Local Members' Interest
N/A

Healthy Staffordshire Select Committee
Monday 15th July 2019

Staffordshire and Stoke-on-Trent Transforming Care Partnership Progress Update Report – Patients with Complex Care needs

Recommendation: That the Healthy Staffordshire Select Committee is asked to be consider the progress being made in delivering the requirements of the national 'Building the Right Support' plan through the Staffordshire and Stoke-on-Trent Transforming Care Partnership (TCP).This report will include the following information:

- Progress towards meeting the discharge trajectories set by NHS England
- Commissioning and monitoring of in-patient facilities.
- Commissioning and monitoring of community placements.
- Additional quality and safety assurance measures being implemented following the TCP becoming aware of the findings of the Panorama programme regarding Whorlton Hall.

Summary

1. Staffordshire TCP did not achieve the end of programme trajectory set by NHS England for either the number of patients in a CCG commissioned bed or for the number of patients in a specialised commissioned bed, which includes young people in a T4 bed and patients in secure beds.
2. This was a very similar situation as seen in very many TCP areas and as a result the TCP programme has been extended and new trajectories have been set. Currently Staffordshire are rag rated as green against this new trajectory set by NHS England.

3. Robust measures are in place to ensure effective commissioning of both hospital beds and community placements which meet the individual needs of individuals in this programme and robust monitoring processes are in place to monitor the safety and quality of these facilities.

4. Additional quality and safety assurance measures have been put in place following the Panorama programme.

Report

Background

5. People with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect. They should expect, as people without a learning disability or autism expect, to live in their own homes, to develop and maintain positive relationships and to get the support they need to be healthy, safe and an active part of society.

6. The aim of the Transforming Care Partnership (TCP) was to drive forward redesign and system-wide change to improve services for people of all ages with a learning disability, autism or both who display behaviour that challenges, including those with a mental health condition. Its aim was to enable more people to live in the community, with the right support, and close to home, in line with Building the Right Support (October 2015) – a national plan to develop community services and close inpatient facilities.

7. The challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital.

8. The TCP programme formally began on 1st April 2016 and ended on 31st March 2019 (3 year programme). However, all activities are on-going and discussions are currently taking place to identify how this important initiative is integrated into a business as usual system going forward. Leadership of the TCP changed mid-way through the programme following the retirement of Andrew Donald. At this point the CCG Executive Director of Nursing and Quality, Heather Johnstone, took over the role of Senior Responsible Officer and she has strengthened the team to enable significant progress to be made in this key area.

Progress towards achieving trajectories

9. Staffordshire TCP did not achieve the end of programme trajectory set by NHS England for either the number of patients in a CCG commissioned bed or for the number of patients in a specialised commissioned bed, which includes young people in a T4 bed and patients in secure beds.

10. This was a very similar situation as seen in very many TCP areas and as a result the TCP programme has been extended and new trajectories have been set. Currently Staffordshire are rag rated as green against this new trajectory set by NHS England.

11. At the beginning of the programme there were 32 patients in CCG commissioned beds. Of these only 6 now remain in hospital. The reason for this is varied, some remain unwell and not ready for discharge but some are ready for discharge but despite on-going efforts it has not been possible to identify a community provider able to provide a suitable placement. This is due to the level of behaviour that challenges and/or the level of risk posed to self or others in the community.

12. One of these original patients, a gentlemen had been discharged successfully to the community but due to changes in legal framework requirements he has had to be recalled on his section. He remains living in his home on extended section 17 leave but technically he is not discharged and remains a hospital in-patient.

13. The TCP team continue to have discussions with providers to overcome these difficulties. Currently the Staffordshire CCG's are commissioning 28 in-patient facilities. It would appear that little progress has been made but this as identified above does not reflect the true picture. To date sixty seven patients have been discharged through this pathway as there are now ninety five patients on the overall cohort (in-patients plus patients discharged from hospital since April 2016 at the start of the programme).

14. As mentioned above the biggest challenge now is preventing the need for individuals to be admitted to hospital. These admission avoidance activities have increased over the last three years and are now absorbing a significant proportion of the team capacity

15. There has been a noticeable increase in the number of young person's 16-25 who are presenting with a high incidence of behaviours that challenge and that is not decreasing. This noticeable trend upwards and the lack of development of treatment and support pathways for adults and young people with ASD remains a concern. NHS England has also noted that this appears to be a National trend and that pathways are not in place to deliver the packages of care required by these individuals. NHS England has also noted that this appears to be a National trend. The TCP project team is meeting with local providers to explore the current processes and identify improvements which can be made in these pathways and the dedicated CYP case worker is working closely with community providers, social care and education to ensure these young people receive the community packages of care they require and the risk of re-admission is reduced.

Commissioning and Monitoring of In-patient Facilities

16. The delivery of admission avoidance strategies is now a clearly defined process within Staffordshire. The majority of individual's in the community with LD or Autism or both are known to either social care and/or health services. When either service become aware of a deterioration of health or behaviours or the potential breakdown of a placement the individual is referred to the Intensive Support Team (IST) provided by Midland Psychiatry Foundation Trust in South Staffordshire or North Staffordshire Combined Healthcare Trust in North Staffordshire. These teams support local teams with additional support as required. If this team assess admission is becoming a risk then contact is made with the TCP team and a community Care and Treatment Review (CTR) is arranged. The urgency of this is guided by the IST. At this forum members of the community multi-disciplinary team discuss current care and risks and agree a detailed action plan to reduce the risk. This may often prompt additional health or social care support and sometimes it is agreed that a move to a new community placement is required.

