Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Redesign Assurance Process: Quality & Safety Assurance Report Report for the AWP NHS Trust Board			
Meeting Date: 30 May 2012	Meeting Time: 10.00am	Agenda Item: 10	Serial: 12.0210
This Report is presented by the Executive Director of Operations for Noting in the Public session of the Board.			

Report Summary

Purpose of this Report:

To brief the Board on EMT on the measures being taken by the Operations Directorate to ensure that patient safety and service quality is maintained during the implementation of new redesigned teams across the Trust.

Board Decisions Recommended:

The Board is recommended to **note** the report.

Actions Arising from the Report:

None specified.

Report Links

Corporate Risk Register	Ops 5

List of Appendices

- Appendix A – Guiding Principles and practice for the management of caseload transfers as part of service change

Report Sponsor: Executive Director of Operations

1. Introduction

1.1. This briefing concerns the measures being taken by the Operations Director, specifically Adult Acute Community Strategic Business Unit (SBU) and Liaison and Later Life SBU, to ensure that patient safety and service quality is maintained during the implementation of new teams across the Trust.

1.2. The redesign of community services entails the establishment of three new types of team in each area: Primary Care Liaison (PCL); Intensive; and Recovery service. Staff at Band 6 and above have been selectively recruited to the posts within these teams. As a result, there will be some movement of staff and managers across teams and areas, particularly from staff currently in CMHTs into the new PCL service. As the PCL service will not have a case management or care co-ordination function, there is likely to be some movement of care co-ordination for some service users to new care co-ordinators.

1.3. Continuity of care and patient safety have been highlighted as significant risks for the Directorate during the transition to the new services. This report outlines how these risks are being managed to ensure that service users and their carers are not adversely affected by the changes being made to services.

1.4. In addition, the Board will also receive a presentation at this meeting from the Adult Acute Community SBU which will outline the clinical practice in relation to the Care Programme Approach (CPA), care co-ordination and the use of supervision and caseload assurance tool (see 2.3 below) to ensure safe and effective practice.

2. Management of continuity of care and patient safety

2.1. The Adult Community SBU has been taking a number of measures to prepare for this movement of staff and consequent movement of caseload. For the last two years, all areas have followed a “Step-down” approach to managing their caseloads and to improve working with primary care to discharge service users where appropriate This has entailed careful analysis of caseloads by care cluster and the establishment of area action plans to bring caseloads down to manageable levels. Alongside these plans, the SBU have developed processes to enable rapid access back to services should this be required.

2.2. This approach has been successful across most areas, however, Bristol and Swindon still have larger than expected (per population) caseloads. Management staff are currently targeting these areas in order to reduce caseloads prior to the implementation of the new services.

2.3. As preparation for implementation of the new teams, the SBU has also developed a Caseload Assurance Tool which ensures that service users

have up-to-date core and risk assessments, care plans and care cluster, This tool also identifies where service users may need to be stepped down to primary care and will identify any service users for whom change of care co-ordinator could be problematic (such as being resistant to change, requiring specific gender etc.).

2.4. Alongside this, the SBU has developed guiding principles for caseload transfers (see attached at appendix A). These guidelines have been written using existing advice from the AWP Care Programme Approach and Care Delivery Procedure 2010, and following consultation with staff and the Service user Reference Group for service redesign.

2.5. The Adult Acute Community SBU and the Liaison and Later Life SBU have agreed that any transfers of service users between clinicians, care coordinators and teams, and transitions of staff between services will be managed to ensure that service users have named care coordinators at all times and that key service standards continue to be delivered.

- Key principles for caseload management have been agreed and communicated with all staff and are underpinned by existing Trust CPA policy and procedural guidance
- Where possible service users will retain their existing care coordinator and Consultant
- Care coordinators have completed caseload assurance work to ensure that all service users have care plans, core and risk assessments and an allocated care cluster in place prior to transfer
- Staff who are moving and need to transfer their caseload will receive specific supervision from the team manager to ensure the transfer is a managed process
- Any specific issues/risks which emerge will be flagged in the care plan and with the line manager in supervision
- The transfer will be a collaborative process and wherever possible, at all stages will include service users and carers (family, friends and supporters)
- The GP will be kept fully informed of any changes in care coordinator or Consultant as they happen, in accordance with usual service standards
- Staff who are identified to move to PCL will seek to achieve a caseload of nil before transfer. Where this is not possible, team managers will work with PCL service managers to identify a clear plan of action to do so
- All staff moving into the Recovery and Intensive teams will have a supervision session within 4 weeks of joining the service and an appraisal within 6 weeks of joining the service to include clinical and quality aspects
- All staff in the Recovery team will receive ongoing caseload profiling on a monthly basis from team managers supported by the clinical development lead for Recovery

