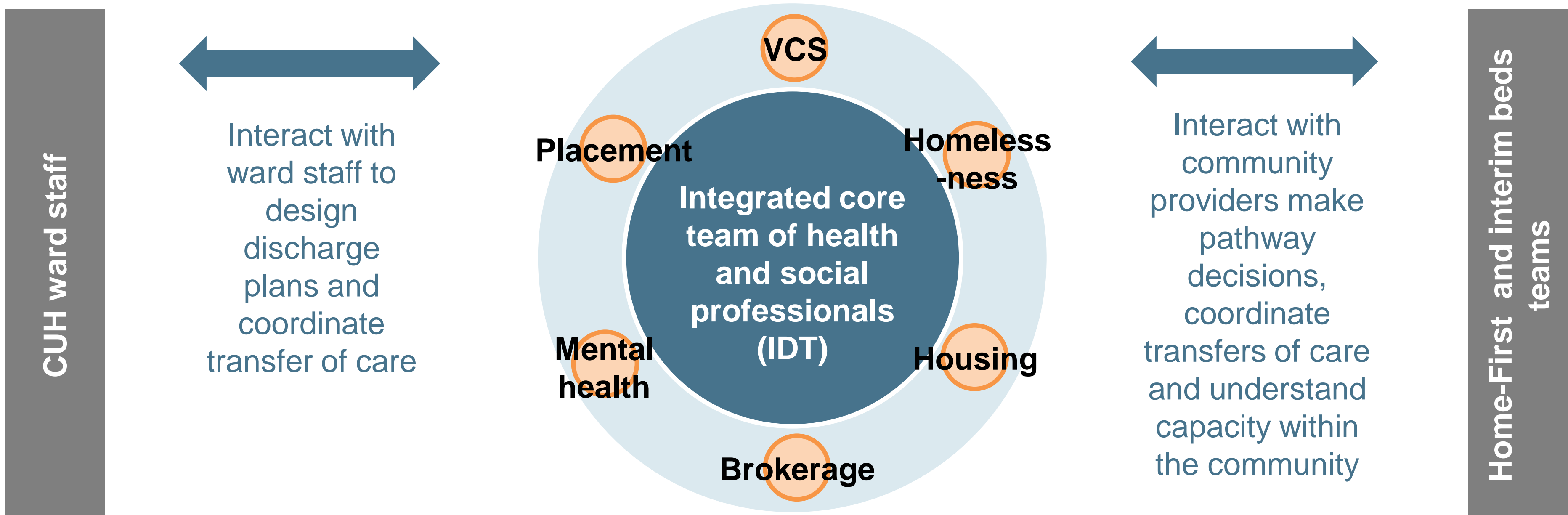
Improving data capture and information flow
Integrating IT systems, improving accurate data reporting and creating insightful KPIs



The Frontrunner blueprint consists of a Transfer of Care Hub responsible for effectively co-ordinating discharge, and an integrated recovery team



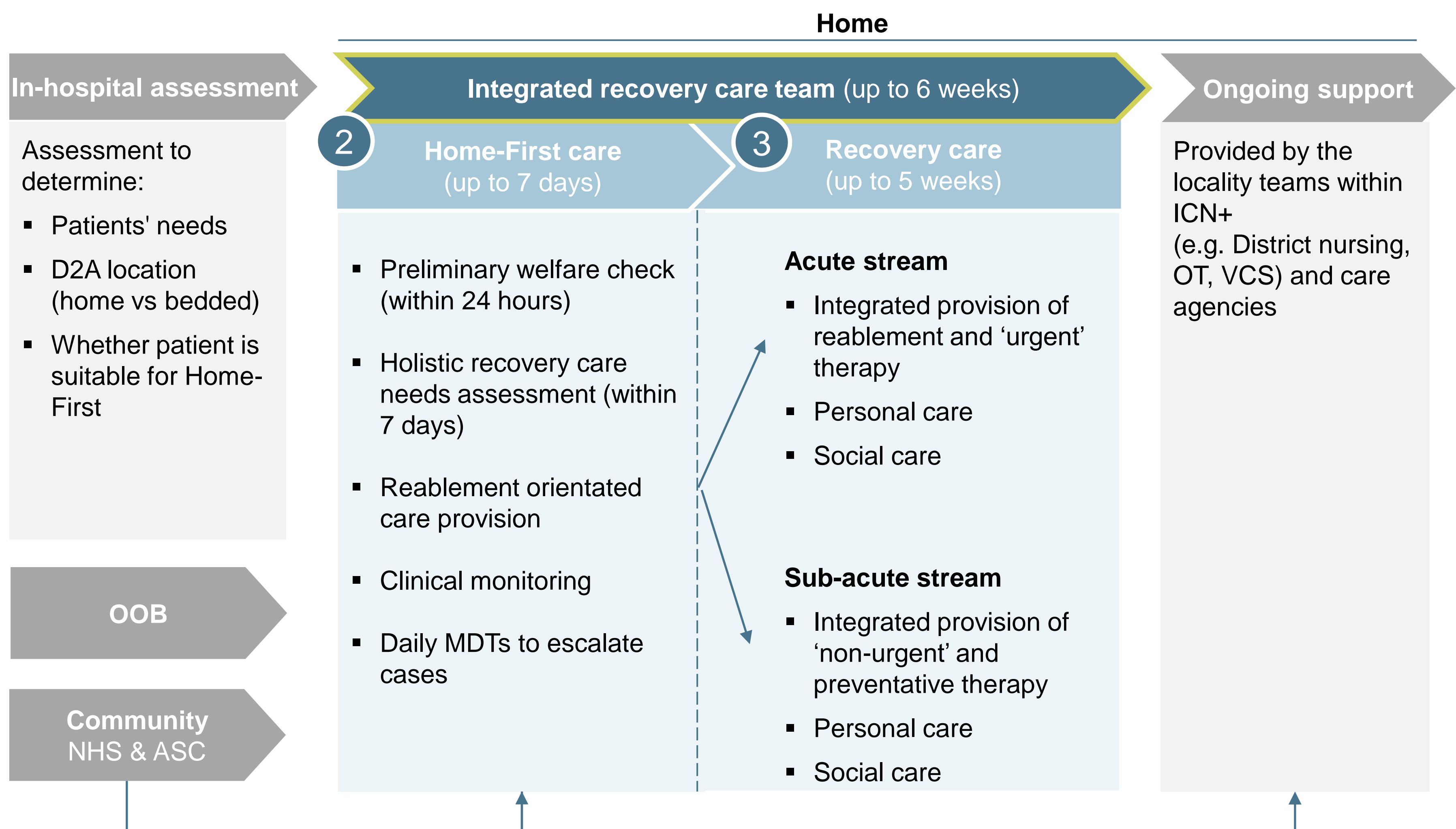
1 Ambition: The IDT is the core of the Transfer of Care Hub (TOCH) – a single point of discharge, responsible for co-ordinating the safe transfer of patients into a D2A setting



Underlying principles of the TOCH:

- Integration
- Home first
- Discharge to assess (D2A)
- Trusted assessor
- Promoting independence

2 3 Pathway 1 ambition: Patients discharged home on Pathway 1 will be referred into an 'integrated recovery care team' that provides Home-First care (up 7 days) followed by recovery care



Note: This is the Phase 1 ambition, the long-term ambition is to have integrated North, Central and South community teams

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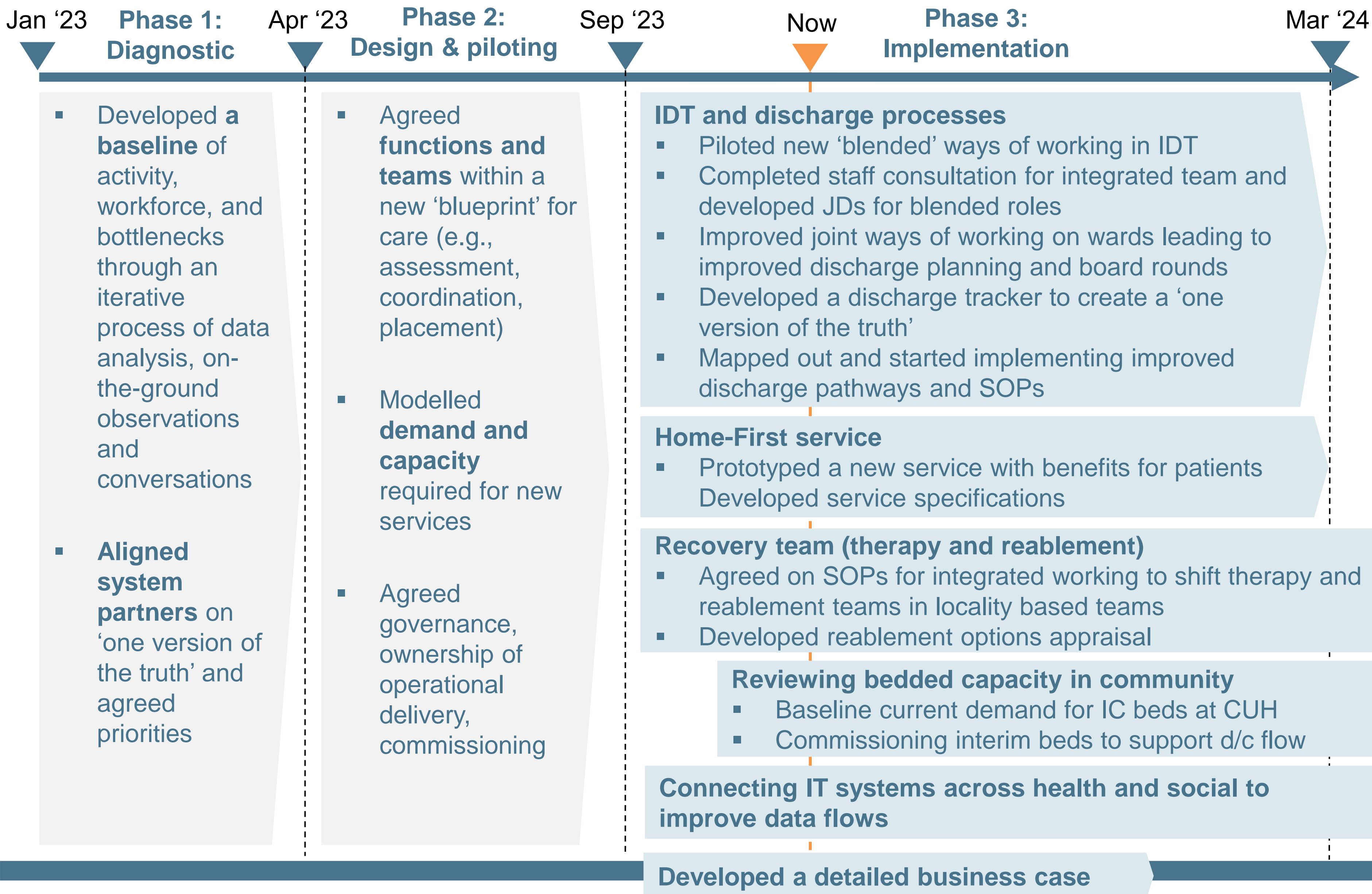
We are partway through implementing the blueprint for a new model of care and have already made significant progress



