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Frontrunner implementation update

Health and Social Care Scrutiny sub-committee
DATE: 30th July 2024

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Hospital Operations Workstream: Improving ways of working

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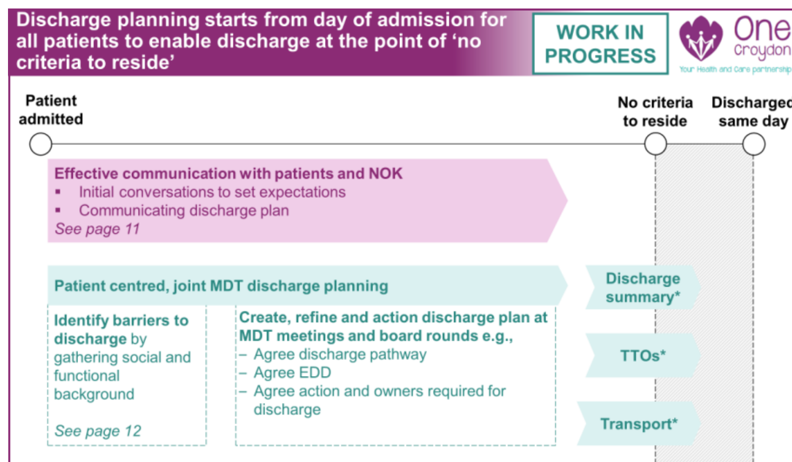

Ward MDT meetings: Prompts for effective discharge planning

Who is the patient?

- ❑ What is their social background? Who do they live with? Existing care/support? Medical history?
- ❑ Are there any potential barriers to discharge? *(see page 12)*

Where are they going and how do we get them there?

- ❑ What is the planned discharge destination?
- ❑ What actions are required to facilitate discharge (e.g., equipment, home environment, organising care)
- ❑ Who is owning each action?

When can we get them there?

- ❑ Are they medically fit for discharge today?
- ❑ If not today, when can they go?

Note: MDT discussions should be focused on discharge planning rather than **detailed medical plans and interventions** (unless entire MDT needs to be made aware)

Summary of progress:

- ✓ Agreed principles of discharge
- ✓ Developed multidisciplinary team (MDT) discharge roles and responsibilities
- ✓ Developed hospital discharge processes including equipment ordering
- ✓ Created checklist of key discharge barriers to identify at admission
- ✓ Agreed and implemented a 'best practice' check list to support effective board rounds and MDT meetings
- ✓ Designed daily discharge form and report to capture insights from 'criteria to reside' data

Next steps:

- ❑ Roll-out Patienteer use to all wards
- ❑ Implement new therapy equipment ordering process including electronic ordering form
- ❑ Finalise joint single discharge form
- ❑ Continued work on communications with patients and families

Hospital Integrated Disharge Team Workstream: Creating a truly integrated Transfer of Care Hub

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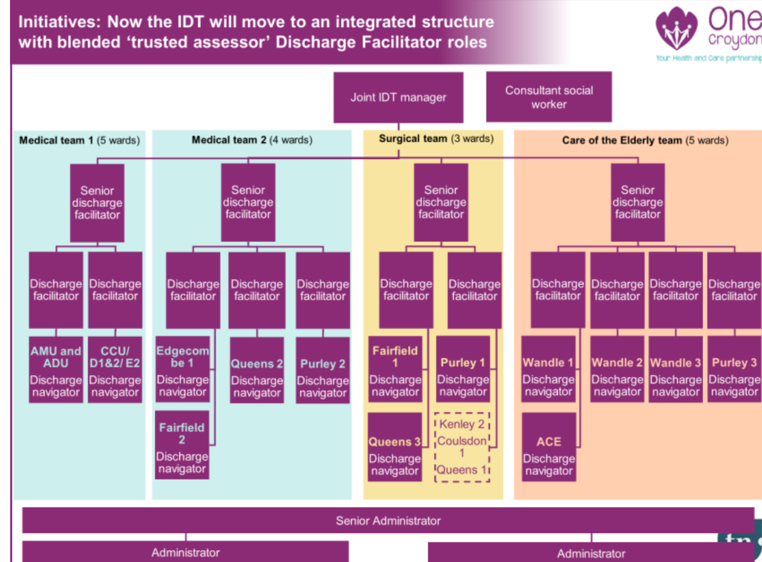

