Appendix 2 - Annex 1 DTOC Action Plan 2017-18							v9 11.09.17	
Task & Sub-task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (Where appropriate)**	**Baseline**	**Intended Outcome**	**Completion Date**
High Impact Change 1: Early Discharge Planning **- In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place for management and discharge and to allow an expected date of discharge to be set within 48 hours. (D2A Level - 0)**								
1.1	Reduce variation in discharge planning between Hillingdon Hospital wards by implementing SAFER care care bundle. Link: A & E Recovery Action Plan (SAFER)	THH	Divisional Director, Medicine (Safer Group Chair)	Assistant Director of Nursing	SAFER Metrics - EDD within 48 hours of admission - target 80-% completion % of patients discharged on their EDD - target 80% successful	See emergency care recovery programme	Advanced discharge planning is applied consistently from point of admission.	Oct-17
1.2	Develop a clear system for how elective admissions to Hillingdon Hospital are managed, ensuring liaison before admission and discharge.	THH	Director of Operationsal Performance, THH	Janet Lynam?	No KPIs set yet as no project is underway	Not applicable	Discharge arrangements are in place prior to admission to facilitate timely post-procedure discharge.	TBD
1.3	A solution to be identified to enable social care team to be based on main Hospital site (*ECIP commitment*). Link: A & E Recovery Action Plan (Discharge)	THH	CEO, THH	Head of Clinical Site Services, THH	No measures set	3 social workers on site; max of 13 available.	Suitable space identified to provide a permanent base of social work staff.	Oct-17
1.3.1	Review space requirements for social care staff.	LBH	Assistant Director, Older People & Physical Disabilities, LBH/Director of Integration, THH	Hospital Discharge Team Service Manager, LBH	No measures set	No measures set	Identification of space required in order to base social work team on THH main site.	Jul-17
1.4	Establish criteria-led discharge arrangements across wards within THH. (Link: MADE event action)	THH	Director of Nursing,THH	Assistant Director of Nursing (Mediciine), THH	Agreed consultant determined criteria in place pertinent to wards	Over-dependence on direct consultant approval for patient discharge.	More clinical staff are empowered to make discharge decisions	Sep-17
High Impact Change 2: Systems to Monitor Patient Flow **- Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.**								
Task & Sub-task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (Where appropriate)**	**Baseline**	**Intended Outcome**	**Completion Date**
2.1	Establish robust systems for verifying numbers of delayed transfers of care prior to submission by providers to NHS Digital.	HCCG	Chair, A & E Delivery Board	Head of Urgent Care, HCCG	% correlation between national data and locally understood position.	There are inconsistencies between submitted data and what is understood locally.	National data accurately reflects the local position, which is fully understood and agreed by partners.	Oct-17