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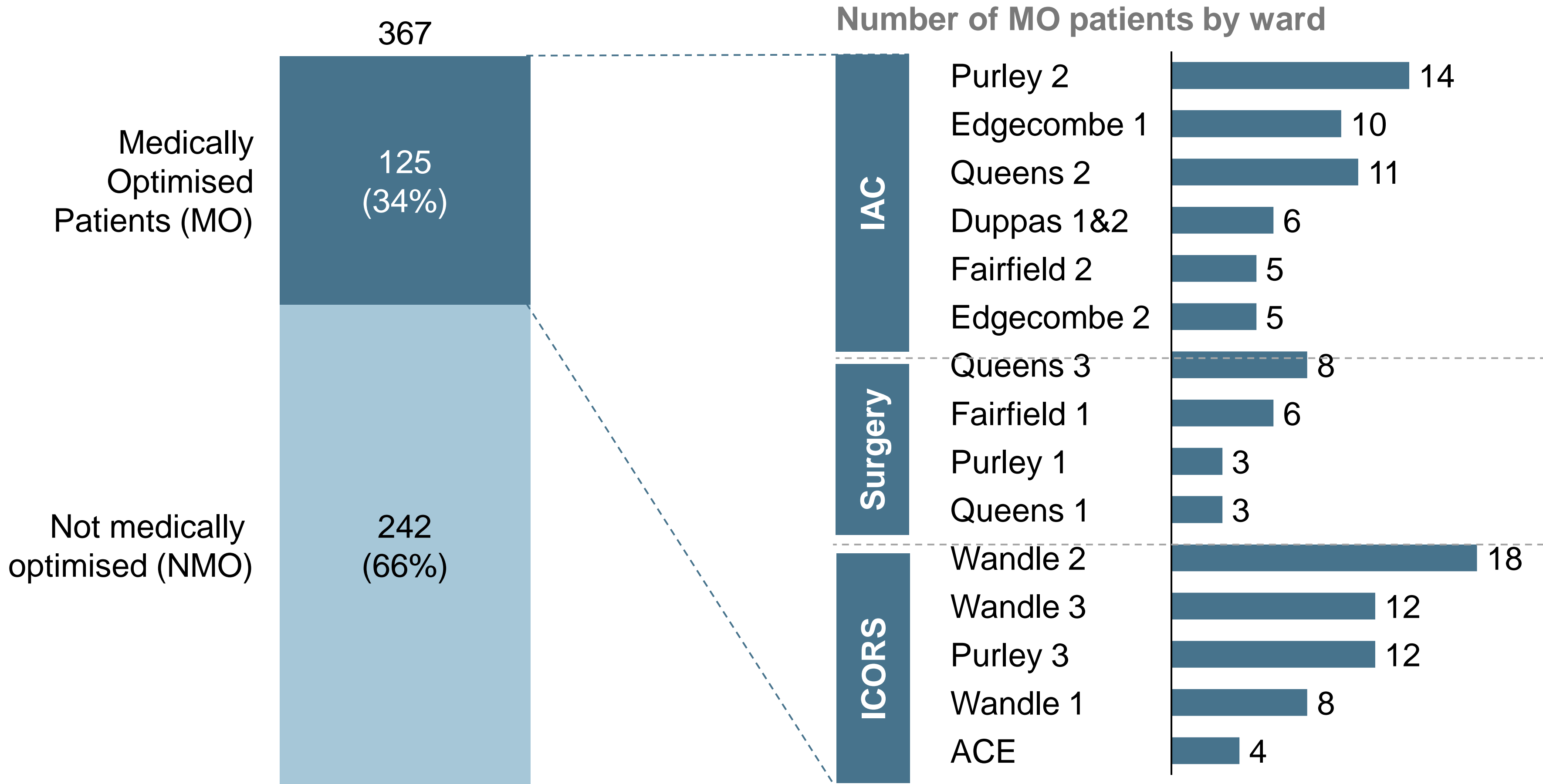
We performed a hospital audit understand the opportunity. 125 out of 367 beds (34%) were occupied by 'medically optimised' patients

MO and NMO patients identified across CUH inpatient wards*,

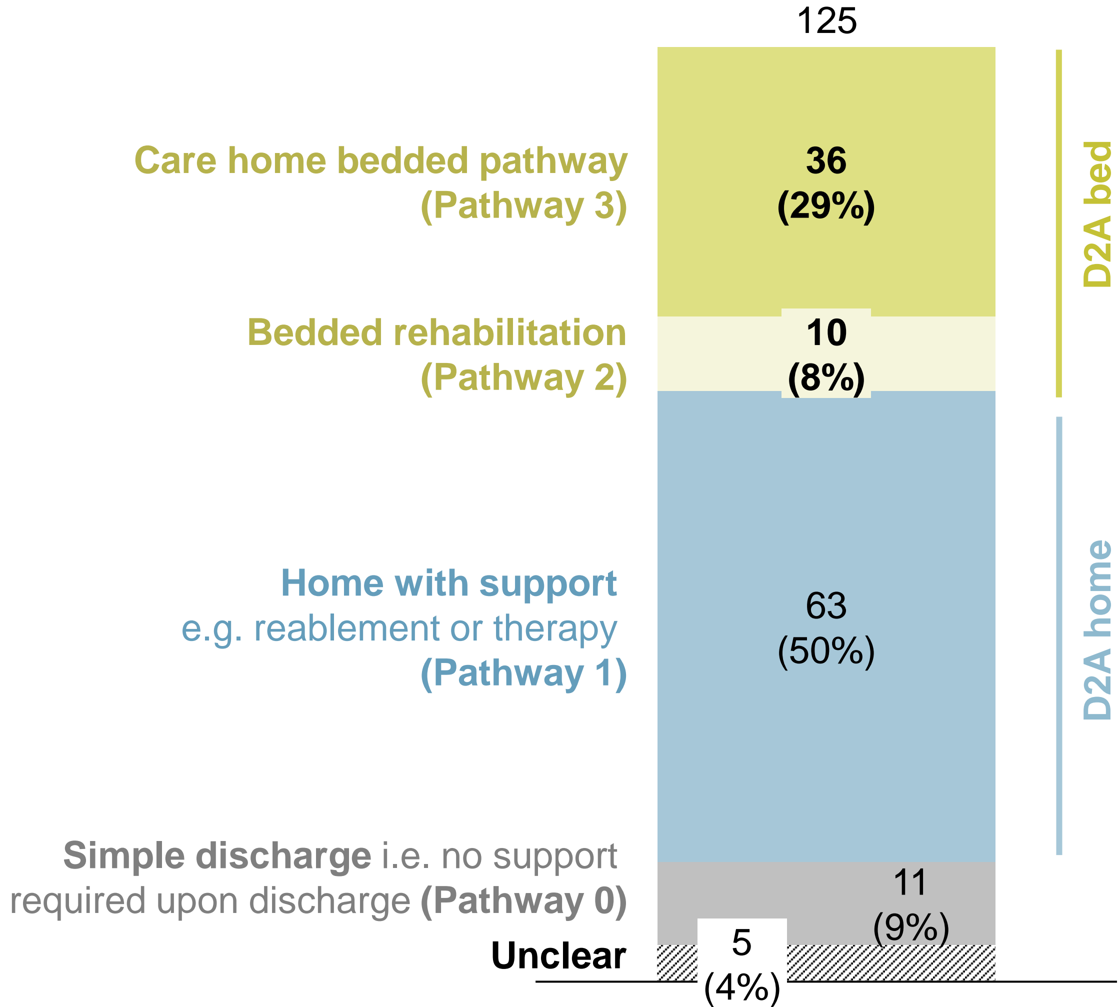
#, 13th November 2023



Source: MO Audit dataset *excludes AMU, Kenley, ADU, CCU

Hospital audit: Of the 125 medically optimised patients, 63 (50%) are waiting for reablement, care or therapy at home (Pathway 1)

MO patients by D2A discharge pathway,
#, 13th November 2023



- There is an ‘opportunity’ of 125 beds that are not required for acute care
- Unnecessary LoS means that patients cannot move through the hospital and ED becomes congested with long waits
- Unnecessary length of stays also lead to higher risk of patients deteriorating on the wards – which mean patients are discharged with higher needs in the community and have less independence

 Source: MO Audit dataset

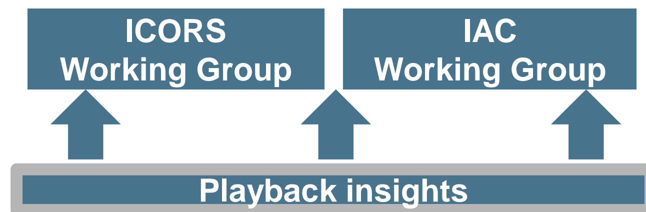
A nursing led improvement workstream piloted improved ways of working on the wards

Objectives:

1. Improved early discharge planning and patient ownership
2. Improving joint ways of working (roles and responsibilities, daily structure, comms)
3. Improving discharge coordination

Ways of working:

- Observations of ways of working through shadowing and attending board rounds
- Capturing feedback from staff
- Review progress against KPIs
- Weekly working groups attended by nurses, therapy leads, IDT



Workstream outputs:

Matrons and ward managers agreed on a template for board round best practice

Croydon Health Services
NHS Trust

Board round best practice

Hospital big picture conveyed
Ward teams made aware of the day's pressures (# of DTAs in ED, # of beds required, outliers)

Effective leadership
- Coordination of board rounds discussions and keeping all members of the team focused and engaged.
- Board rounds start and end on time

Prioritisation of actions, with strong push for discharges
Prioritising 'sick and quick' patients and summarising key actions

EDDs and Medically Optimised (MO)
EDDs reviewed for all patients, MO patients identified

Golden patients
Early discharges (pre-12) identified for the morning, as well as for the following morning, and the required actions

Whole-MDT presence and engagement
Constructive challenge, curious questions and creative problem-solving to expedite discharges and minimise delays

Early discharge planning
Discharge planning upon admission, i.e., even for NMF patients

Actions & ownership, and effective use of white board
Discussions are action-focused and owners assigned. Previous actions followed up, and owners held accountable

Weekend di
Patients iden

Afternoon b
Updating and

11

Output: Sharing best practices across wards – Board round checklist

Croydon Health Services
NHS Trust

Wandle 1
9:15 BOARD ROUND
DATE:

HOSPITAL BIG PICTURE
INCIDENTS
GOLDEN PATIENTS
DISHARGES
WEEKEND DISCHARGES
NEW ADMISSIONS
INFECTIOUS CASES
UPCOMING MEETINGS
OTHER MATTERS
4PM BOARD ROUNDS

Board round checklist

Purpose:
- Crib sheet to support 9am board round discussions

How is it used?
- Filled out by NIC/nurse leading board round following nursing handover, e.g.:
  - How many DTAs in ED
  - Who are the golden patients and outstanding discharge-dependent tasks
- Used daily at W1 and W3 board rounds to agree priority actions

Benefit
- All discharge-relevant information is covered
- Non-person dependent i.e. standardised process to be completed by any individual

How was it created?
- Developed by Vivian, ward leader on Wandle 1, following discussions on board round best practices

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Transformation Nous

Impact: On pilot wards the board round quality has improved, there are more discharges and earlier discharges

Board round observations

Week 1 | Week 3 | Week 6

- Conveyance of hospital big picture
- EDDs
- Prioritisation of actions, strong push for discharge
- Discharge planning
- Golden patient identification
- Daily rhythm
- Leadership
- MDT presence & engagement
- Real time use of Patienteer

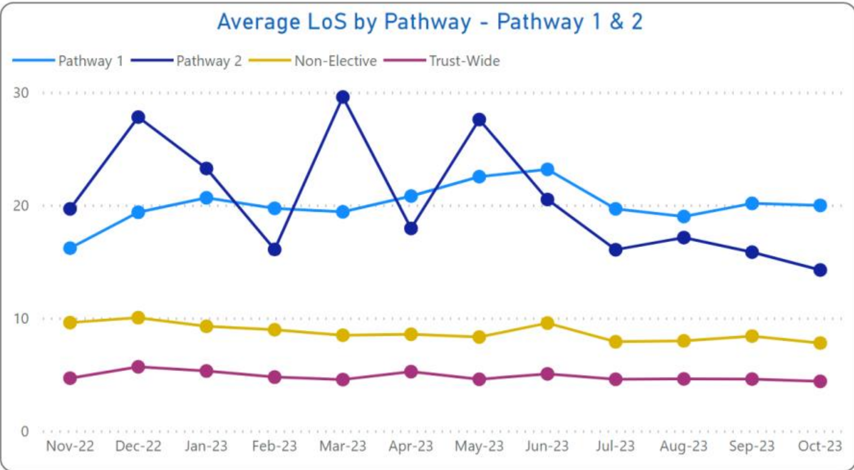
Average number of daily discharges by week,
(%), 31st July 2023 – 11th November 2023