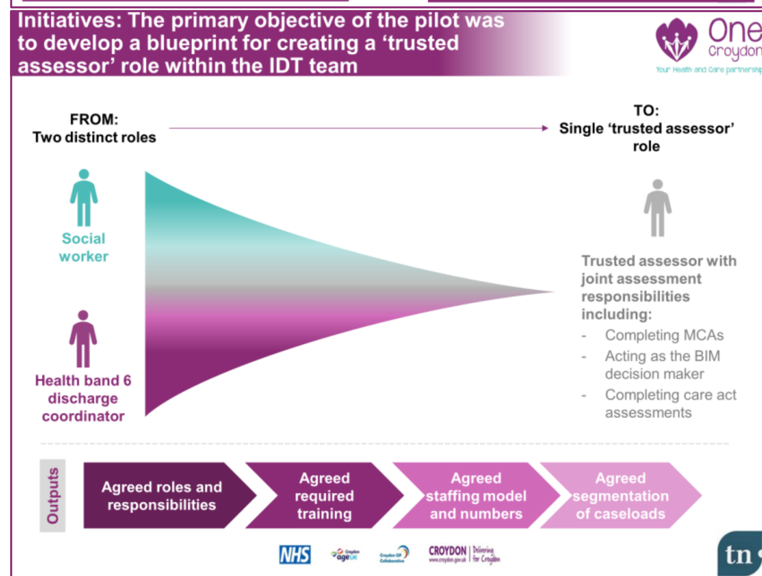

Summary of progress:

- ✓ Performed a pilot to develop trusted assessor roles that included 'blended' tasks and required trainings
- ✓ Completed consultation for staffing restructure with new trusted assessor roles and integrated line management
- ✓ Captured ways of working into draft handbook including:
  - Staff survey with automated results
  - Daily check-ins and check-outs
  - Checklist of discharge barriers to identify at admission
  - All Croydon pathway referral procedures
  - Team Key Performance Indicators
- ✓ Recruitment to vacant posts
- ✓ Drafted Section 75 agreement for pooled staffing budget
- ✓ Funding agreed for Transfer of Care Hub Lead role
- ✓ Weekly meetings to support staff
- ✓ Finalise access to the Council's system for discharge facilitators

Priority next steps:

- ❑ Recruit to TOCH Lead role
- ❑ Continue working on ensuring adequate space for the team to work together, including partners who should be co-located
- ❑ Roll out of continuing professional development plan – ongoing. There is an existing plan in place that will be followed for existing staff and new staff members once in post
- ❑ Organisational development for the team

Home First workstream: Providing holistic care assessments and recuperation on discharge

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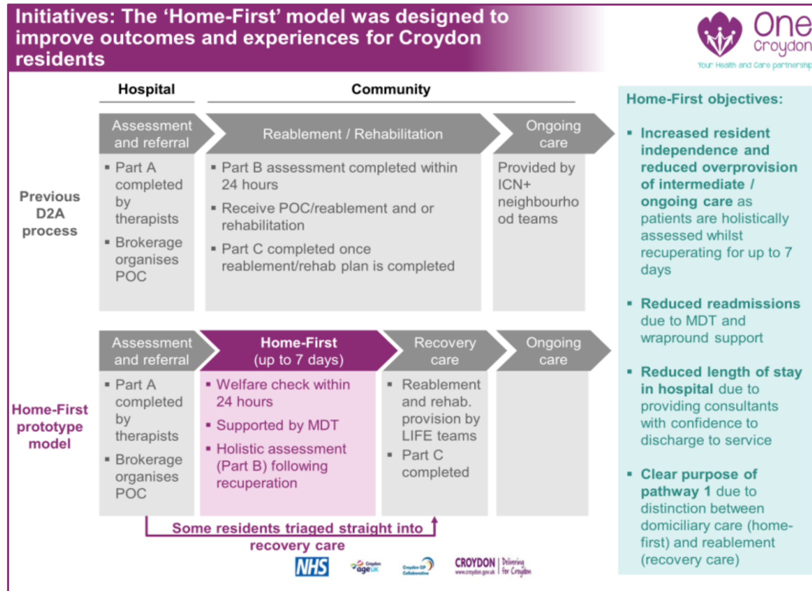