2.6. The table below gives an example of a transition plan for a high-risk service user in BANES:

Client LC has a significant abuse history with associated OCD and eating disorder. Her abuse history makes it difficult for her to Trust and build new relationships so the loss of her care co-ordinator will be significant;

Her transition plan is :
1. Identify a new care co-ordinator well before existing one leaves the team
2. Ensure old and new care co-ordinatrs have a cohesive handover of history and clinical issues both from a verbal and documentary point of view before first meeting with client
3. Undertake at least two joint handover meetings with client, new and old co-ordinator
4. Ensure that the service user's carer is communicated with on an ongoing basis given he is a significant carer (living outside the area)
5. Ensure that the transition of workers is staggered, therefore making no change to consultant at the same time
6. Build on relationships that will remain unchanged (floating support and DBT therapist) and agree with them the strategy if the service user's risks increase because of her experiential loss
7. Inform A and E of potential increase in vulnerability (they already have a support plan for when she presents) .

2.7. In addition, the operational teams are ensuring that the patient record is being maintained in an accurate and timely way in line with Trust policy. All staff will receive "team days" which will focus on customer care, including service quality requirements. Staff will also be supported by regular supervision, appraisals and team meetings and the development of good practice networks will be led by the clinical development leads. Team performance will be monitored through the team and area managers to support the transition arrangements.

2.8. There is also adequate administrative capacity and capability in terms to facilitate service continuity and appropriate patient record-keeping. These staff will be supported both by their team manager and a central point of contact in their SBUs.

3. Risks

3.1. Operational services are acutely aware of risks during implementation of redesign to reported performance to ensure their transition risk mitigation plans have been successful in maintaining service and patient record-keeping continuity. To support this, data quality metrics for timeliness and completeness will be reviewed daily by teams.

3.2. However a number of risks are also identified, for consideration:

Risk	Impact	Mitigation
Vacancies in management posts	Transfers of caseloads may be delayed	Posts have been advertised internally and are now being advertised externally. Area managers will give additional support where required.

Risk	Impact	Mitigation
		Caseloads will remain with existing teams until care co-ordinators are in place.
Vacancies in clinical posts	Transfers of caseloads may be delayed and transfers of staff to new teams may be delayed	Posts have been advertised internally and will soon be advertised externally. Bank staff may be used in PCL to support the transition to the new service if required. Each area has agreed a transition plan with PCL in order to maintain capacity across teams.
Overall scale of movement of staff	Co-ordination of transfers may be disrupted	Strong project management structure in place, centrally and locally. Readiness reviews held to determine and manage key risks.

4. Conclusion

4.1. In summary, the overall approach being adopted by the Directorate to manage implementation is as follows:

- Identification and development of a local plan to complete the caseload assurance work for each care coordinator in the identified team
- Development of detailed step down plans as appropriate for individual service users and review the progress of each through regular supervision
- Development and handover of an established and functioning supervision process to the new incoming managers
- Ongoing monitoring of the effectiveness and ensuring that the quality of the supervision process is being maintained.

4.2. Business continuity is being managed via local implementation groups (including PCL and Adult community services), a central redesign project team, weekly conference call and through reporting into the Operations Directorate Management meeting. In addition, local clinical meetings are being held on a weekly basis when the new services being in order to manage patient safety, monitor performance and identify any issues with the implementation of the new service models.

4.3. Alongside these regular reviews, there will be a formal reviews in September to assess the impact of the new service on quality, performance and service user experience. This review is currently being planned with the Performance team and will be reported to the Board accordingly.

4.4. PALs have also been briefed on the planned changes in order to provide additional support to service users if they have concerns. Each area is also establishing, or has established, a Community Care forum with representatives from service user and carer groups, Voluntary Sector and Local Authority in order to develop good working relationships within the community care pathway.

5. Recommendation

5.1. The Board is asked to note the content of this report.

6. Additional Report Contributors

6.1. Emma Adams, Project manager - Operations

6.2. Sarah Frizzle, Service Improvement Manager – Adult Acute Community SBU.

APPENDIX A

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Business Continuity

Guiding Principles and Practice for the Management of Caseload Transfers as part of Service Change. V1

Avon and Wiltshire Mental Health Partnership NHS Trust	
Project Name:	Adult Service Redesign- Community
Project Executive Director:	Kevin Connor, Service Director – Adults Acute Community SBU
Project Lead:	
Project Manager:	Sarah Frizzle, Service Improvement manager
File name and Location:	X:\Community Services Redesign Project Steering Group\Area by Area Planning/V3 Guiding Principles and Practice for the Management of Caseload Transfers

Version	Date	Comments	Composed	Authorised	Status
0.1	15/03/11	Initial draft	Sarah Frizzle		Draft
0.2	04/04/11	Second draft incorporating comments from the service user reference group	Sarah Frizzle		Draft
1	19/05/11	Final- incorporating comments from NCAS	Sarah Frizzle/Alan Metherall/Mark Bunker		Final

Introduction

This paper, written using existing advice from the AWP Care Programme Approach and Care Delivery Procedure 2010, and following consultation with staff and the Service user Reference Group which is meeting as part of service redesign.