2.1.1	Verification mechanism for social care delays at THH established and operational.	LBH/THH	Assistant Director, Older People & Physical Disabilities, LBH/Director of Operational Performance, THH	Hospital Discharge Team Service Manager, LBH	N/A	Mechanism in place	National data accurately reflects the local position, which is fully understood and agreed by partners.	Apr-17
2.1.2	Verification mechanism for social care delays in other acute trusts established and operational.	LBH/HCCG	Assistant Director, Older People & Physical Disabilities, LBH	Hospital Discharge Team Service Manager, LBH	Robust systems in place for acute trusts that are main source of non-THH aute activity.	Robust systems not in place for all non-THH main sources of activity.	National data accurately reflects the local position, which is fully understood and agreed by partners.	Sep-17
2.1.3	Verification mechanism for non-acute (inc HICU and mental health) social care delays with CNWL established and operational.	LBH/CNWL	Discharge Coordinator	Service Improvement Manager	Robust system in place	System in place for MH; but inconsistent for HICU	Effective, timely discharge management following DTOC guidance from Trust	Oct-17
2.2	Establish systems for reporting the number of patients admitted to THH for planned and unplanned procedures to which delayed days are attributed (NHS, social care and both).	THH	Director of Operational Performance, THH	Head of Clinical Site Services, THH	No measures set	No work towards a 6 day	Clarity about number of patients to which DTOCs are attributed.	Aug-17
2.3	Establish systems for reporting the number of patients admitted to CNWL beds (HICU and mental health) to which delayed days are attributed (NHS, social care and both).	CNWL	Discharge Coordinator	Service Improvement Manager	No measures set	No measure in place	Multi agency meetings take place at Woodlands. Trust DTOC criteria used for reporting	Sytems are in place
2.4	Establish a systematic process for reviewing any inpatient stay that exceeds six days and monitor progress using the 'stranded patient metric'. (Link: A & E Recovery Action Plan (Discharge))	THH	Director of Operational Performance, THH	Head of Clinical Site Services, THH	No measures set	No measure in place	Reasons for prolonged LOS are known and appropriate actions put in place.	Aug-17
2.5	Establish electronic transfer of assessment and discharge notices and withdrawal and change of circumstances notices.	THH/LBH	Director of ICT,THH/IT Business Partner, LBH	Health and Social Care Integration Manager, LBH/HCCG	No measures set	Notices currently sent by secure email.	Transfer of notices is expedited and stored electronically.	Oct-17
2.6	Develop a dashboard showing community capacity, inc NHS, social care and independent sector provider.	HHCP	Hillingdon ACP Programme Director/Director of Integration, THH	ACP Service Improvement and Business Development Lead	KPIs linked to service delivery	Information about provider capacity not systematically shared	Tool developed to make community capacity available to health and care partners.	Oct-17
2.6.1	Identify service lines/pathways that would benefit from capturing capacity and demand that can be shared with all providers.	HHCP	Director of Integration, THH	ACP Service Improvement and Business Development Lead	KPIs linked to service delivery	Information about provider capacity not systematically shared	Tool developed to make community capacity available to health and care partners.	May-17
2.6.2	Identify 'As is' on how information is captured and shared.	HHCP	Director of Integration, THH	ACP Service Improvement and Business Development Lead	KPIs linked to service delivery	Information about provider capacity not systematically shared	Tool developed to make community capacity available to health and care partners.	May-17

2.6.3	Establish IT requirements	HHCP	Director of Integration, THH	ACP Service Improvement and Business Development Lead	KPIs linked to service delivery	Information about provider capacity not systematically shared	Tool developed to make community capacity available to health and care partners.	Jun-17
2.7	Pilot a discharge planning tool in adult mental mental health.	CNWL	Borough Director, CNWL	Acute Service Manager	Reduction in MH delayed days.	47% delayed days in 2016/17 attributed to CNWL beds.	Effective tool to support earlier discharge planning in place.	Oct-17

High Impact Change 3: Multi-disciplinary/multi-agency discharge teams, including the voluntart and community sector - **Coordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.**

Task & Sub-task	Task Description	Organisational Owner	Lead	Project Manager	Measure (Where appropriate)	Baseline	Intended Outcome	Completion Date
3.1	Complete development of a joint discharge policy based on patient choice.	HCCG/LBH	Assistant Director, Older People & Physical Disabilities, LBH/Deputy Chief Operating Officer,	Older People Commissioner, HCCG/Health and Social Care Integration Manager, LBH/HCCG	Not applicable	Not applicable	A clear policy approved by partners is in place.	Oct-17
3.1.1	Series of patient letters contained within the policy specific to patient circumstances adopted by THH.	THH	Deputy Director of Nursing, THH?	Head of Clinical Site Services, THH	Not applicable	Letters need revision in line with policy.	A clear policy approved by partners is in place.	Jul-17
3.1.2	Discharge policy ratified by THH, CNWL, LBH and H4All.	HHCP/LBH	Chair, Discharge Workstream Group	Older People Commissioner, HCCG/Health and Social Care Integration Manager, LBH/HCCG	Not applicable	Contributory role of community partners not reflected in existing THH policy	A clear policy approved by partners is in place.	Oct-17
3.2	Complete development of a joint operating discharge procedure across partner organisations.	THH/LBH	Assistant Director, Older People & Physical Disabilities, LBH/Director of Integration, THH	Older People Commissioner, HCCG/Health and Social Care Integration Manager, LBH/HCCG	Not applicable	Not applicable	A clear procedure agreed by partners is in place.	Oct-17
3.3	Undertake a review of the integrated discharge function at THH main site. (Link: A & E Recovery Action Plan (Discharge))	HHCP	Leadership Centre	Assistant Director, Older People & Physical Disabilities, LBH/Director of Operational Performance, THH	See outcome	Lack of clarity about role, function and effectiveness of current arrangements.	Agreement on role and function of the IDT.	Jul-17
3.4	Identify wards that require social care participation in MDMs. (Link: A & E Recovery Action Plan (Discharge))	LBH	Assistant Director, Older People & Physical Disabilities, LBH	Team Leader, Hospital Team, LBH	No measure in place	No measure in place	Reduced delays	Sep-17
3.5	Review mental health pathway within THH. (Link: A & E Delivery Board action)	THH/CNWL	Director of Operational Performance, THH/Borough Director, CNWL	Borough Director, CNWL	No measure in place	No measure in place	New standard operating procedure in place	Oct-17