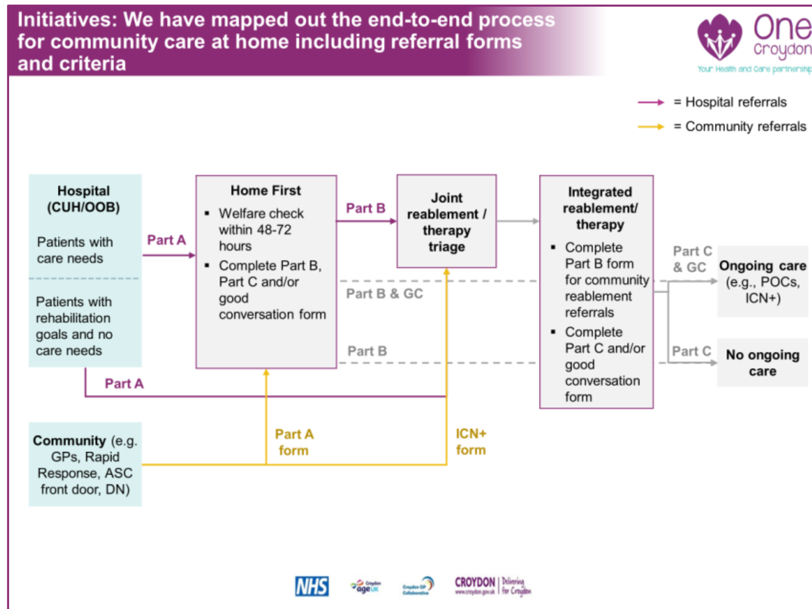

Summary of progress:

- ✓ Prototyped the Home First model to test the impact on resident outcomes and to develop a detailed blueprint for the service
- ✓ Mapped the assessments performed for residents in the Home First service
- ✓ Designed a daily multi-disciplinary team procedure including attendance, content and preparation required
- ✓ Created procedure for equipment and directory to enable care providers to make home adaptations
- ✓ Analysed demand to model workforce capacity required to deliver Home First
- ✓ Designed integrated assessor roles to enrich current roles and align ways of working
- ✓ Working with care market as part of the Home First MDT service
- ✓ Home First funding from Better Care Fund
- ✓ Go live of Home First service June 2024.

Next steps:

- ❑ Continued development with staff and home care providers to embed and improve new ways of working
- ❑ Socialisation of service to systemwide stakeholders, including resident groups
- ❑ Service implementation and supporting documents to be evaluated at the end of Sept 2024

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RESTART Workstream: Creating an Integrated Community Therapy and Reablement Provision

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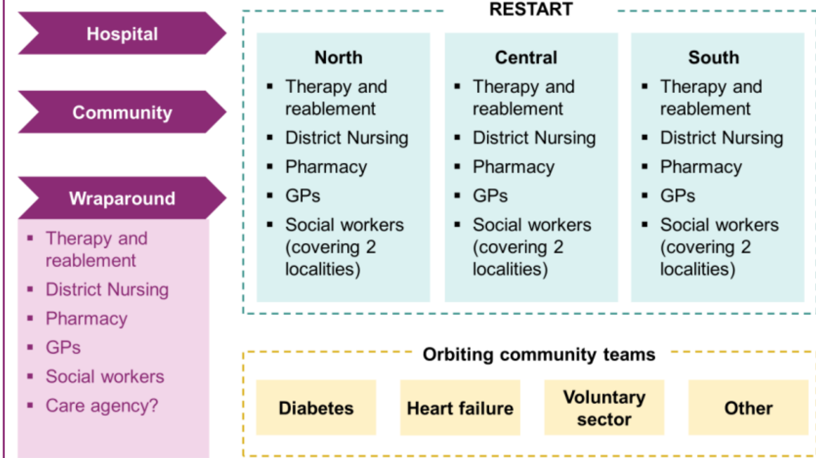
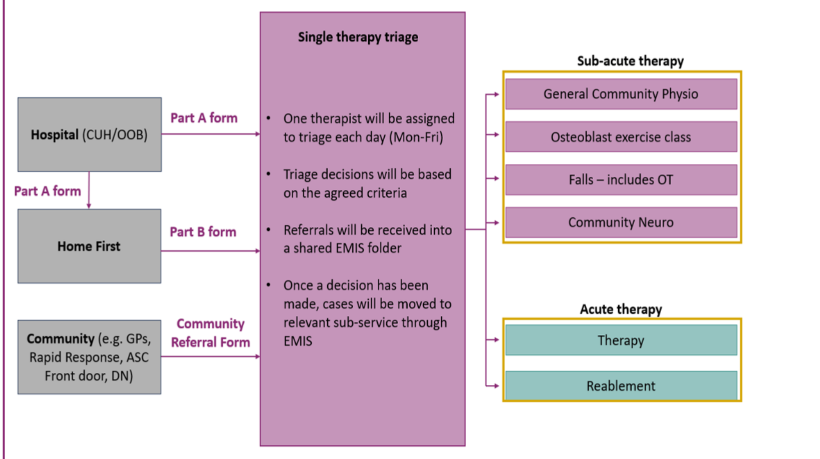
Initiatives: The long-term ambition of the RESTART service is to develop integrated North, Central and South community teams



