LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**
DATE OF DECISION	**30 July 2024**
REPORT TITLE:	**Integrated Discharge Frontrunner Programme**
CORPORATE DIRECTOR	**Annette McPartland** Corporate Director Adult Social Services **Liz Wells** Managing Director, Acute Services, Croydon Health Services
LEAD OFFICER:	**Rachel Flagg** Programme Director, One Croydon Alliance
LEAD MEMBER:	Councillor Yvette Hopley Adult Social Care and Health
AUTHORITY TO TAKE DECISION:	
WARDS AFFECTED:	**All**

1. SUMMARY

1.1 In December 2022 Croydon was selected as one of six national Frontrunner sites in England and awarded £800,000 funding by NHS England (NHSE) to build on the success of its ground-breaking integration work by the One Croydon Alliance.

1.2 The Discharge Integration Frontrunner programme aimed to bring together transformation efforts from across Croydon to develop an effective, integrated system across hospital, social and community care.

1.3 The Frontrunner programme objectives included the following:

- Develop a granular multi-dimensional baseline to map the activity, workforce, challenges, and existing initiatives across the system.
- Review and redesign patient pathways to develop the right reablement and care offer for the Croydon population.
- Improve the integration of teams across the system, in terms of:
    - IT systems and data
    - Funding
    - Leadership and workforce
    - Developing the right resources (workforce, IT systems) to deliver effective care provision

1.4 One Croydon received £800,000 from NHSE to support the development and implementation of the Frontrunner programme, focused on developing a baseline of the Croydon system and agreeing a delivery model and supporting the mobilisation and implementation process.

1.5 The objectives were to reduce the amount of time that medically well people spend in hospital awaiting discharge and to improve outcomes for our residents supporting them to live independently for as long as possible.

1.6 Reducing the amount of time that medically well people spend in hospital means that people can be admitted more quickly from A&E to wards, reducing pressure on the Emergency Department at Croydon University Hospital and speed-up ambulance handovers to help get paramedics back on the road to care for the critically ill.

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Overview of the programme:

The NHS funding for the Frontrunner programme supported a range of activity to enable the objectives of the programme to be delivered.

- A multi-dimensional baseline of the current system was generated through an iterative process of data analysis and interviews / observations with system partners.
- This exercise looked at existing initiatives, quantitative analysis (activity, workforce, and finance) and qualitative insights (challenges, bottlenecks, processes) including whether current pathways were working effectively.
- This was followed by further stakeholder engagement to create a ‘one version of the truth’ baseline as well as agreed priorities for system-wide transformation.

- Developed workplans for agreed long term priorities, and a delivery model to implement agreed transformation initiatives.
- Developed a blueprint for a Transfer of Care Hub (TOCH), building upon the baseline and stakeholder engagement.
- To support the development of the blueprint, the programme piloted blended assessor roles and new ways of working within the hospital integrated discharge team.
- Several workstreams were set up to deliver different elements of the programme:
    - Internal hospital ways of working.
    - Development of the Transfer of Care Hub
    - Recovery care (reablement/rehabilitation)
    - Enablers: IT/systems, estate, organisational development
    - Development of the business case for additional funding to achieve the objectives of the programme

Development of the business case for implementation

A business case was developed during 2023/24. This involved:

- Quantifying activity of new services by analysing referral data (i.e. factoring for the number and type of tasks generated from referrals, length of stay in services etc.)
- Quantifying workload by shadowing staff to determine length of time required per type of task
- Modelling WTE required by role (i.e. defining tasks performed by role, workload of tasks in hours, other time spent in meetings and doing admin, and accounting for sickness and leave)
- Modelling overhead costs by service
- Developing option appraisals for reablement delivery and recommending the model to be implemented

The business case set out the 'Frontrunner blueprint' for transformation as follows:

- A truly integrated 'Transfer of Care Hub' consisting of an Integrated Discharge Team (IDT) that supports early discharge planning and pathway identification, and a Home First team that provides care, support and assessments following discharge;
- Integrated therapy and reablement in the community to reduce siloed working and duplication.

The benefits of implementing this model include:

- **Reduced length of stay in hospital** by improving IDT ways of working and increasing capacity in community
- **Reduced readmissions** by providing holistic assessments and care at home
- **Fewer patients requiring ongoing care** due to improved assessments, 'right-sizing' of care packages, and higher quality reablement/therapy services in the community

The business case for the new model of integrated intermediate care was agreed by senior executives in Health and Social Care.

Additional investment was agreed from the Better Care Fund to be used jointly by the NHS and the Local Authority to support implementation of the Frontrunner programme including

additional staff for Home First, the Council's internal reablement team and the Transfer of Care hub and for provision of care post-discharge.

The Better Care Fund updated plan for 2024/25 was signed off by the Health and Wellbeing Board on 11 July 2024.

Implementation and next steps

We are now in the implementation phase of the programme. A summary of progress made on implementation is attached at Appendix 1.

Alongside implementation of the Frontrunner blueprint, One Croydon partners are working together on the wider aspects of discharge and intermediate care in terms of ensuring we have the right provision for people who need bedded intermediate care following a stay in hospital and those who need a long-term residential or nursing home placement.

We also continue to collaborate on supporting people in a joined up way in the community to prevent escalating health and care needs through our work on proactive care and Integrated Neighbourhood Teams.

Performance and outcomes

The expected outcomes of implementation are as follows:

Hospital based:

- Reduced inpatient average length of stay
- Reduced length of stay in the Emergency Department
- Lower bed occupancy rate
- Fewer patients not meeting criteria to reside in acute beds

Community based:

- Fewer readmissions
- Greater right-sizing of packages of care
- Higher quality assessments
- Fewer patients requiring ongoing packages of care or residential or nursing placements

Recovery care (integrated therapy and reablement)

- More patients fully reabled
- Reduced waiting lists
- Greater resident independence
- Reduced duplication of assessments and service provision

A new system, Patienteer, is currently being implemented to improve:

    - communication between health (hospital and community) and social care case recording systems

- reporting by creating a regular and reliable dashboard that uses triangulated data that can be accessed by system leadership and that can inform all partners equally and simultaneously.

The system is being piloted in one of the hospital wards, the Living Independently for Everyone (LIFE) team and Adult Social Care triage team currently and will be rolled out over the summer. From the autumn, strategic performance metrics will be able to be pulled from the shared Patienteer cloud which will allow us unprecedented insights into the whole system and a live system level dashboard which will provide One Croydon leadership an up to the minute overview of activity, stresses and performance from A&E, hospital wards, discharges, pathway activity reablement and rehabilitation and long term outcomes.

2. RECOMMENDATIONS

2.1. The Sub-committee Members are recommended to:

- Note the progress with the implementation of the Integrated Discharge Frontrunner programme.
- Note that the data on performance and outcomes is under development and can be brought back to the Committee in due course.

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APPENDIX 1

PowerPoint presentation:

Update on implementation of the Frontrunner Programme