High Impact Change 4: Home First/Discharge to Assess - Providing short-term care and reablement in people's homes or using 'step-down'beds to bridge the gap between hospital and home mean that people no longer need to wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow. (D2A Levels 1 -								
Task & Sub-task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (Where appropriate)**	**Baseline**	**Intended Outcome**	**Completion Date**
4.1	Develop proposals for step-down/step-up provision in extra care sheltered housing.	LBH	Assistant Director, Older People & Physical Disabilities, LBH	Health and Social Care Integration Manager, LBH/HCCG/Older People's Commissioner, HCCG	Not applicable	One flat in place at Cottesmore House.	Step-down/Step-up provision is available in an alternative setting to a care home.	Jul-17
4.2	Establish block arrangements with a nursing home for discharge to assess beds for 12 months (*ECIP commitment*). (Link: A & Recovery Action Plan (Integrated Discharge)	HCCG/LBH	Assistant Director, Older People & Physical Disabilities, LBH/Deputy Chief Operating Officer, HCCG	Health and Social Care Integration Manager, LBH/HCCG/Older People's Commissioner, HCCG	Not applicable	7 beds at Franklin House & 7 beds at Parkfield Nursing Home	A sufficient supply of bed-based step-down provision is in place to meet demand.	Apr-17
4.3	Deliver discharge home to assess pilot working with Hayes and Churchill wards at Hillingdon Hospital for up to 8 weeks. (Link: A & Recovery Action Plan (Integrated Discharge)	HHCP	Director of Operational Performance, THH	Project Manager, D2A	30 medically optimised patients discharged home	Not applicable	Model to improve flow out of hospital tested	Jul-17
4.4	Use learning from pilot to inform full implementation using Plan, Do, Study, Act (PDSA) cycles. (Link: A & Recovery Action Plan (Integrated Discharge)	HHCP	Director of Operational Performance, THH	Project Manager, D2A	Not applicable	Not applicable	Sustainable D2A model developed and implemented across all THH wards.	Aug-17
4.5	Refresh gap analysis against 8 High Impact Changes to identify further areas for improvement. (Link: A & Recovery Action Plan (Integrated Discharge)	HHCP	ACP Programme Director	Project Manager, D2A	Not applicable	Gap analysis undertaken in Jan 16.	Collective ownership of further areas for improvement.	Sep-17
4.6	Ensure that the majority of NHS CHC assessments take place outside of an acute setting by 31/03/18. (Link: A & Recovery Action Plan (Integrated Discharge)	HCCG	Head of Continuing Healthcare and Complex Care, BHH CCGs	Older People Commissioner, HCCG	85%	Awaited	CHC assessments take place in the most appropriate setting for a patient's needs to be accurately reflected.	Mar-18
4.6.1	Agree the capacity for timely Continuing Healthcare screening and assessment within the discharge planning process.	HCCG	Head of Continuing Healthcare and Complex Care, BHH CCGs	Older People Commissioner, HCCG	Number of assessments occurring within 28 days of notification of need.	Awaited	Timely CHC screening and assessments are undertaken.	Jul-17
4.7	Ensure that discharge processes are responsive to the needs of people with learning disabilities, people with autism and people with mental health needs.	THH	Director of Operationsal Performance, THH	Head of Safeguarding, THH	No measure set	No measure set	Discharge process is responsive to the needs of vulnerable adults.	TBC