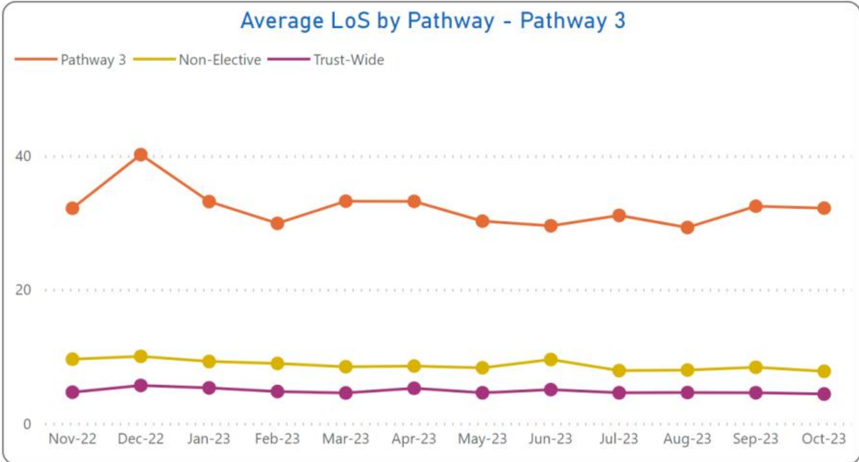
	Total	06:00 - 12:59	13:00 - 16:59	17:00 - 5:59
Week 1	1.1	12%	50%	38%
Week 2	1.0	14%	29%	57%
Week 3	2.3	13%	38%	50%
Week 4	1.4	10%	60%	30%
Week 5	1.7	17%	50%	33%
Week 6	1.6	27%	18%	55%
Week 7	1.0	29%	57%	14%
Week 8	2.1	13%	13%	73%
Week 9	2.0	7%	36%	57%
Week 10	1.9	15%	23%	62%
Week 11	2.6	22%	33%	44%

Impact: The average length of stay has dropped on Pathways 0, 2, and 3

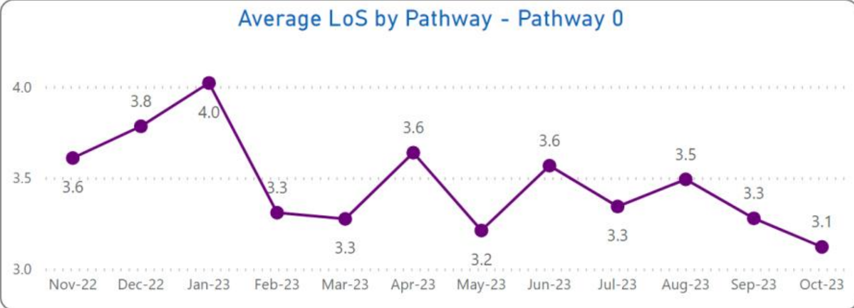
Hospital - LoS by Pathways

Pathway 1 20.0 | Pathway 2 14.3 | Pathway 3 32.2 | Non-Elective 7.8 | Trust-Wide 4.4





Pathway 0 3.1

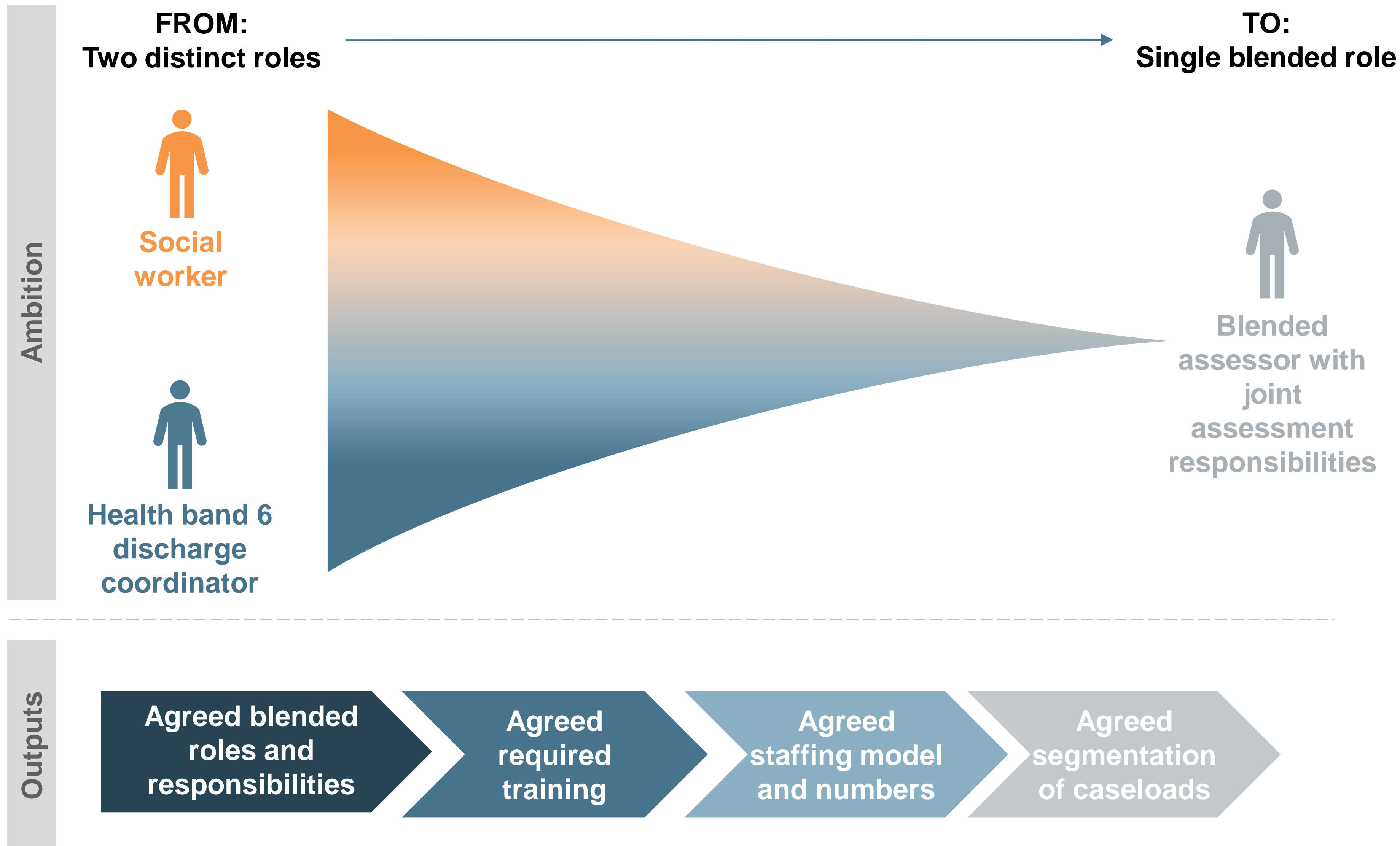


Avg. Daily Discharge & Avg. LoS by Pathway

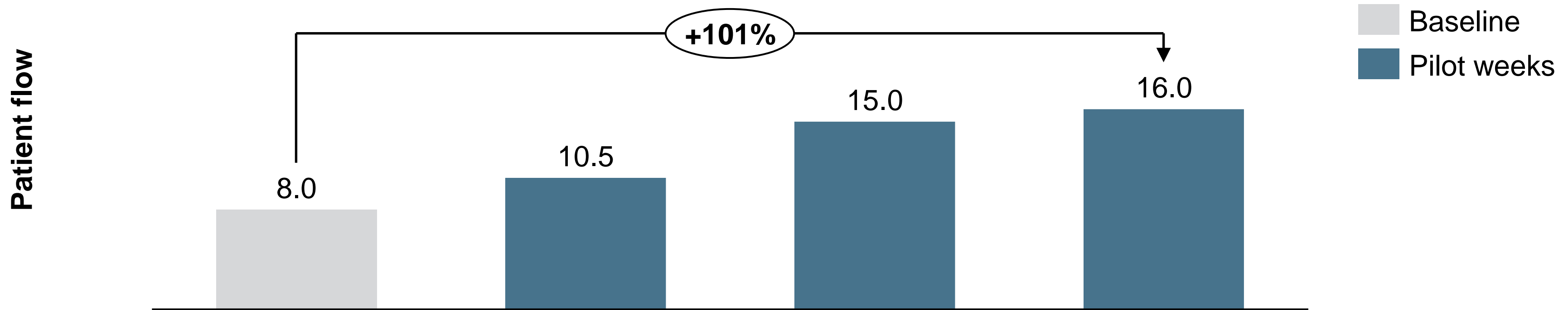
Month	Aug-23			Sep-23			Oct-23		
Pathway	Avg. LoS	Daily Avg Discharge	Prop.	Avg. LoS	Daily Avg Discharge	Prop.	Avg. LoS	Daily Avg Discharge	Prop.
Pathway 0	3.5	83.9	93.6%	3.3	86.5	93.0%	3.1	82.6	93.2%
Pathway 1	19.0	4.5	5.0%	20.2	5.1	5.4%	20.0	4.9	5.5%
Pathway 2	17.1	0.3	0.3%	15.8	0.4	0.4%	14.3	0.3	0.3%
Pathway 3	29.3	1.0	1.1%	32.5	1.1	1.1%	32.2	0.9	1.0%
Total		89.6	100.0%		93.0	100.0%		88.6	100.0%

Note: The Average LoS on this page includes patients admitted through both elective and emergency routes and zero LoS patients except where stated otherwise.

We conducted a pilot to develop a blueprint for creating a 'blended assessor' role within the IDT team



Impact: The pilot of blended roles showed there was improved flow of patients and staff satisfaction



Staff feedback

Area	Reflections from IDT staff following the pilot of the blended role
Benefits	▪ IDT members and ward staff have **responded positively to increased IDT presence on the wards** and have seen **improved referral times** ▪ **Collaboration** between the health and social sides of the IDT has improved – *"I didn't really know the discharge coordinator before the pilot – but now we're best friends" – social worker* ▪ IDT staff feel they have **developed professionally and gained confidence** through the pilot
Challenges	▪ IDT staff **don't see the value in the blending** of social workers and Band 6s

▪ CUH daily discharge sitrep & TN data collection

We have completed a consultation to move from an IDT with a split structure (Trust and Council)…

Integrated Discharge Team Operations Manager
Band 8a
1.0 WTE

Medical complex discharge lead
Band 7
1.0 WTE

VACANT
COTE complex discharge lead
Band 7
1.0 WTE

Surgical complex discharge lead
Band 7
1.0 WTE

Advanced Dis/Co
Band 6
1.0 WTE

Advanced Dis/Co
Band 6
1.0 WTE

Advanced Dis/Co
Band 6
1.0 WTE

Advanced Dis/Co
Band 6
1.0 WTE

Senior Dis/Co
Band 5
1.0 WTE

VACANT
Senior Dis/Co
Band 5
1.0 WTE

Senior Dis/Co
Band 5
1.0 WTE

Senior Dis/Co
Band 5
1.0 WTE

Dis/Co
Band 3
1.0 WTE

Dis/Co
Band 3
1.0 WTE

VACANT
Dis/Co
Band 3
1.0 WTE

VACANT
Dis/Co
Band 3
0.43 WTE

Dis/Co
Band 3
1.0 WTE

Dis/Co
Band 3
1.0 WTE

VACANT
Dis/Co
Band 3
1.0 WTE

Dis/Co
Band 3
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Band 3
1.0 WTE

Dis/Co
Band 3
1.0 WTE

Dis/Co
Band 3
1.0 WTE

Dis/Co
Band 3
1.0 WTE

IDT Administrator
Band 4
1.0 WTE

IDT duty coordinator
Band 3
1.0 WTE

VACANT
Integrated Discharge Team Operations Manager
Grade 15
1.0 WTE

Advanced Social Worker
Grade 14
1.0 WTE

Advanced Social Worker
Grade 14
0.88 WTE

Advanced Social Worker
Grade 14
1.0 WTE from winter budget non-recurrent

Experienced Social Worker
Grade 12
1.0 WTE

Experienced Social Worker
Grade 12
1.0 WTE

VACANT
Experienced Social Worker
Grade 12
1.0 WTE

Social Worker
Grade 10
0.88 WTE

VACANT
Social Worker
Grade 10
2.0 WTE (2.0 used by G9)