Initiatives: Referrals will pass through a single point of triage for all community therapy and reablement teams, aligning referral forms and reducing paperwork



Summary of progress:

- ✓ Piloted single point of triage into sub-acute and acute therapy services
- ✓ Quantified the benefit of single point of triage
- ✓ Designed a joint triage procedure
- ✓ Analysed patient outcomes to create detailed options appraisal for reablement delivery
- ✓ Analysed demand to model workforce capacity required to deliver RESTART
- ✓ Created JDs and recruited into occupational therapy assistant roles
- ✓ Performed audit of medically optimised patients in Croydon University Hospital to model step down beds required as a Croydon system
- ✓ New community referral from GP huddles and localities team
- ✓ Funding for Sub-acute clinical lead agreed
- ✓ Funding for additional therapy staff agreed
- ✓ Started recruitment process to expand internal reablement team
- ✓ Launched single point of triage
- ✓ Service implemented in May 2024

Priority next steps:

- ❑ 3-month evaluation of service due in September 2024.
- ❑ Continue with systemwide communications – hospital, GPs, locality teams etc

Data and IT Workstream: Integrating Croydon Data and IT (patient records and performance monitoring)

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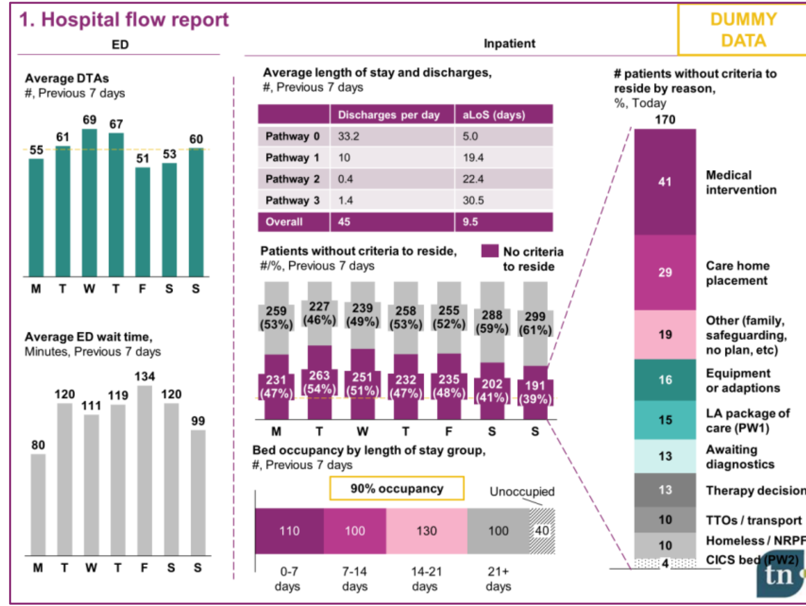

Data recording: The Patienteer 'spider diagram' summarises where patients are in their discharge journey for the entire hospital

Summary of progress:

- ✓ Procured Patienteer app to act as live 'whiteboard' pulling automatically form both health and social patient records
- ✓ Designed and implemented Patienteer patient list view including: columns, data validation rules and automatic workflows
- ✓ Designed and implemented Patienteer 'spider diagram' view to visualise where patients are in their discharge journey
- ✓ Introduced 'daily discharge form' to accurately capture key discharge data for each patient
- ✓ Introduced a weekly hospital flow report to view criteria to reside performance and delay reasons
- ✓ Mapped full list of KPIs to capture and which system they will need to be pulled from
- ✓ Weekly CTR reports
- ✓ Ward staff training on Patienteer – in progress

Priority next steps:

- ❑ Complete roll out of Patienteer – Q3 2024/25
- ❑ Incorporate KPIs into monthly performance reports
- ❑ Integrate health and social monthly reports into a live dashboard