High Impact Change 5: Seven Day Services **- Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care and means that services are more responsive to people's needs.**								
Task & Sub-task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (Where appropriate)**	**Baseline**	**Intended Outcome**	**Completion Date**
5.1	Ensure district Nurse/Community Matron involvement pre-discharge for high risk patients 7-days a week. (Link: A & E Recovery Action Plan (D2A))	HHCP	Head of Adult Services, CNWL	Clinical Services Manager, CNWL	No measure set	No measure set	Appropriate clinical community health support is in place prior to discharge.	Dec-17
5.1.1	Ensure that Care Connection Teams are incrementally scaled up across the whole borough.	HHCP	GP Lead, HHCP	ACP Service Improvement and Business Development Lead	No measure set	No measure set	A consistent, multi-disciplinary approach to addressing health and care needs is applied across the borough.	Jun-17
5.1.2	Explore solutions for information sharing between providers.	HHCP & LBH	Head of ICT, THH	ACP Service Improvement and Business Development Lead	No measure set	No measure set	Number of times patient story has to be told reduced.	Dec-17
5.2	Undertake a live audit to capture the future requirements of patients requiring increase in the frequency of IV. (Link: A & E Recovery Action Plan (D2A))	HHCP	Head of Adult Services, CNWL	Rapid Response Team Leader, CNWL/AMU Matron, THH	No measure set	No measure set	Patients requiring IV administration in the community can be discharged at weekends.	Jul-17
5.3	Ensure District Nurse, Rapid Response and Community Rehab capacity is aligned to match demand from discharges at weekends. (Link: A & E Recovery Action Plan (D2A))	CNWL	Head of Adult Services, CNWL	Clinical Service Managers, CNWL	DN 24 hrs Homesafe - same day	DN 0 RRT 0 CRT 0	Discharges at weekends are not prevented by staff capacity issues.	Mar-18
5.3.1	Monitor weekend demand for DN, CR and RR.	CNWL	Head of Adult Services, CNWL	Clinical Service Managers, CNWL	No of acute referrals from acute to community	0	Demand for DN, CR and RR quantified to determine capacity to adjust provision to meet demand.	Mar-18
5.4	Ensure that there is appropriate social care support on the THH main site 7-days a week.	LBH	Head of Older People's Services, LBH	Service Manager, Access Team, LBH	No measures set	Generally Emergency Duty Team access	There is an appropriate level of social care support on the THH site to support discharges 7-days a week.	Mar-18
5.4.1	Review the need for a social care presence on the main THH site at weekends.	LBH	Service Manager, Access Team, LBH	Service Manager, Hospital Discharge Team, LBH	No measures set	No measures set	Value of having social care presence on THH main site at weekends is quantified.	Mar-18
5.5	Review weekend infrastructure requirements at THH.	THH	Chief Operating Officer, THH	Head of Clinical Site Services, THH	% of discharges taking place at weekends (elective and non-elective)	TBC	Internal systems are in place to support discharges at weekends	Dec-17

5.5	Ensure early notification of need to homecare agencies to facilitate weekend restarts.	THH	Director of Operational Performance, THH	Head of Clinical Site Services, THH	Number of weekend discharges	16/17 Outturn Awaited.	Improved patient flow through the Hospital.	Oct-17?
5.6	Secure sufficient capacity within the homecare market to meet local demand.	LBH/HCCG	Head of Older People's Services, LBH	Homecare Project Manager, LBH	% delayed days attributed to package of care DTOC reason.	6% delayed days 2016/17	There is a reduction in package of care attributed DTOCs.	Nov-17
5.6.1	Undertake a tender for an integrated model, e.g. including health and social care, of homecare provision for all population groups across the borough.	LBH/HCCG	Assistant Director, Older People & Physical Disabilities, LBH	Homecare Project Manager, LBH/Older People Commissioner, HCCG	Not applicable	Not applicable	An integrated model for homecare is in place that enables residents/patients to access appropriate to need.	Jul-17
5.6.2	Incorporate specialist palliative homecare provision within integrated homecare specification.	LBH/HCCG	Assistant Director, Older People & Physical Disabilities, LBH	Homecare Project Manager, LBH/Older People Commissioner, HCCG	Not applicable	Not applicable	Appropriate care provision is in place to support people who wish to die at home.	Jul-17
High Impact Change 6: Trusted Assessors - Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.								
Task & Sub-task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (Where appropriate)**	**Baseline**	**Intended Outcome**	**Completion Date**
6.1	Establish trusted assessor arrangements between health and care partners. (Link: A & E Recovery Action Plan (D2A))	HHCP/LBH	ACP Programme Director/Assistant Director, Older People & Physical Disabilities, LBH	Project Manager D2A/Service Manager Hospital Team, LBH	No measure set	No measure set	Trusted assessor arrangements are in place between health and care providers.	Sep-17
6.1.1	Establish operating protocol and procedure between health and care partners for trusted assessor arrangements.	HHCP/LBH	ACP Programme Manager/Assistant Director, Older People & Physical Disabilities, LBH	Older People Commissioner, HCCG/Health and Social Care Integration Manager, LBH/HCCG	No measure set	No measure set	A clear protocol and procedure is in place to support the operation of trusted assessor arrangements.	TBC
6.2	Establish trusted assessor arrangements between health and care partners and care home providers. See task 8.3.	HHCP/LBH	ACP Programme Manager/Assistant Director, Older People & Physical Disabilities, LBH	Early Intervention & Prevention Service Manager, LBH.	No measure set	No measure set	Trusted assessor arrangements are in place between health and care providers and care home providers.	Mar-18
6.2.1	Establish operating protocol and procedure between health and care partners and care home providers for trusted assessor arrangements.	HHCP/LBH	ACP Programme Director/Assistant Director, Older People & Physical Disabilities, LBH	TBC	No measure set	No measure set	A clear protocol and procedure is in place to support the operation of trusted assessor arrangements with care home providers.	Mar-18