Purpose for the Paper.

The adult project board is requested to agree the principles and practice outlined here will guide local areas in their consideration of how to facilitate any caseload transfers which need to take place as part of service change.

Context

The care of service users is transferred regularly during normal everyday clinical practice. It happens when the service user transfers from team to team or when a worker commences a longer period of leave or when a worker leaves the trust. It is always a process which, wherever possible, is undertaken in collaboration with service users, their carers (friends family and supporters), and it is underpinned by existing Trust CPA policy and procedural guidance.

At the point of implementation of the redesign it is likely that some service users will need to have their care transferred to another clinician, and this might occur in larger numbers than would happen during normal day to day practice. The exact number of people affected will not be known until after the point at which the jobs choice exercise has been completed, and it is known where each individual member of staff will work.

Acknowledging that the numbers involved in this situation may therefore be different to those occurring in clinical practice every day the following guiding principles have been prepared to help teams manage the process safely and effectively.

Overarching Principles

- The transfer of care from one care coordinator to another will be in collaboration with the service user, and their family/friends/supporters
- The service user and carers, (family/friend/supporters) will be fully involved in any transfer if it needs to occur.
- The service will keep any inconvenience to the service user, and their family/friends/supporters to a minimum.
- Any transfer should happen in a timely fashion in line with service and policy standards
- The GP will be kept fully informed of any changes in care coordinator as they happen, in accordance with usual service standards.
- The existing care coordinator should ensure that the detailed information is current and available on file and electronically ahead of any transfer. This should include:
    - Core assessment
    - Risk assessment, clearly identifying the nature, complexity, and content of risk
    - Legal status
    - All legal documentation eg MHA, MCA, Safeguarding documentation
    - Hospital passport for those with a learning disability
    - Care plan, including crisis and contingency plan and indicators of relapse
- The service user, and carer, where appropriate, will receive a copy of the plan.
- All stages in the process will be documented in the clinical record.

Guiding Practice Principles

- The transfer process is a collaborative process and wherever possible, at all stages, will include service users and carers(family, friends, and supporters)
- Where possible the service user would retain their existing care coordinator. Exceptions to this maybe where the service user requests a change or where the member of staff believes a change of care coordinator would be clinically appropriate. This will be discussed with the service user and their views recorded as part of the decision making process.
- Wherever possible a handover meeting should take place between all parties prior to the transfer. Where this is not possible there will be handover between the existing and new care coordinator using the detailed information available, ahead of the new are coordinator meeting the service user. These discussions must be recorded in the clinical record and provided in letter for to the letter to the service user and GP.
- Detailed and accurate supervision notes will be kept, of caseload management sessions, preferably using the caseload profiling tool to enable managers to make effective decisions about transferring cases.

Procedural Guidance

- All workers in all existing teams are to maintain up to date information about the service users on their caseload, and to ensure all current goals and actions are clearly outlined on the existing care plan
- Existing care coordinators are to discuss with service users, family friends and supporters, at their review, preferences around possible change of care coordinator, eg Gender, using the available guidance.
- Any specific issues/ risks which emerge are to be flagged up in the care plan and with the line manager in supervision and recorded in the notes.
- At the point of implementation and when workforce plans are known, specific supervision sessions are to be held with the purpose of identifying new CCO where appropriate.
- Existing Care coordinators where appropriate to make contact with the new Care coordinator and make suitable arrangements for the transfer of Care.
- Once the transfer has been agreed then the process will be undertaken within 2 weeks.
- After transfer has taken place the care coordinator should take steps to follow up with the service user, family friends and supporters how any new arrangements are working.
- Any issues or concerns are to be raised by the worker as part of routine and regular caseload supervision
- All parts of the process to be documented in the clinical record.

Dispute resolution

- The resolution of any disputes will follow the CPA procedural guidance
- Where transfer cannot be agreed the CCO and/or Responsible Clinician (or Team Manager if the post holder has left to a different team) remain responsible for ensuring the CPA is followed until any disputes are resolved
- Disputes between teams must ensure that the needs of the service users remain paramount in decision making and that all disputes will be resolved within 2 weeks (on CPA) and 4 weeks (non CPA). Clinical and Service Directors would be the final arbitrator in the escalation process.
- Any potential disputes will be raised at an early stage through the line management route