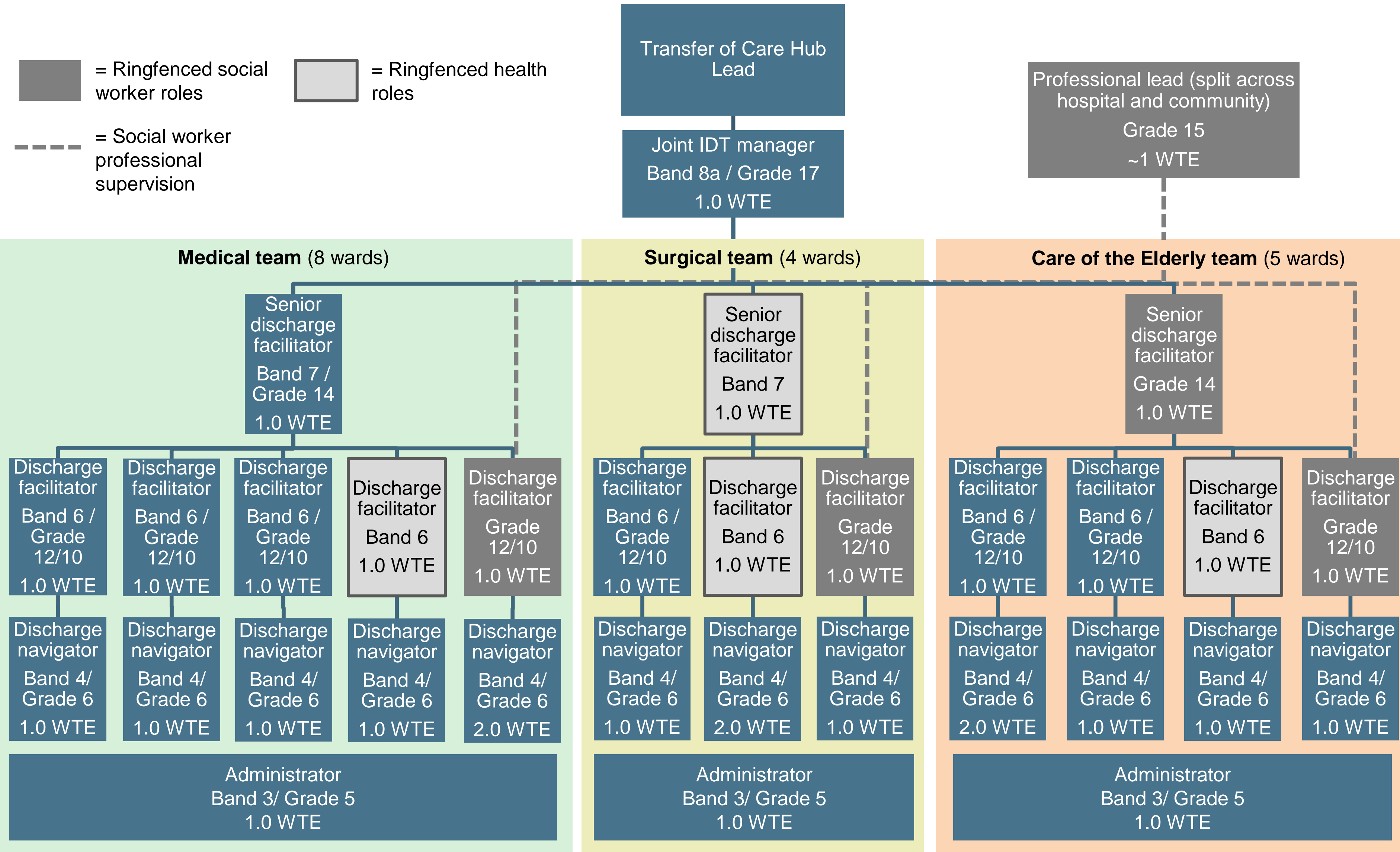
Newly Qualified Social Worker
Grade 9
1.0 WTE – NO BUDGET – using G10

Newly Qualified Social Worker
Grade 9
1.0 WTE – NO BUDGET – using G10

LOCUM
Health and Wellbeing Assessor
Grade 8
1.0 WTE

Administrator
Band 3
1.0 WTE post within Business Support Unit

…to an integrated health and social structure



Note: The ringfenced G14 and B7 could be in any of the three teams – they are shown in COTE and Surgery as an example. Similarly the ringfenced B6 and G12/10 roles could be in any of the posts in each team.

To improve variation in assessment practices, we co-developed with teams a single assessment team, developed a joint tracker with agreed KPIs to assess performance

Improving flow and reporting of data in the Integrated Discharge Team:

- ASC and hospital colleagues identified the lack of a ‘one version of the truth’ on patient flow into the community

What we did

- We co-designed and implemented a joint tracker (for hospital & council teams) that follows Pathway 1 discharges from referral to discharge

Impact

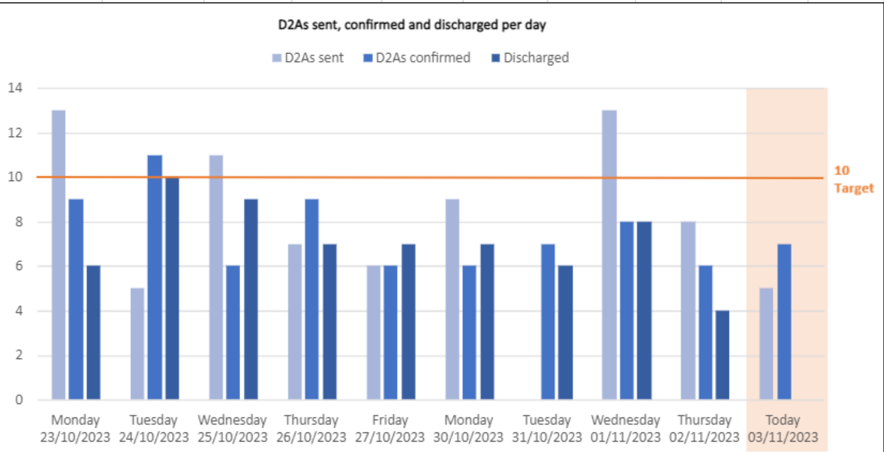
- Head of ASC brokerage – “It’s great to have everyone working from a One Version of the Truth”
- Deputy Chief of Operations (CUH) – “Now we can clearly see the failed discharges and get learnings for next time”

Pathway 1 discharge planning

Date and time stamp	11:40 07/12/2023
Total waiting POC	14
Awaiting triage	10
Awaiting brokerage	4

Wednesday 06/12/2023		Today 07/12/2023		Friday 08/12/2023	
Patients discharged yesterday:	0				
Failed discharges	1	POC confirmed and to start today:	0	POCs confirmed and to start next day:	0

Dashboard



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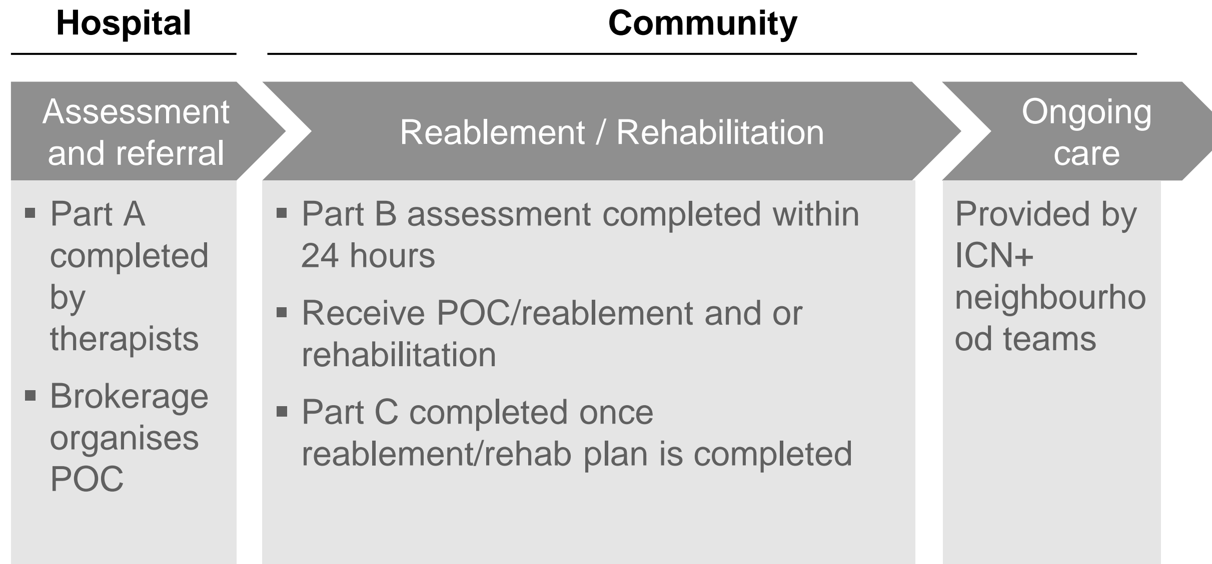
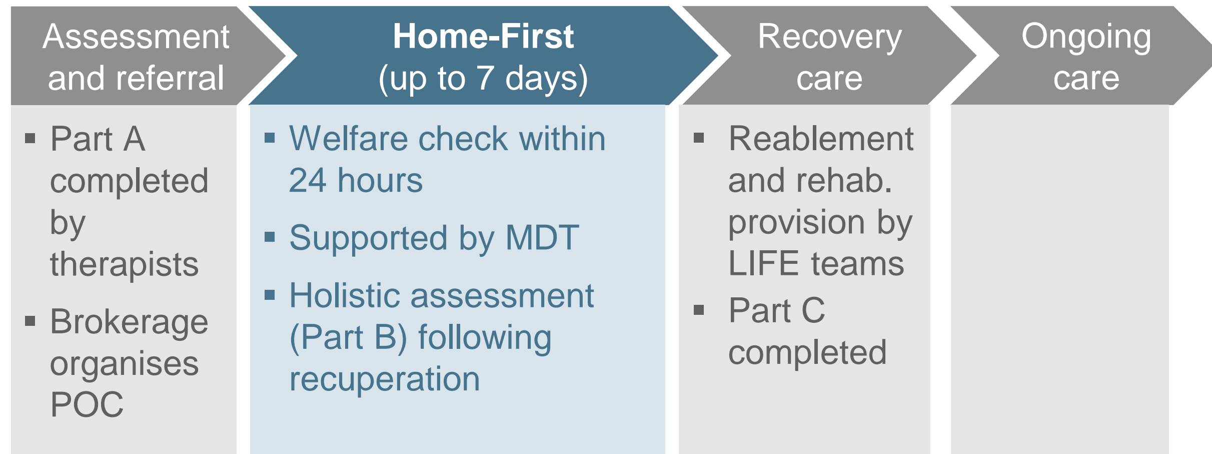
A prototype tested the ‘Home First’ model to improve outcomes and experiences for Croydon residents