6.3	Explore scope for establishing a jointly agreed functional assessment form across that will support a trusted assessor model in Hillingdon.	HHCP/LBH	ACP Programme Manager/Assistant Director, Older People & Physical Disabilities, LBH	OT Team Leader, LBH	No measure set	No measure set	Tool agreed for referrals from other, i.e. not THH, acute trusts in NWL.	Oct-17

High Impact Change 7: Focus on Choice **- Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options.**

Task & Sub-task	Task Description	Organisational Owner	Lead	Project Manager	Measure (Where appropriate)	Baseline	Intended Outcome	Completion Date
7.1	Develop provision of consistent independent advice and support about onward destination pathway options at THH, including for self-funders.	THH/LBH	Director of Operational Performance, THH/Assistant Director, Older People & Physical Disabilities, LBH	Health and Social Care Integration Manager, LBH/HCCG	No measure set	No measure set	Patients are enabled to make informed choices.	Mar-18
7.2	Develop a directory of services that is accesible to staff and patients. (Link: MADE event action)	HHCP/LBH	Head of Urgent and Emergency care, HCCG		No measure set	No measure set	There is elecontric access to available services in Hillingdon.	Mar-18
7.3	Ensure that patients who would benefit from independent advocacy have access to appropriate provision.	THH/LBH	Assistant Director Learning Disabilities and Mental Health, LBH	Health and Social Care Integration Manager, LBH/HCCG	Utilisation of advocacy services via THH.	TBC	Patients are supported to say what they want, secure their rights, represent their interests and obtain services they need.	Oct-17
7.4	Secure agreement within THH on how the patient discharge information booklet, Working Together will be utilised at Hillingdon Hospital.	THH	Deputy Director of Nursing, THH	Deputy Director of Nursing, THH	% of DTOCs attributed to patient/fmaily choice reason.	Leaflet due to be delivered end of May.	Working Together booklet is used consistently across THH.	May-17
7.5	Ensure that Carers are supported through the process of hospital admissions and discharge care planning.	THH	Head of Patient and Public Engagement, THH	CEO, Hillingdon Carers	No process in place for this.	No measure in place	Carers, when asked, identify that they are recognised, supported and listened to.	Mar-18

High Impact Change 8: Enhancing Health in Care Homes **- Offering people joined-up, coordinated health and care services, for example, by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improving hospital discharge.**

Task & Sub-task	Task Description	Organisational Owner	Lead	Project Manager	Measure (Where appropriate)	Baseline	Intended Outcome	Completion Date
8.1	Develop appropriate care home provision for older people with challenging behaviours, including people with dementia.	LBH/HCCG	Assistant Director, Older People & Physical Disabilities, LBH	Health and Social Care Integration Manager, LBH/HCCG/Older People's Commissioner, HCCG.	Reduction in number of DTOCs attributed to car home reason.	59% of delayed days in 2016/17	Care home capacity meets demand.	Mar-18

