Appendix 2:
Programme Delivery Group
Terms of Reference

Cambridgeshire and Peterborough Discharge Transformation Programme

Programme Delivery Group – Terms of Reference v4.0

June 2018

1. The role of the Delivery Group:

The fundamental goal of the Delivery Group is to ensure that all elements of the Cambridgeshire and Peterborough Discharge Pathways are functional, resilient in times of high demand/pressure, and deliver high quality, timely and safe services to all our patients/service users through an Integrated Discharge Team approach

- Will develop, steer, direct and secure delivery of the benefits associated with creating the Integrated Discharge Teams as outlined in the Plan B DTOC Recovery Approach (attached) through a dedicated programme structure, resource and plan to ensure delivery at scale and pace
- Ensure quality and outcomes are at the centre of the work
- Patient engagement, Equality and diversity is prioritised
- Will provide oversight of delivery against outcome measures
- Ensure delivery of effective Discharge Pathways
- Ensure organisations are accountable
- Unblock system issues and enable delivery

And:

- Improve DTOC performance through the range of integrated services which enable the discharge pathways within an agreed cost envelope and as part of the wider strategic plan in both health and social care settings;
- Work across organisational boundaries to improve patient experience and clinical outcomes;
- Review clinical risk associated with pressures in the system;
- Establish partnerships and better working relationships between all Health and Social Care organisations across the C&P geographical area;
- Agree and sharing goals, objectives and responsibilities throughout the community;
- Make sure any developments produce system wide improvement;
- Make sure delays are not caused by organisational boundaries or other non-clinical reasons.

The Delivery Group will achieve these goals by:

- Reviewing the implementation and delivery of DTOC management through the Integrated Discharge Teams performance, monitoring the recovery and delivery of system performance;
- Making patient perspectives and quality of care the top priorities in planning discharge;
- Offering patients appropriate choices;
- Ensuring easy access to clinically appropriate services at the appropriate time without unnecessary duplication and in line with national standards;
- Ensure the Integrated Discharge Teams enable patients to achieve their

discharge into the most clinically appropriate environment at the right time;
- Working with the C&P Health and Social Care Commissioners and Providers to agree our local priorities;
- To improve and spread knowledge and understanding of the role of the Integrated Discharge Teams throughout the system
- Supporting and maintaining improvement work in line with the other strategic programmes of work;
- Keeping professionals and patients informed about developments in discharge planning.

2. Focus of the Delivery Group

The initial focus for the Delivery Group will be to review the current performance issues inherent across all providers, and implement an action plan to manage this performance to ensure that there is sufficient improvement within a contractual framework to deliver safe and clinically appropriate care, and to meet the 3.5% DTOC target. The work programme for the Delivery Group is centred around, but not restricted to the effectiveness of the Integrated Discharge Teams and their management of Discharge and out of hospital care – "Outflow".

The key focus of an initial review will be to examine the following areas:

- The establishment and implementation of the Integrated Discharge Teams, Plan B DTOC Recovery Approach;
- The effectiveness, the range and scale of discharge pathways including the range of professions and skill sets available, along a range of clinical pathways INCLUDING Discharge to Assess;
- The capacity and quality of community based services to facilitate discharge and step up/step down services available across the county;
- The effectiveness of the Intermediate Care services available post discharge (step down care).
- The capacity and quality of services managing the patient journey as part of their discharge process through hospital services (both acute and community)
- The capacity and resource available in both health (CHC) pathways and social care pathways to facilitate discharge;
- The patient and carer experience of discharge planning across C&P.

3. Responsibilities

- Oversee the establishment and implementation of the Integrated Discharge Teams alongside the development of the programme plan to enable the Health and Social Care partners to achieve their objectives and ensure a single integrated approach across the system.
- Establish reliable metrics and outcome measures to inform progress against plan
- Monitor and review system performance against agreed baselines;
- Ensure the co-ordination of projects and programmes across all stakeholders.
- Oversee the delivery of improvement plans in line with national imperatives and local priorities
- Review pathway change proposals for the whole system to ensure alignment of work streams.
- Maintenance of a risk register
- Provide inter-programme links with other high level programmes of work (e.g. D2A; the BCF)
- Oversee the performance management and delivery of the Integrated Discharge

Teams;.