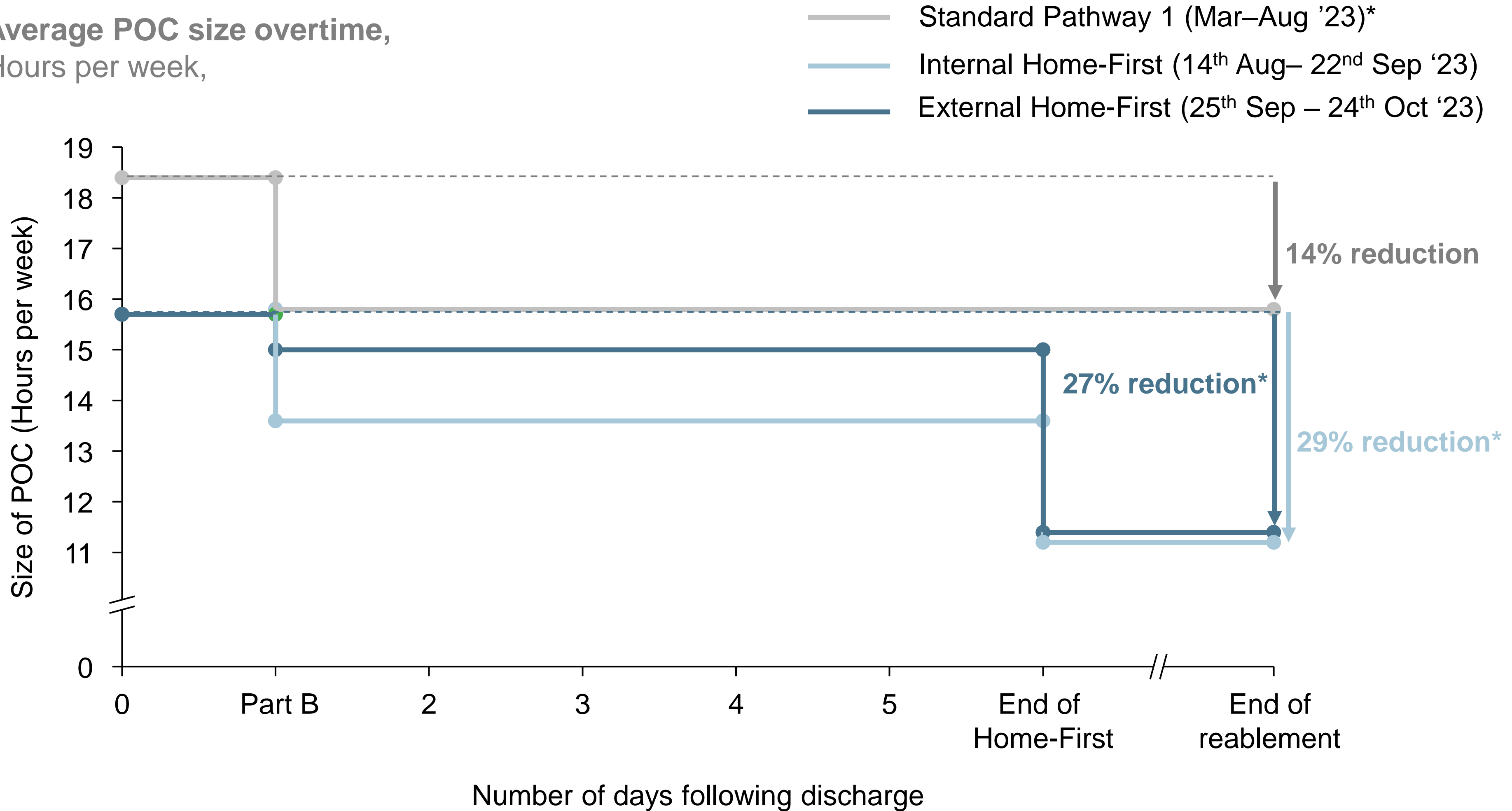




Home-First objectives:

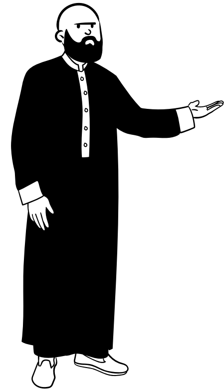
- **Increased resident independence and reduced overprovision of intermediate / ongoing care** as patients are holistically assessed whilst recuperating for up to 7 days
- **Reduced readmissions** due to MDT and Home-First support
- **Reduced length of stay in hospital** due to providing consultants with confidence to discharge to service

Impact: The Home-First team has resulted in have seen an improvement in the 'right-sizing' of care in the days following discharge



* Assuming the average visit is 50 mins. 4 external Home-First patients are missing information on POC size

Impact: Jack's case study



Context: Jack is a 66-year-old man who lives in a lower ground floor flat. Prior to his hospital stay, he had been completely independent and had never had a package of care. He enjoys cricket, travel, and his grandchildren.

Timeline summary:

31/08/23	Admission to CUH
15/09/23	Referral to Home-First Service
16/09/23	Discharge from CUH. A&E Liaison Officer, attended for welfare check
17/09/23	Home-first team assessed and put in a plan of action
17/09/23	Equipment delivered (shower stool and walking stick)
20/09/23	Family informed officers Jack was travelling to Jamaica and keen to get better
22/09/23	Jack was supported effectively, he followed his plan, got well and was discharged
23/09/23	Jack was fit enough to fly to Jamaica

Benefits of Home-First care for Jack:

- **Increased independence:** Going to the home-first team for 7 days prevented Jack from receiving a 6 weeks long package of care that he did not require and may have reduced his independence
- **Effective communication with family:** The Home First team worked / communicated effectively with Jack's family to identify tailored goals and work up a plan to help achieve them
- **Personalised care:** By spending the time to get to know Jack and his hobbies, the Home First team was able to align the right member of staff to help achieve his goals
- **Collaborative MDT:** Daily monitoring and discussing of Jack helped put in the right support to reach his goals within 7days

Impact: Home-first staff reflections

MDTs a success & improved:
- Information flow
- Staff confidence
- Shared learning

Great conversations at MDT enhancing staff knowledge on other areas and knowing each other better

Created a mechanism for using resources efficiently

make our job enjoyable

Improved working relationships between all stakeholders especially with our external care providers

Discussing residents in an MDT speeds up care & help us all put robust care plans in place for our residents

Highlighted areas that needs improvement especially communication between all staff

This way of working should be encouraged and implemented

Supported identifying areas of training needs for staff

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Workstream 3 is integrating six separate therapy and reablement to reduce duplication and siloed working

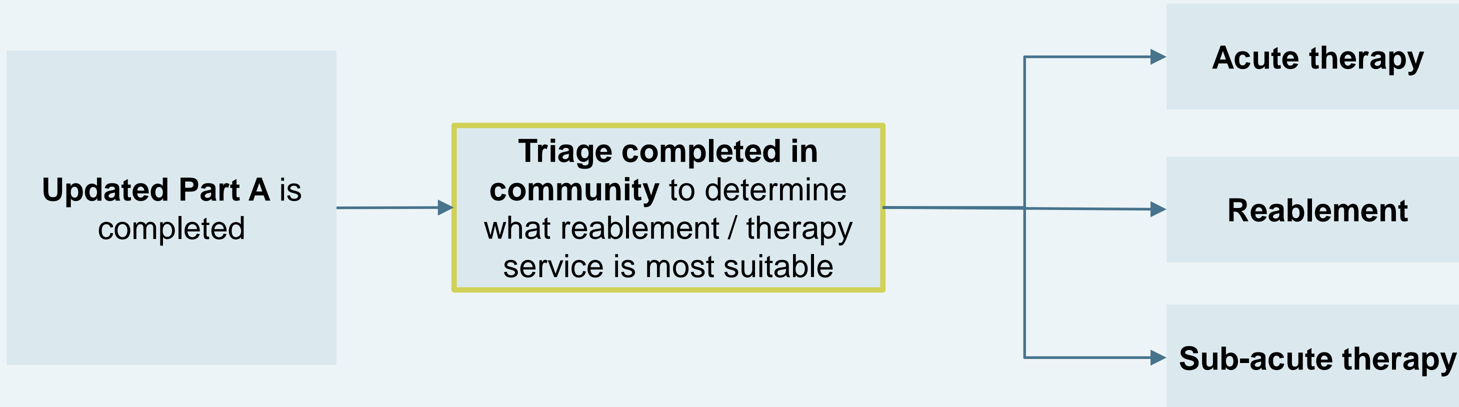
Reablement (Social)				
	Teams and responsibilities	**1. LIFE Early Reablement:** Complete Part Bs and Cs and offer social support in community	**2. LIFE Reablement and Recovery:** Complete Part Bs and Cs and provide reablement visits	**3. OOB social care:** Complete Part Bs and Cs, offer social support in community and complete in-hospital Pathway 3 assessments
	Workforce	▪ Social workers ▪ Health and wellbeing assessors (HWA)	▪ Senior reablement officers ▪ Reablement officers	▪ Social workers ▪ HWAs

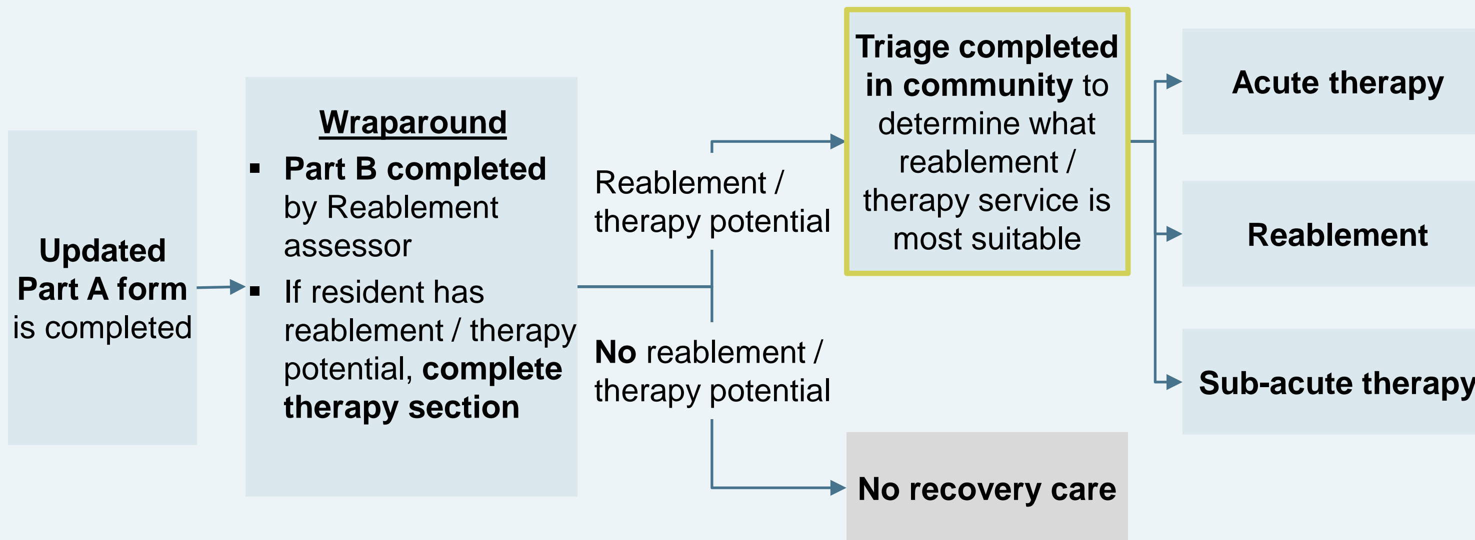
Therapy (Health)				
	Teams and responsibilities	**4. LIFE Therapy:** Provide rehabilitation to patients discharged from CUH	**5. Domi Physio:** Provide rehabilitation to residents in their home	**6. Falls:** Provide rehabilitation to residents that have had a fall
	Workforce	▪ Physios (PTs) ▪ Occupational therapists (OTs) ▪ Therapy assistants (TAs) ▪ HWAs	▪ PTs ▪ TAs	▪ PTs ▪ OTs ▪ TAs ▪ Practitioners

Areas of opportunity for integration:

- **Reablement:**
  - Overlapping responsibilities
  - Different roles with different bandings that have same responsibilities (e.g., HWAs and Senior reablement officers)
- **Therapy:**
  - Multiple triages
  - Different referral forms
- **Reablement and therapy:**
  - Duplication of assessments and visits
  - Different systems (LAS and EMIS)

Impact: We have introduced a joint triage or single point of access into reablement and therapy to reduce duplication



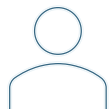


Impact of the new process:

- **Referrals all via SPOA** from any source, uploaded to a main EMIS inbound folder
- **Single referral** will be made, rather than scattergun referrals to each of the existing services
- **Single triage** to determine the best service rather than each team triaging in isolation
- **Same system** would be used by each team leading to better oversight of patients

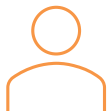
Impact: We have developed single job descriptions for community assessors to integrate teams and improve standards

FROM: 3 distinct 'reablement assessor' roles



Health and Wellbeing Assessor (Grade 8)

- Responsibilities: Complete Part Bs and Cs, escalate any social/reablement challenges and provide induction and LAS support to new workers
- Employed by the council
- Currently sit within the LIFE early reablement and OOB social care team