17. Currently there are on average three to four of these taking place per week. The instigation of this process has hugely reduced the number of new admissions to hospital of individuals in the community. Enhanced joint working between health and social care services and early intervention are the primary reasons for this improvement.

18. Following this process if it is agreed that admission has become unavoidable then the commissioning of the in-patient facility is led by the CCG TCP team. A detailed picture of the individual's needs and risks (Person Centred Care and Support Plan) is circulated to the TCP enhanced provider network. This is a group of known hospital bed providers with whom the TCP team have built trusted relationships with and are confident of the quality and safety of the services provided. This forum includes both NHS and independent providers of in-patient services and community residential and supported living services. In area beds are always sought and out of area bed is only selected if the services needed to meet the individual's needs are not available in area.

19. This is distributed anonymously to the provider forum and providers then come forward to assess the patient and put forward their care plan proposals which will meet the holistic needs of the individual. Costings are also submitted. These proposals are then rigorously evaluated by the TCP clinical team and the most appropriate provider selected. Where

possible the individual and family are part of this process and are fully involved in the selection process.

20. Transfer to this in-patient facility is also arranged by the TCP team if required. This process of clinical due diligence is now well established and is being very effective in finding the most appropriate bed for the individual patient.

21. Costings for the bed are sent to the TCP funding panel for approval. This panel meets monthly but is often virtual if the need for a bed is urgent. When the costing for the bed is high it is required that these costs are escalated to the CCG executive team for final approval.

22. A CCG TCP case manager is always allocated to any patients admitted to hospital and further CTR's regularly take place during the patients hospital stay. The first takes place within four weeks of admission and thereafter a minimum of every six months but this is often more frequent if requested by the case manager. In between these full reviews the case manager attends the hospital multi-disciplinary team meetings to ensure the care plan is being delivered as proposed and monitor the progress of the patient.

23. The TCP team have now reduced the number of hospitals being selected. Having a higher number of patients in fewer hospitals is ensuring a higher level of presence in these units (often 3 times per week). The team are also taking appropriate opportunities to repatriate patients out of area. This can only be completed if this move will fit into the care plan of the patient and if there is an appropriate bed available.

Commissioning and Monitoring of Community Placements

24. This process is also led by the TCP team but closely involves both hospital and community multi-disciplinary teams. Agreement has to be reached by both teams that discharge to the community is possible and that the patient is soon to be ready for discharge.

25. A similar process is followed. The Person Centred Care and Support plan is completed. This is required to be more robust as many more professionals will now be involved with delivering the package of care required in the community.

26. Once a community provider has been agreed they will then join the multi-disciplinary team meetings taking place in the hospital and be an integral part of the discharge planning.

27. A jointly funded Health and Social Care Deputy Senior Responsible Officer is in place and focusses on working alongside the community providers to drive forward the timely discharges of the TCP patients. There is a particular focus on patients who have been in a hospital environment for over 5 years.

28. The TCP team continue to meet weekly as a group to discuss the actions required to progress the discharge of each patient and ensure all requirements are in place to meet the needs of each individual.

29. The TCP team are continuing to seek appropriate placements for the remaining patients on the cohort who have no solution in place, however, some patients currently present a very high risk in the community and no provider has come forward and is willing to offer a

community placement. Discussions are on-going with NHSE to address this issue as this is an issue also shared with other TCP areas.

30. The TCP team are focussed on ensuring all community placements commissioned on behalf of these patients meet quality standards required. All supported living providers and residential home providers are required to meet CQC standards and are monitored accordingly.

31. All patients being placed in the community have a very detailed and robust 'Person Centred Care and support Plan' (PCCSP) completed which identifies all needs, goals and risks associated with the proposed care plan.

Additional quality and safety assurance measures post Panorama programme

32. The CCG were made aware of the planned screening of the Panorama programme and its content on 3rd May. At this point immediate actions were taken to establish whether local patients were involved and once this was confirmed further action took place.

33. Immediate actions taken by the CCG in response to the incidents at Whorlton Hall were to prioritise all individuals at establishments owned by this provider. Multidisciplinary meetings were held with all patients, with at least 1 or 2 professionals (external to the main Provider) whom had regular contact with the resident demonstrating independent assurances. This methodology worked well and will be used wider as the patients involved are not always receptive to the interaction with 'strangers'.

34. NHSE/I have made the decision that each CCG will have the responsibility for assuring the overarching quality & safety of all the independent hospitals in their local area through a reciprocal agreement. As a result all are being visited over the next 8 weeks to establish strong relationships and ensure they are aware of the CCG expectations going forward. This process has now already begun. The Executive Director of Nursing and Quality has also written to all other CCG Directors of Nursing requesting the same levels of assurance.

35. The initial visit is to build the relationship and to detail future expectations and to work with the providers to examine both internal and external assurance processes. The independent hospitals have the additional challenge as they are commissioned by multiple CCGs meaning there is no coordinated process. Therefore, Staffordshire & Stoke on Trent CCGs will lead on this process within the local health economy.

36. Six independent hospitals have been identified in Staffordshire and there are planned visits to them all over an eight week period, with follow up visits planned within 2 months with a strategy for each one.

37. The first of the six was visited on Monday 1st July 2018 by the Interim Deputy Director of Nursing & Quality and the Designated Nurse Adult Safeguarding. This independent hospital has had a recent CQC visit and the Interim Deputy Director of Nursing and Quality has been in contact with the CQC and asked if they can work together going forward with this and other independent hospitals. The CCG are attending the CQC team meeting in Birmingham on the 11th August to discuss and agree a more innovative way of working together in monitoring the quality and safety of these establishments.

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