8.1.1	Submit an application to the Admissions Credit Reserve/Systems Resilience Fund to develop and implement management strategies for inpatients with challenging behaviours to facilitate discharge to their pre-admission place of care.	HHCP	Borough Director, CNWL/Mental Health Commissioner, HCCG	Deputy Borough Director, CNWL/Mental Health Commissioner, HCCG	Application submitted	Not applicable	There are fewer MH-related NEL from care homes and increased capacity to facilitate discharge.	Jul-17
8.1.2	Implement service.	HHCP	Borough Director, CNWL/Mental Health Commissioner, HCCG	Deputy Borough Director, CNWL/Mental Health Commissioner, HCCG	Service implemented	Not applicable		Aug-17
8.1.3	Seek funding approval for a borough wide GP advice and visiting serivce for care homes, extra care housing and non-ambulant adults as part of the Primary Care Framework of Services for 2017/18.	HCCG	Older People's Commissioner, HCCG	Older People's Commissioner, HCCG	Application submitted	Not applicable	All care homes have access to appropriate primary care support	Aug-17
8.1.4	Implement service.	HCCG	Older People's Commissioner, HCCG	Older People's Commissioner, HCCG	Service implemented	Not applicable		Oct-17
8.1.5	Explore affordable supply options to meet residential dementia and nursing (inc. dementia) need.	LBH/HCCG	Assistant Director Adult Social Care - Provider & Commissioned Care/Deputy COO, HCCG	Project Manager, LBH/Older People Commissioner	Costed options developed	Not applicable	Identification of the most affordanle option.	Mar-18
8.2	Model demand for care home placements across health and social care over the next 10 years.	LBH/HCCG	Assistant Director Adult Social Care - Provider & Commissioned Care	Health and Social Care Integration Manager, LBH/HCCG	Report setting out 10 year demand requirements.	No modelling of demand across health and social care has been undertaken.	Clear demand requirements available to inform care home providers.	Mar-18
8.3	Work with care home providers to facilitate them being able to assess people in hospital within 48 hours of referral. *See also 6.2.*	LBH/HCCG	Assistant Director Adult Social Care - Provider & Commissioned Care	Health and Social Care Integration Manager, LBH/HCCG/Older People's Commissioner, HCCG.	At least 2 care homes prepared to be part of a 2017/18 pilot.	Not currently measured.	Care homes are willing and able to assess people referred from Hospital within 48 hours of referral.	Mar-19
8.3.1	Engage with providers through Care Home Managers' Forum to identify actions required to deliver task.	LBH/THH	Assistant Director Adult Social Care - Provider & Commissioned Care	Quality Assurance Social Worker, LBH/Head of Clinical Site Services, THH	Care Forum meeting at least four times a year.	Not applicable	Issues for care homes identified.	Nov-17

Appendix 2 - Annex 1A Mental Health DTOC Action Plan

The plan is in addition to the statement that your trust must complete to provide assurance on implementation of the 8 Improving and Sustaining Performance Priorities for the 62 Day Cancer Standard.

Submission Details	
Name	Hillingdon Mental Health
Submission Date	**06-Sep-17**

Section 1 - Expected date of achievement of the DTOC action plan:

	Specific recovery date	Comments
DTOC <2.5% (regional expectation)	Trajectory in place to achieve 4.5%	

Section 2 – week by week trajectory for achievement of the national standard (<2.5% DTOCs):
Please complete the table detailing the week by week trajectory for achievement of the DTOC targets.

WEEK:		Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17				
Number of patients with DTOC		9.6%	20.0%	20.6%	20.4%	17.3%	22.2%	19.2%	14.0%	13.4%	10.5%	7.1%				
Total bed base		66	66	66	66	66	66	66	66	66	66	66				

Percentage (%) of bed day delays due to DTOCs as a proportion of available beds	Trajectory as per January Submission	
Are all DToCs agreed by the MDT	Decisions regarding DTOC are agreed at ward level patient reviews attended by the Consultant and	If not, when will this be in place?
Are DToCs monitored on a daily basis via bed management processes	Yes	If not, when will this be in place?
Do you have weekly meetings between partner organisations to validate DToCs	Detailed review of DTOC takes place at local weekly bed management meetings, attended by members of the MDT Team.	If not, when will this be in place?
Is there weekly multi-agency escalation for complex DToCs?	1. Central Bed Management Business Support emails Borough Social Care Leads DTOC report from clinical system on weekly basis. 2. Social Care Leads check Clinical System (JADE) to review all identified patients in their area where the attributed reason for the delay is Social Care or Both. 3.Social Care Lead to report any challenges/queries to Inpatient Service Manager/Discharge Co-ordinator and arrange to meet to discuss if required. Inpatient Service Manager to involve MDT clinical team to review decision.	If not, when will this be in place?
Do you have an agreed escalation process for when you do not meet your agreed DTOC trajectory?	Yes - weekly bed local bed management meetings escalate, agree and plan for discharges	
Please provide details of your DTOC escalation process?	N/A	

Please use the table below to detail the key actions you are taking to address delays.