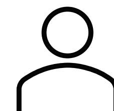
Health and Wellbeing Support Worker (Grade 6)

- Responsibilities: Complete Part Bs and Cs and escalate social/reablement challenges
- Employed by the council
- Currently sit within the LIFE early reablement team

Senior Reablement Officer (Grade 7)

- Responsibilities: Complete Part Bs and Cs, escalate any social/reablement challenges and supervise reablement officers
- Employed by the council
- Currently sit within the LIFE recovery and reablement team

TO: 1 integrated 'Reablement assessor' role



Reablement assessor (Grade 8)

- Complete Part Bs and Cs, escalate any social/reablement challenges and supervise reablement officers
- Employed by the council/NHS
- Sitting across the Community Recovery Service

We have developed an options appraisal for reablement considering direct costs, ongoing costs, quality and feasibility of delivery

FOR DISCUSSION

	1	2	3	4
	Fully external *(see page 7)*	**Hybrid: Internal team provide ~15% of reablement** *(see page 8)*	**Hybrid: Internal team provide 50% of reablement** *(see page 9)*	**Fully internal** *(see page 10)*
Description	Reablement provision outsourced to a care agency	▪ Croydon employed staff provide 3 reablement visits each week to reablement only patients (~15%) ▪ Care agency provide remaining reablement	Reablement provision split equally between Croydon employed staff and a care agency	Reablement provided by Croydon employed staff
Annual cost of reablement and assessment	**£2.6 million**	**£3.1 million**	**£4.0 million**	**£6.0 million**
Required staffing	**N/A**	▪ **17 reablement officers** ▪ **1 manager**	▪ **60 reablement officers** ▪ **4 managers**	▪ **120 reablement officers** ▪ **8 managers**
Annual cost of ongoing care	**£6.8 million** (26%* patients require ongoing care)	**£3.7 million** (14%** patients require ongoing care)	**£3.2 million** (12% patients require ongoing care)	**£2.6 million** (10% patients require ongoing care)
Implications	▪ Lose the existing high quality internal reablement team ▪ Need to incentivise care agencies to provide reablement	Need to incentivise care agencies to provide reablement focused care	▪ Need to incentivise care agencies to provide reablement focused care ▪ Additional funding required for estates	▪ Potential drop in quality of reablement when managing a large team ▪ Additional funding required for estates

Note: Cost of assessment is not included – required capacity is already within the system so no additional funding is required

*Current outcomes of external reablement
** Current outcomes of internal reablement

Agenda

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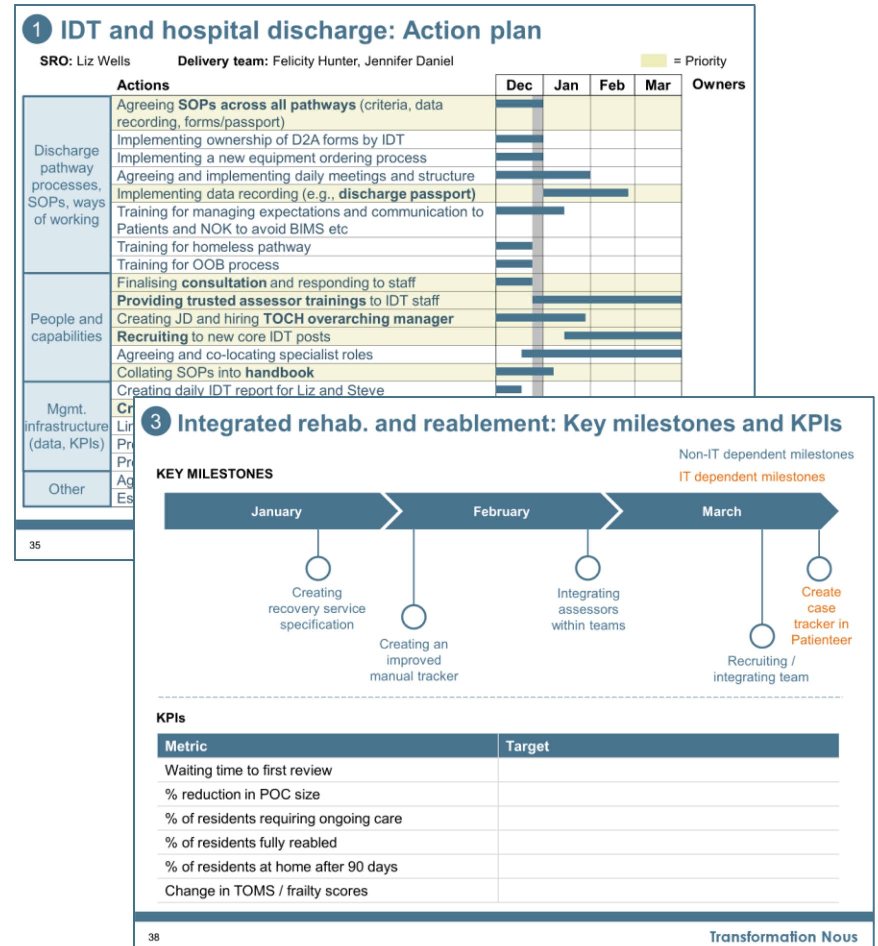
- Appendix

There is still a way to go on our transformation journey. To support the ongoing implementation, we have developed action plans and clear governance for each workstream

Each workstream lead has developed:

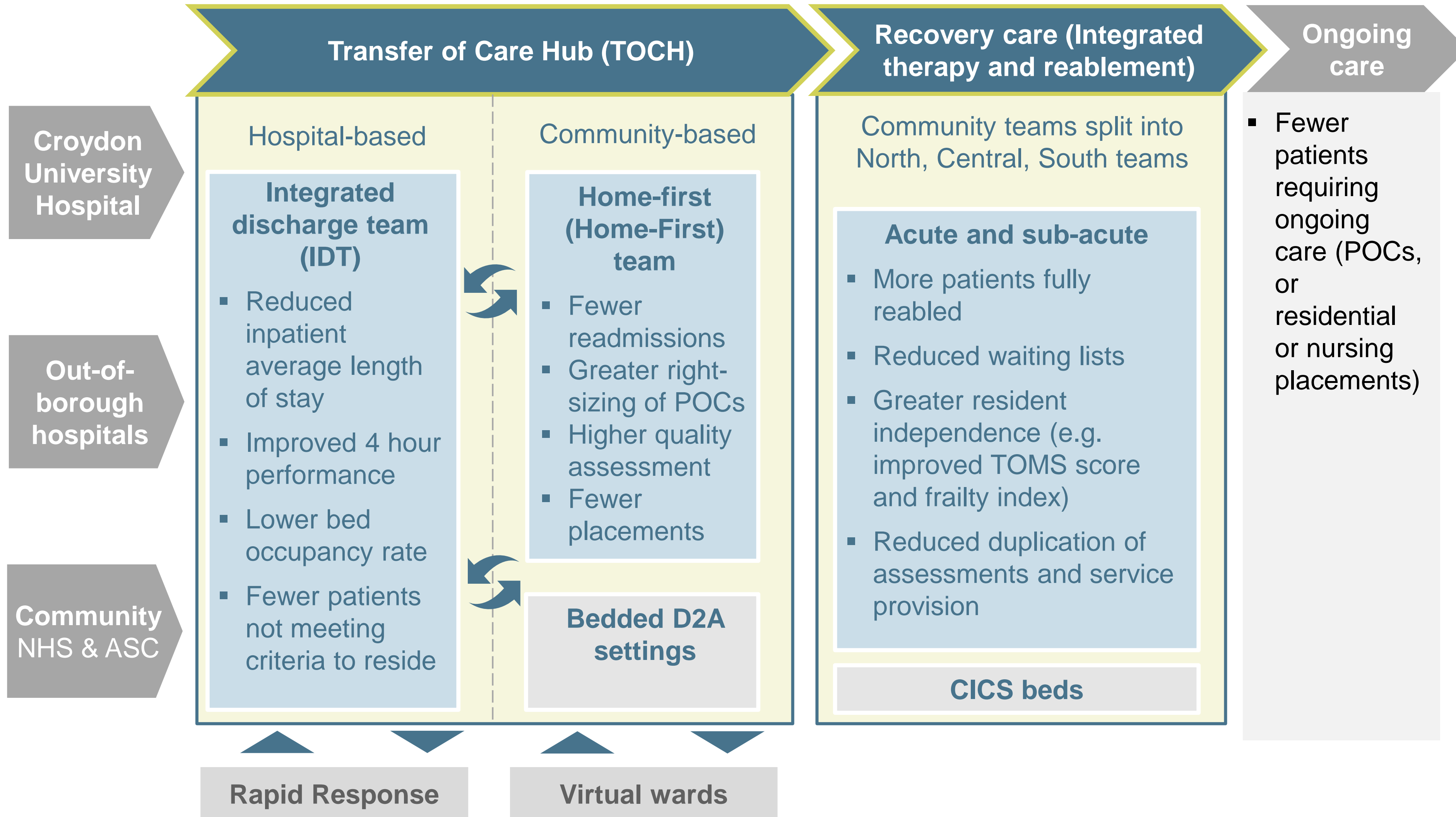
- High level workstream milestones to measure success against
- Clear workstream action plans with assigned owners and timelines
- Regular reporting and governance routes
- Agreed KPIs to monitor progress against

See following pages for detail

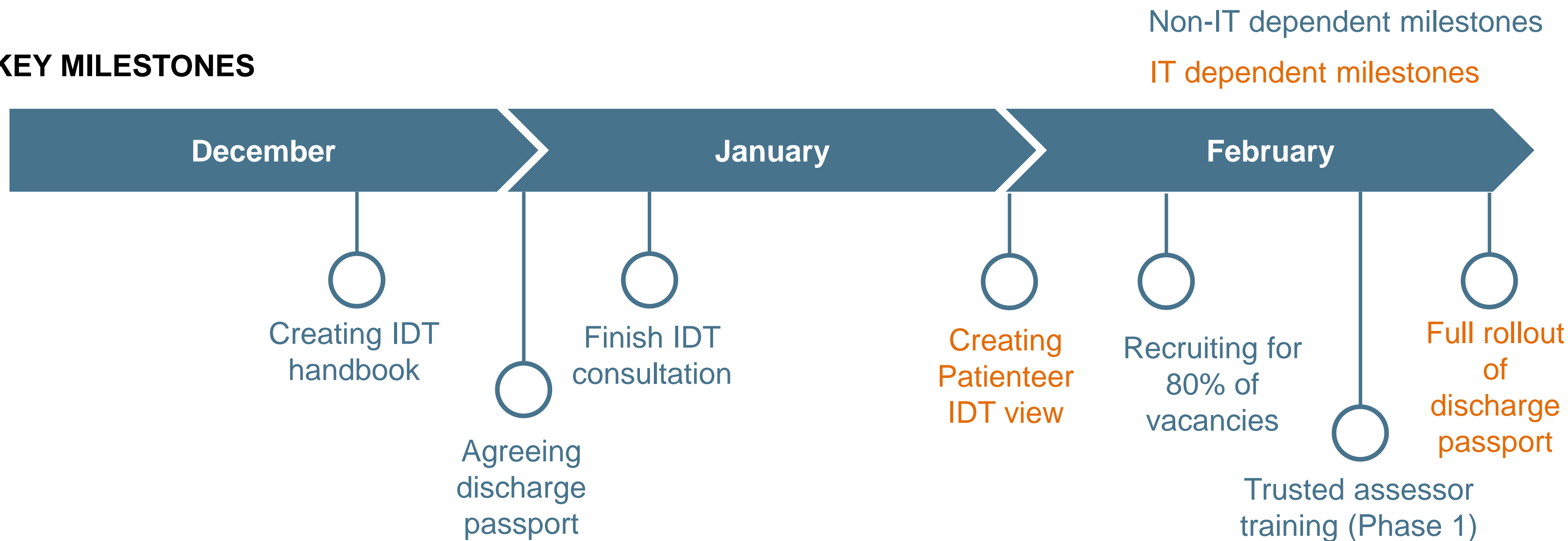


Implementing the ‘blueprint’ will provide benefits across the entire system including reduced unnecessary length of stay in hospital, improved intermediate care outcomes and less ongoing care required