- Supervise any additional non-recurrent or recurrent resources specifically allocated to the delivery of Discharge standards including the recovery of operational performance.
- Promote the adoption of care pathways across all components of the discharge process which deliver best practice and meet national standards and guidance.
- Hold the whole system to account to ensure that productivity and efficiencies are delivered through patients being treated and cared for by evidence based services that meet their needs in the least intensive environment.
- Ensure local service developments provide support to specific groups of patients who are likely to be at increased risk of needing longer term care e.g. the frail elderly, children with disabilities or long term illness, vulnerable adults including people with Mental Health problems, learning disabilities and substance misuse problems.
- Ensure that the patient and carer perspective and quality of care are the priorities in planning discharge pathways in the local Health and Social Care community.

4. Prioritisation

The Delivery Group will base its prioritisation for its work programme on answers to the following questions:

1. Where are we experiencing the biggest issues in system performance?
2. What is working well locally and elsewhere?
3. Which areas can be improved?
4. Whether services are safe, and providing a good patient experience
5. Where are delays occurring?
6. Is there any duplication or bottlenecks in the local system?
7. Are services effective and providing good value?
8. Are all services that patients and providers need available?
9. What quality measures can be applied across the whole patient journey?

4. Performance

5.

The Delivery Group will further develop and publish an operational dashboard and will receive weekly performance reporting to monitor its progress. High impact changes/actions will be contained within a Recovery Action Plan.

The current proposed metrics by site and as a system are as follows:

1. Percentage DTOC rate at close of play
2. Percentage of discharges from hospital before and after midday.
3. Delayed transfers of care standard metrics
4. Classification of Delayed transfer of care using national metrics
5. Emergency Readmissions (i.e. failed discharges) within 30 days
6. Discharges by day of week
7. Long term admissions to residential care

6. Frequency of meetings

The Delivery Group will meet fortnightly in the first instance, with this being reviewed in the Summer of 2018.

7. Communications
8.

The Delivery Group will be responsible for ensuring stakeholder organisations are communicating and engaging with each other and within their own organisations and that all stakeholders have identified champions to optimise the delivery of discharge pathways.

9. Membership and Responsibilities

The Delivery Group membership is drawn from the local Health and Social Care organisations across Cambridgeshire and Peterborough. The membership of the group and the attendance will be reviewed regularly to ensure constituent organisations are being represented by senior clinical and senior management and operational leads with delegated authority to make decisions on behalf of their organisations.

Senior membership of the Delivery Group is required and received from all contributing organisations:

Clinical Leaders

To be completed

Organisational Leaders

Jan Thomas – Chair, (COO Cambridgeshire and Peterborough CCG)
Amy Page – Programme Director, C&PDP
Sam Merridale – Programme Manager, C&PDP
Sandra Myers – COO - Addenbrookes Hospital
Neil Doverty, COO - Hinchingbrooke Hospital
Charlotte Black – Service Director, Adults and Safeguarding - Cambs CC
Julie Frake Harris – Director of Operations, CPFT
Oliver Hayward – AD Commissioning, Peterborough CC
Debbie McQuade – AD Adult Services, Peterborough CC
Sam Higginson – COO, Addenbrookes Hospital
Caroline Townsend – BCF lead
Sara Rodriguez-Jiminez – Cambs CCG
David Allison – DTOC lead (Hinchingbrooke Hospital
Eliza Bautista – DTOC lead (Peterborough Hospital)
Sue Graham – DTOC Lead (Addenbrookes Hospital)
Mark Cook – Head of Out of Hospital Care – Cambridgeshire Partnership Foundation Trust
Vicky Main – Head of Transfers of Care – Cambridgeshire County Council / Peterborough City Council
Tom Barden – BI lead – Peterborough City Council
Greg Lane – BI lead – Cambs CCG

This list to be reviewed and amended

Further attendees will be invited on an ad-hoc basis for specific programmes of work.

Samantha Merridale
Interim Programme Lead
5th June 2018

Appendix 2: Programme Governance structure

Discharge Transformation Programme Resource & Structure