Recovery actions aligned to specific challenges (prioritised list)	Action linked to DTOC trajectory	Owner (Trust, CCG, LA etc)	Key milestones	How will you measure progress/delivery? (KPIs)	completion date (week and month	Quantifiable impact of actions
1.Work ongoing with CCGs and LAs to develop s117 policies outlining funding splits. There is not one approach across all 5 Local Authority/CCGs. Updating s117 CNWL Policy	Increased understanding of s117 and agreed policy will reduce delays due to Awaiting Public Funding	CCG/LA - funding split decision Trust - internal s117 Policy	Reconfirm national mandates around S117 as per guidance. Ensure full processes are in place. Escalate all delays over 7 days. s75 between LA and CCG by Policy signed off . Recirculate S117 funding pathway agree programme of workshop training on S117 matrices and funding splits	Submission of funding pathway and training programme	01-Mar-18	Reduction in DTOC. Reduced spend on activity and increasing numbers returning from out of area. No unwarranted delays in agreeing joint placements, clear framework for agreeing funding decisions for all placements.

2. Mapping of all Panel Pathways and improved and more consistent decision making on improving discharge care pathway, including planing for discharge on admission	**Improved clarity of an individual's discharge pathway will ensure presentation to the right panel with the right information to avoid delays**	**Trust, CCG, LA**	**In first quarter 2017 agree and confirm all pathways, Develop forward planner of all panel pathways which support hospital discharges**	**Monitor Care Coordinator Vacancy Rates, Caseload and timeliness of Placement Papers and Reviews to Panel, jointly with LA in s75, at local Monthly Performance Meeting with Trust. Submission of the Forward planner Failure to agree pathways will incur sanctions (5% of performance)**	**Dec-18**	**Improved quality and timeliness of placement reports and reviews to panel. Reduction in DTOC.**
3. Establish single, clear and understood definition of DTOCs	**Shared understanding of DTOC definiiton**	**Trust, CCG, LA**	**Develop definition of mental health DTOC and agree with CCG & LA**	**Agreed and DTOC definition**	**31-Mar-17**	**Reduction in DTOC. Reduced spend on activity and increasing numbers returning from out of area**
4. Institute clear reporting tool which includes both DTOCs and early warming for clients likely to become DTOCs to be reviewed at regular DTOC conference calls involving key stakeholders and commissisoners	**Regular joint work and visability to promote timely discharges.**	**Trust, CCG, LA**	**Trust has developed tool, full insitgation during 2017/18**	**Pilot of an operational DTOC tool commencing on 1st April 2017 The trust will have an early detection and escalation process with all aprties meeting as needed (at least weekly when more than 5 indivduals identified)**		**Reduced DTOC, reduced LOS, increased shared/system understanding of issues and joint working.**
5. Review training and guidanve provided to staff presenting cases to the Joint (LBH/CCG/CNWL) Funding Panel for mental health patients.	**Improved process and understanding of the information required to access approriate placements**	**CCG/LA**	**Training sessions planned and commenced**	**reported improvement in quality of presentations to panel and reduction in delay caused by inadequate information**	**On-going**	**streamlined and efficient panel process'**
6. Regular liaison meetings to be established between MH team and Housing.	**Shared understanding of current need and provision**	**Trust/LA housing authority**	**Regular attendance of the housing named representative at the weekly discharge plannign meetings**	**Shorter delays attributable to housing need**	**Sep-17**	**Fewer delays due to housing need and clear understanding of the provisions available**
7 Discharge planning should commence at the point of the admission including early identification of potential DTOCs and early allocation of Care Co-ordinator. Project to be developed to identify key action and timescales to address these issues.	**Consistent approach to discharge planning across the Borough**	**Trust**	**Definition of project actions reporting tool identified in 5 above.**	**Achievement of project milestones**	**Aug-17**	**Reduction of DTOCs**

Section 5 – Governance and programme management arrangements **Please use this space to describe the governance and programme management arrangements in place to ensure this improvement plan will be implemented and achieve the standard by the date provided in Section 1 above.**
Governance: There will be daily bed management meetings to discuss DTOC and weekly bed management meeting attended by CCG and LA. Routine reporting of all metrics monthly and escalation as needed
Programme Management: There will be daily bed management meetings to discuss DTOC and weekly bed management meeting attended by CCG and LA.