Benefits and KPIs of implementing the blueprint



1 IDT and hospital discharge: Key milestones and KPIs



KPIs

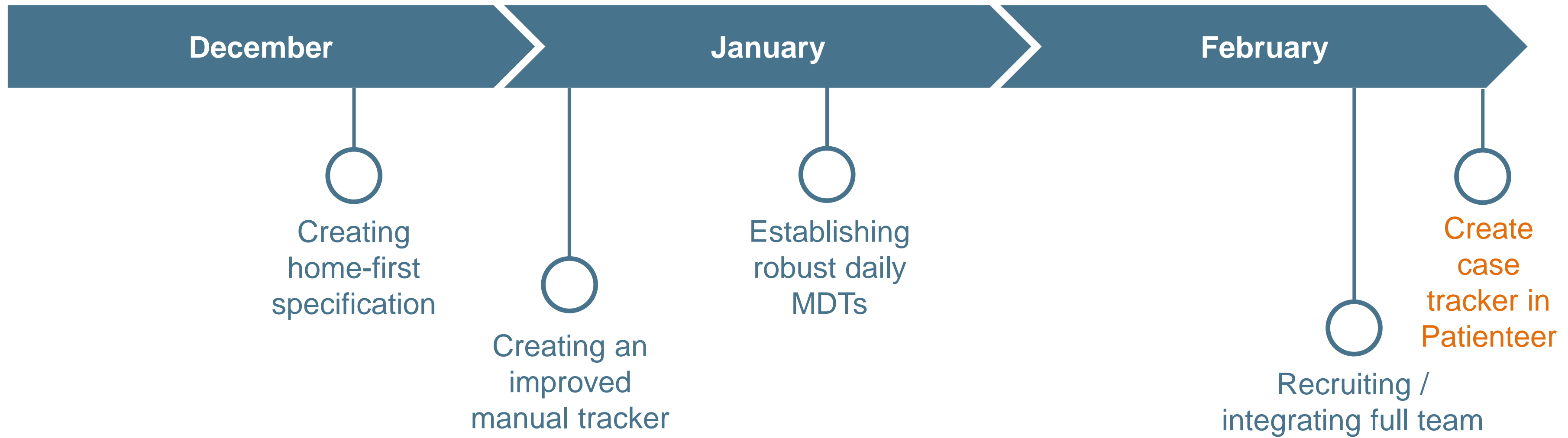
Metric	Target
Average length of stay by pathway	~8 days (pre-Covid metric)
Bed occupancy rate	~85% bed occupancy rate (with escalation areas closed during non-winter months)
Proportion of patients in acute beds that meet criteria to reside	90% of patients meeting criteria to reside
# of BIMs completed	
Average time from Part A referral to discharge	

1 IDT and hospital discharge: Action plan

Lead: Liz Wells **Delivery team:** Felicity Hunter, Jennifer Daniel = Priority

	Actions	Dec	Jan	Feb	Mar	Owners
Discharge pathway processes, SOPs, ways of working	Agreeing **SOPs across all pathways** (criteria, data recording, forms/passport)					
	Implementing ownership of D2A forms by IDT					
	Implementing a new equipment ordering process					
	Agreeing and implementing daily meetings and structure					
	Implementing data recording (e.g., **discharge passport)**					
	Training for managing expectations and communication to Patients and NOK to avoid BIMS etc					
	Training for homeless pathway					
	Training for OOB process					
People and capabilities	Finalising **consultation** and responding to staff					
	Providing trusted assessor trainings to IDT staff					
	Creating JD and hiring **TOCH overarching manager**					
	Recruiting to new core IDT posts					
	Agreeing and co-locating specialist roles					
	Collating SOPs into **handbook**					
Mgmt. infrastructure (data, KPIs)	Creating daily IDT report for Liz and Steve					
	Creating IDT tracker in Patienteer including KPI reporting					
	Linking data with community teams through Patienteer					
	Provide managers with access to HR software					
	Providing IT access to all staff					
Other	Agreeing S75 funding					
	Estates improvements					

2 Home-first team: Key milestones and KPIs

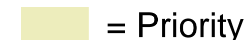


KPIs

Metric	Target
Time from discharge to first assessment (Part B)	
Readmission rate	
% reduction in POC size	
% of residents requiring no ongoing care	
# of hospital placements	

2 Home-first team: Action plan

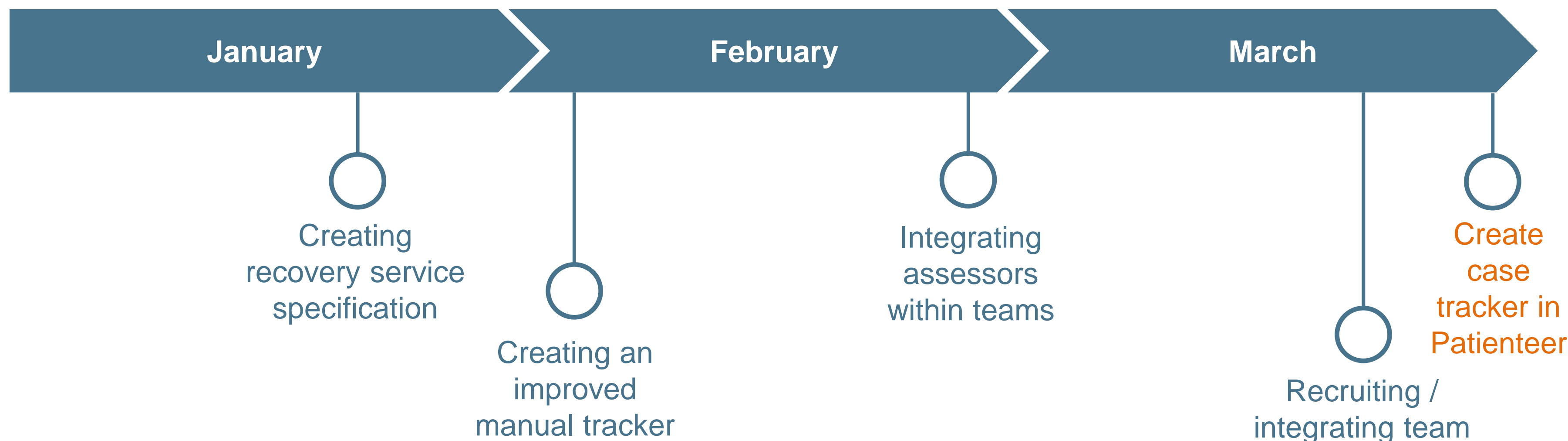
Lead: Maria Knopp **Delivery team:** Jennifer Daniel, Cynthia Abankwa

 = Priority

	Actions	Dec	Jan	Feb	Owners
Processes, SOPs, ways of working	Creating updated **assessment forms** (Part B)				
	Creating **specification** for home-first service				
	Establishing daily MDTs				
People and capabilities	Integrating existing **assessor roles** (OOB, Mary's team)				
	Creating JD and hiring **TOCH overarching manager**				
	Agreeing home-first manager				
	Recruiting to new posts and building teams (e.g., therapists, nurses, assessors, manager)				
	Developing training materials				
	Providing trainings to staff (e.g., assessors on holistic assessments)				
	Engaging with care agencies to agree partnership model and commissioning arrangements				
Mgmt. infrastructure	**Agreeing KPIs** and targets				
	Creating improved excel tracker and reporting mechanism				
	Creating case tracker in Patienteer				
Other	Agreeing S75 funding				
	Agree estates for team				

3 Integrated rehab. and reablement: Key milestones and KPIs

KEY MILESTONES



KPIs

Metric	Target
Waiting time to first review	
% reduction in POC size	
% of residents requiring ongoing care	
% of residents fully reabled	
% of residents at home after 90 days	
Change in TOMS / frailty scores	

3 Integrated rehab. and reablement: Action plan

Lead: Maria Knopp **Delivery team:** Jennifer Daniel = Priority

	Deliverables	Dec	Jan	Feb	Mar	Owners
Processes, SOPs, ways of working	Agree referral forms into **therapy/reablement teams**					
	Creating **specification** for integrated teams					
	Establishing daily triage					
	Implementing partnership ways of working with care agencies					
	Agreeing transport arrangements for staff					
People and capabilities	Integrating existing **assessor roles** (OOB, Mary's team)					
	Creating JD and hiring **overarching manager**					
	Agreeing management structure					
	Agreeing reablement options appraisal					
	Recruiting to new posts (e.g., therapists, reablement officers)					
	Developing training materials					
	Providing trainings to staff (e.g., assessors)					
	Develop capability to use TOMS outcome measure					
Mgmt. infrastructure (data, KPIs)	Create a **Patienteer solution** to case manage across therapy and reablement teams					
	Agreeing KPIs and reporting mechanisms					
	Improving commissioning arrangements to create Outcomes based reablement					
Other	Agreeing S75 funding					
	Agree estates					

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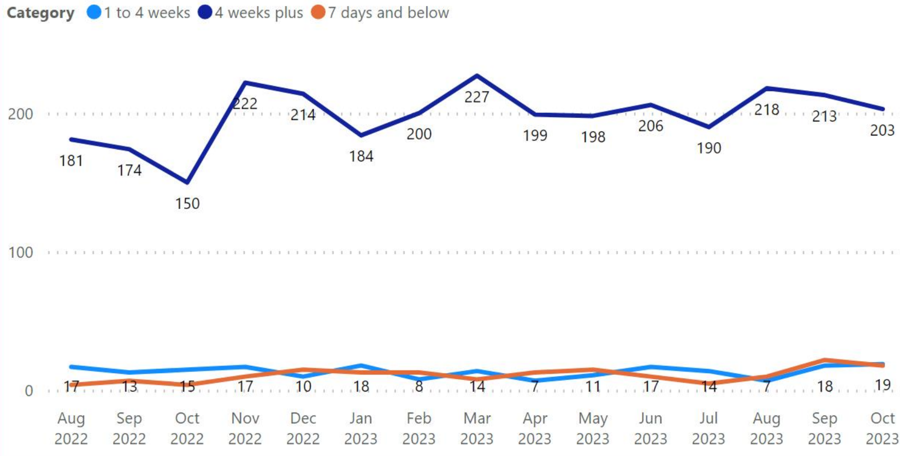
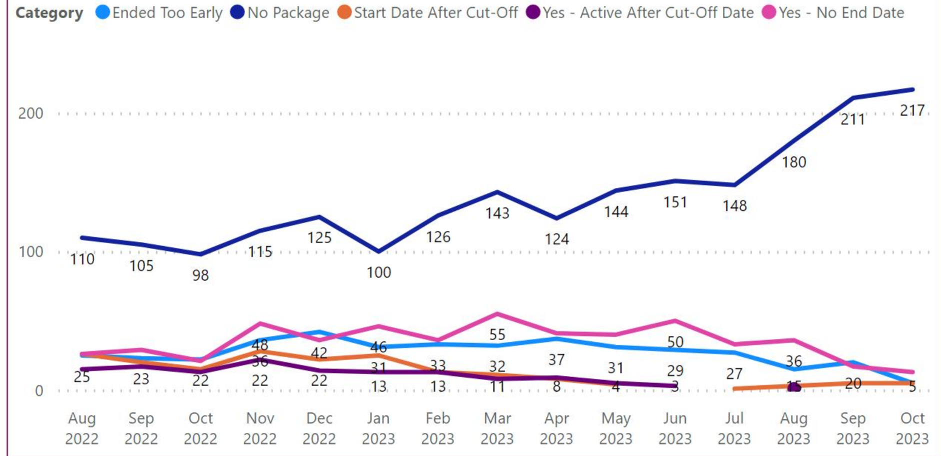
- **Appendix**

POC Length & Post Reablement Packages of Care

Oct 2023





Category	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
1 to 4 weeks	17	13	15	17	10	18	8	14	7	11	17	14	7	18	19
4 weeks plus	181	174	150	222	214	184	200	227	199	198	206	190	218	213	203
7 days and below	4	7	4	10	15	13	13	8	13	15	10	5	10	22	18
Total	**202**	**194**	**169**	**249**	**239**	**215**	**221**	**249**	**219**	**224**	**233**	**209**	**235**	**253**	**240**

Category	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
Ended Too Early	25	23	22	36	42	31	33	32	37	31	29	27	15	20	5
No Package	110	105	98	115	125	100	126	143	124	144	151	148	180	211	217
Start Date After Cut-Off	26	20	15	28	22	25	13	11	8	4		1	3	5	5
Yes - Active After Cut-Off Date	15	17	13	22	14	13	13	8	9	5	3		1		
Yes - No End Date	26	29	21	48	36	46	36	55	41	40	50	33	36	17	13
Total	**202**	**194**	**169**	**249**	**239**	**215**	**221**	**249**	**219**	**224**	**233**	**209**	**235**	**253**	**240**

Comments

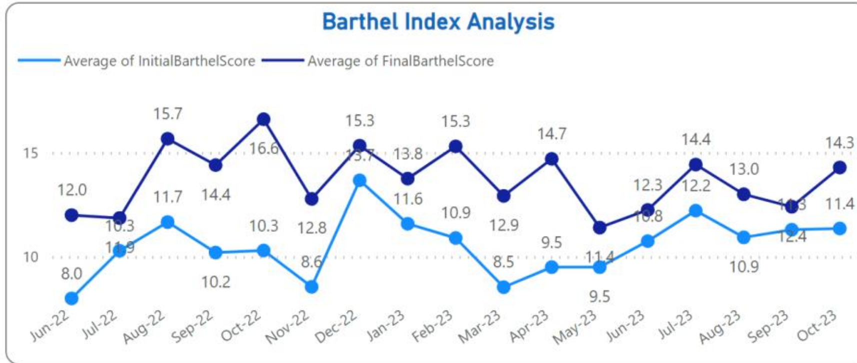
Intermediate Bed

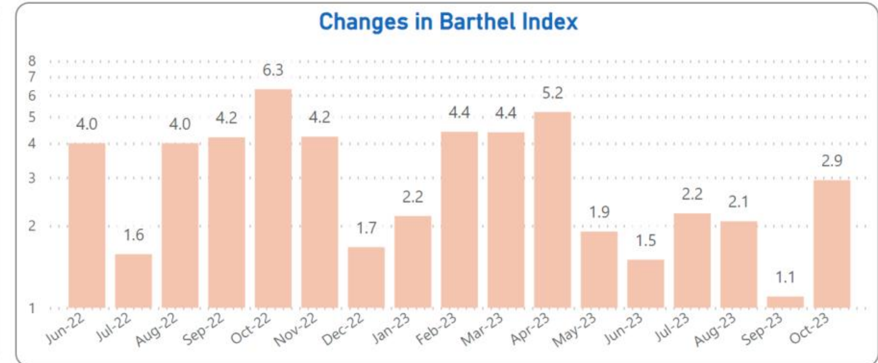
One Croydon

NHS Croydon Health Services NHS Trust

Avg. Initial Score 11.4 Avg. Final Score 14.3

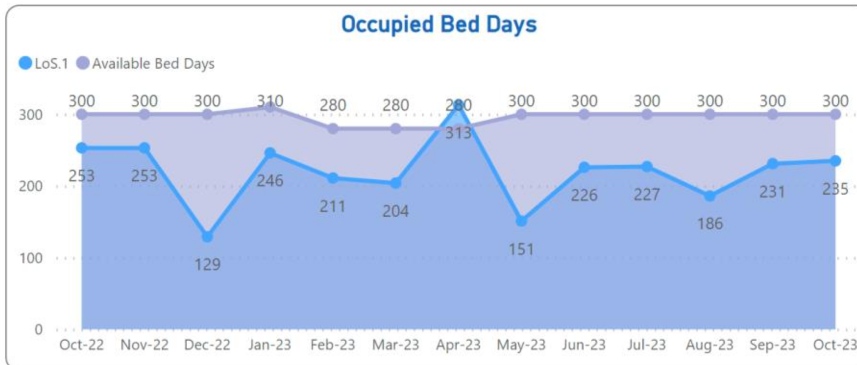
2.9





235

78%

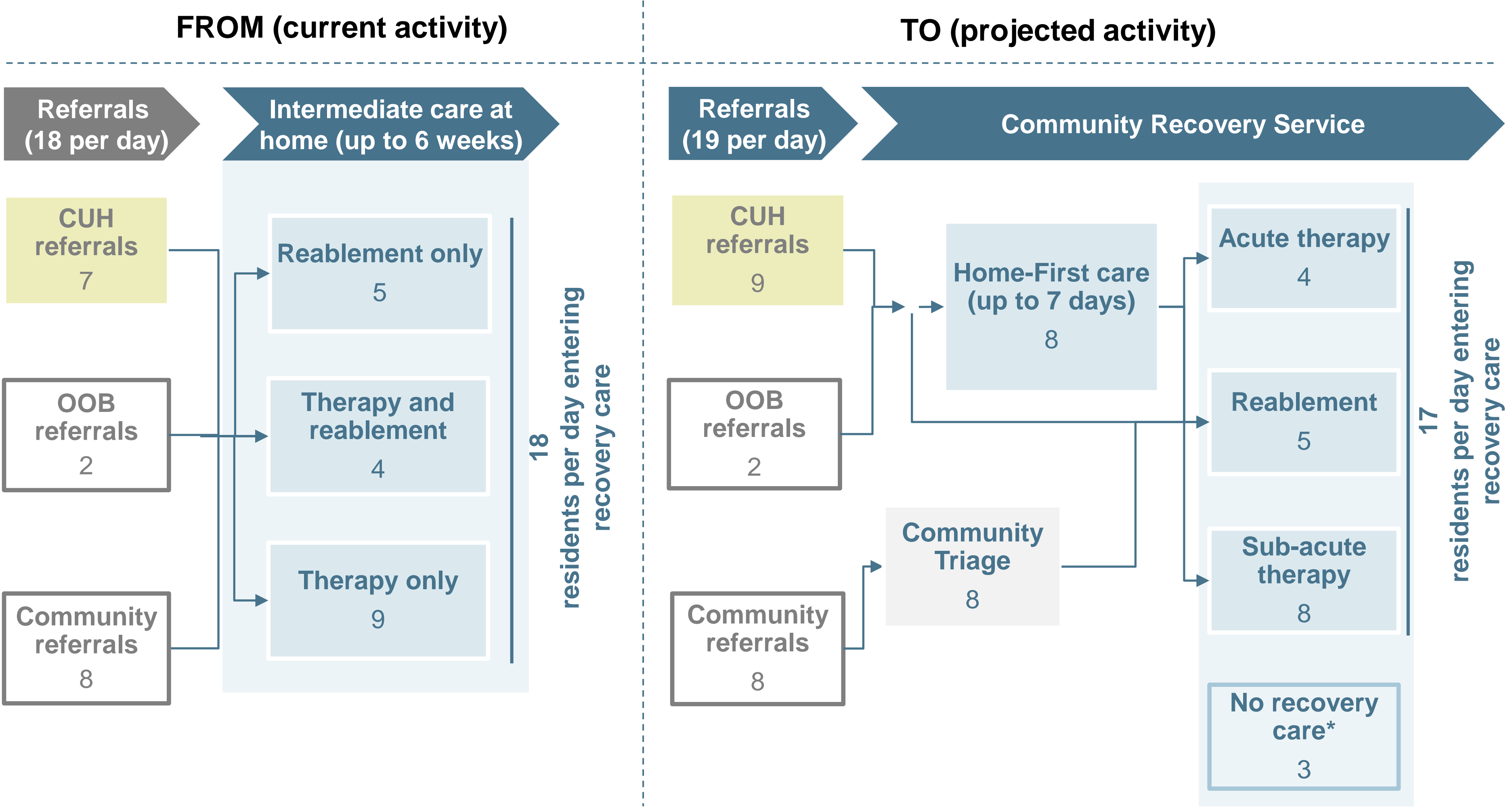


Note: Patient LoS is being used to calculate Occupied Bed Day due to the lack of mid-night occupancy data for intermediate beds. Hence, there is possibility of over counting of occupied bed days where two patients have used a bed on the same day.

Professional | Compassionate | Respectful | Safe

Activity: We predict that despite an increase in referrals, fewer residents will require recovery care (decrease from 18 to 16 each day) due to the Home-First service

Daily number of referrals for intermediate care at home from Croydon residents by source and outcome,
#, Aug '22 – Jul'23



 Note: Some numbers may not add up due to rounding

*including patients that go straight into ongoing care e.g. no reablement potential

	Key Outcomes	KPIs
	Pathway 1	
	Reduction in waiting lists for community therapy and reablement	• Average waiting time across recovery care services (for urgent within 2 days. Non-urgent within 2 weeks
	Improved outcomes for patients receiving therapy and reablement in the community • Increased independence at home • Reduction in average time spent under the care of the services • Increased proportion of residents being fully reabled / rehabilitated within 6 weeks (50% of people being fully reabled) • Greater increase in Bartel Index and TOMs score	• Number of resident's receiving recovery care at home by referral source (Step up and Step down) • Number of resident's returning to their usual place of residence (link to BCF Metric) • Reablement: 50% of patients fully reabled within 6 weeks • Therapy: 50% of patients not requiring a POC after 6 weeks of referral • Target: 85% of residents achieving their goals post discharge from Intermediate care
	Reduction in readmissions to hospital	• Readmission rate of patients discharged from hospital
	Reduction in avoidable admissions to hospital	• Number or rate of avoidable admission (link to BCF Metric)
	Improved wellbeing of residents (patients and carers)	• Increase in Wellbeing scores • 80% of people achieving their goals (wholly or partially)
	Reduction in siloed working and duplication across community teams to maximise the use of available resources to offer the best possible support to residents	• 90% of residents satisfaction/ FFT • 90% of Staff satisfaction • 100% of resident's and carers that feel involved in the planning of their care
	Preventing or reducing the need for long term packages of care	• Number of new long term residential placements / POCs (link to BCF metric) • Number of long-term nursing placements / POCs (link to BCF metric)
	Pathway 2	
	Retaining the LOS to 2 weeks for all residents	• 90% of residents being discharged within 14 days
	Reducing the waiting times for medically fit residents discharged	• TBC – Hospital to identify residents suitable to pathway 2
	Reducing the number of inappropriate referrals from hospital	• Service should have no greater than 5% inappropriate referrals
	Reducing the number of residents who go into a step-up bed	• 95% of residents fully discharged home
	Measure the quality of care provided to residents include carers	• 95% of residents satisfied with the service
		•
	Pathway 3 reducing the LOS in hospital	• Reduce LOS in hospital by 10% (11 days)

The proposed blueprint will have a number of benefits across hospital and community

	Hospital	Community
Benefits	▪ Improved flow through the hospital ▪ Fewer handovers and duplication of tasks ▪ Fewer discharge delays ▪ Fewer MO patients ‘stuck’ in hospital ▪ Better discharge experiences for patients ▪ Less deconditioning of patients	▪ Improved assessment quality ▪ Reduced duplication across teams ▪ Easier access to multidisciplinary support for residents ▪ Reduced spend on care agencies
How these benefits will be achieved	▪ Creating an effective IDT ▪ Improved early discharge planning on the wards ▪ Improved information flows between wards, IDT and community teams ▪ Streamlining discharge pathways ▪ Improving joint ways of working	▪ Delivering a new ‘Home-First’ service ▪ Integrating teams ▪ Developing an integrated ‘assessor’ JD and providing training where required
KPIs	▪ Average length of stay ▪ Daily number of discharges ▪ Bed occupancy rate	▪ Percentage of people fully reabled ▪ Improvement in Barthel index ▪ Waiting list ▪ Number of patients going into ongoing POC or residential care ▪ Reduced readmission rates

Home-First: Resident feedback

Really pleased to confirm that the Home-First service has worked well for us

Lack of Liaising with family regarding time of care provision. Otherwise, service was really good

I am very happy with the care package provided

Good service, they took good care of me but requires improvement

I have received nice treatment from my carer