CLINICAL AUDIT
SERVICE EVALUATION
NICE COMPLIANCE

Leeds and York Partnership NHS
NHS Foundation Trust

Community Redesign Caseload Transfer

September 2019

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Executive Summary

Earlier this year the Trust took part in an initiative to redesign community services. This redesign involved separating existing community services into the older people and 'working age adult' services. Several care coordinator transfers needed to take place due to some staff moving into new roles and locality geographical boundaries changing for services.

It was acknowledged that these transfers were unavoidable, however it was expected that transfers would be carefully managed between teams to minimise disruption for service-users. As part of the community redesign it was noted that there were significant risks associated with large scale transfers of care coordination. Over 7000 transfers occurred as part of the data migration process on the PARIS electronic system, as new community teams on PARIS were created. This involved considerable work predominantly by community support services and Clinical Team Managers. Approximately 170 care coordinator transfers that affected service-users directly also took place. This transfer process involved care coordinators and clinical team managers effectively communicating and carefully managing transfers as safely as possible. As part of the evaluation an audit of care coordinator transfers took place. The purpose of the audit was to assess the impact of the transfers for service-users and127 cases were considered, which is a considerable percentage of the total number (170).

As part of the Community Redesign Caseload Transfer project 127 cases were considered. The results suggest that overall the transition of care undertaken as part of the community redesign was effective and caused the service the least amount of disruption. For a small percentage of cases (2-3%) no answer was given. It is unclear if this means no evidence was available to answer the question, or if the respondent had another reason for not answering the question.

The open-ended questions - when coded into themes, highlighted some areas of operational issues, such as *"Service user was not reallocated to a new care-coordinator or team and was discharged from care-coordination months after service changes had occurred."* This and similar issues highlight the importance of following-up with patients after projects similar to community redesign to ensure continuity of care is maintained.

Based on the results, the following recommendations are suggested:

- Review the results with the wider team and identify areas where there are gaps in the service which need to be addressed. This can be done in existing meetings or via a separate meeting.
- Follow up on service-users with delays in transfer to ensure continuity of care was maintained.

The project aimed to assess the impact of the community redesign on the transfers of care which took place. The results overall suggested a positive experience for service users, though areas of improvement and learning were identified. Recommendations have been made based on the results.

Introduction

Earlier this year the Trust took part in an initiative to redesign community services. The changes included:

- Two distinct community mental health services have formed providing the delivery of two dedicated services and pathways for older people (OPS) and working age people.
- The establishment of a Crisis Resolution Intensive Support Service (CRISS), offering urgent assessment and intensive home based treatment support. Their role also involves the gatekeeping of all acute admissions to hospital.
- The Single Point of Access (SPA) function has separated from the Crisis Resolution Intensive Support Service, with the aspiration that this will become a predominantly administrative function.
- The working age adult (WAA) community mental health teams have aligned to revised geographical boundaries so they are of an equal population across all three localities. Each locality now consists of two sub-teams, which are divided into smaller clinical teams, known as pods. There are new meeting structures aligned to the locality sub teams and newly formed leadership teams, consisting of Clinical Team Managers (CTM's), Psychology leads and Medical leads. Clinical huddles have embedded well within the clinical teams.
- A revised Memory Service pathway which focusses on early diagnosis and post diagnostic support.
- The development of a Care Homes Service, that includes an enhanced service which can provide intensive support to people in care homes in order to prevent hospital admission.
- A centralised citywide physical health service that provides ongoing Clozapine monitoring services, as well as monitoring requirements for people needing certain treatments.
- The development of a Community Practice Development Leads team, who will work closely with their Practice Development Lead colleagues who are attached to inpatient services. Their work will be driven by key priorities determined with Clinical Governance structures and profession specific priorities.

After the community redesign was complete it was identified that there were a number of risks associated with large scales transfers that took place. Therefore it was imperative to understand the impact of the transfers to ensure the care of service-users continued to a high standard.

Aims and Objectives

The aim of the project was to assess the impact of the transfers for service-users and staff in the community. This was achieved by conducting an audit of service-users who had undergone a care coordinator transfer to another locality as part of the redesign.

Methods

An audit proforma was devised by the Clinical Effectiveness Team and approved by the project lead. The proforma was made available on Smart Survey. A complete list of questions can be found in Appendix 1.

Results

As part of the Community Redesign Caseload Transfer project 127 cases were considered. The results of the core questions relating to the triangle of care are presented in (Figure 1). The results suggest that overall the transition of care undertaken as part of the community redesign was effective

and caused the service the least amount of disruption. For a small percentage of cases (2-3%) no answer was given. It is unclear if this means no evidence was available to answer the question, or if the respondent had another reason for not answering the question.

Results for all the questions are presented in Table 1, with similar results as observed for the triangle of care questions.

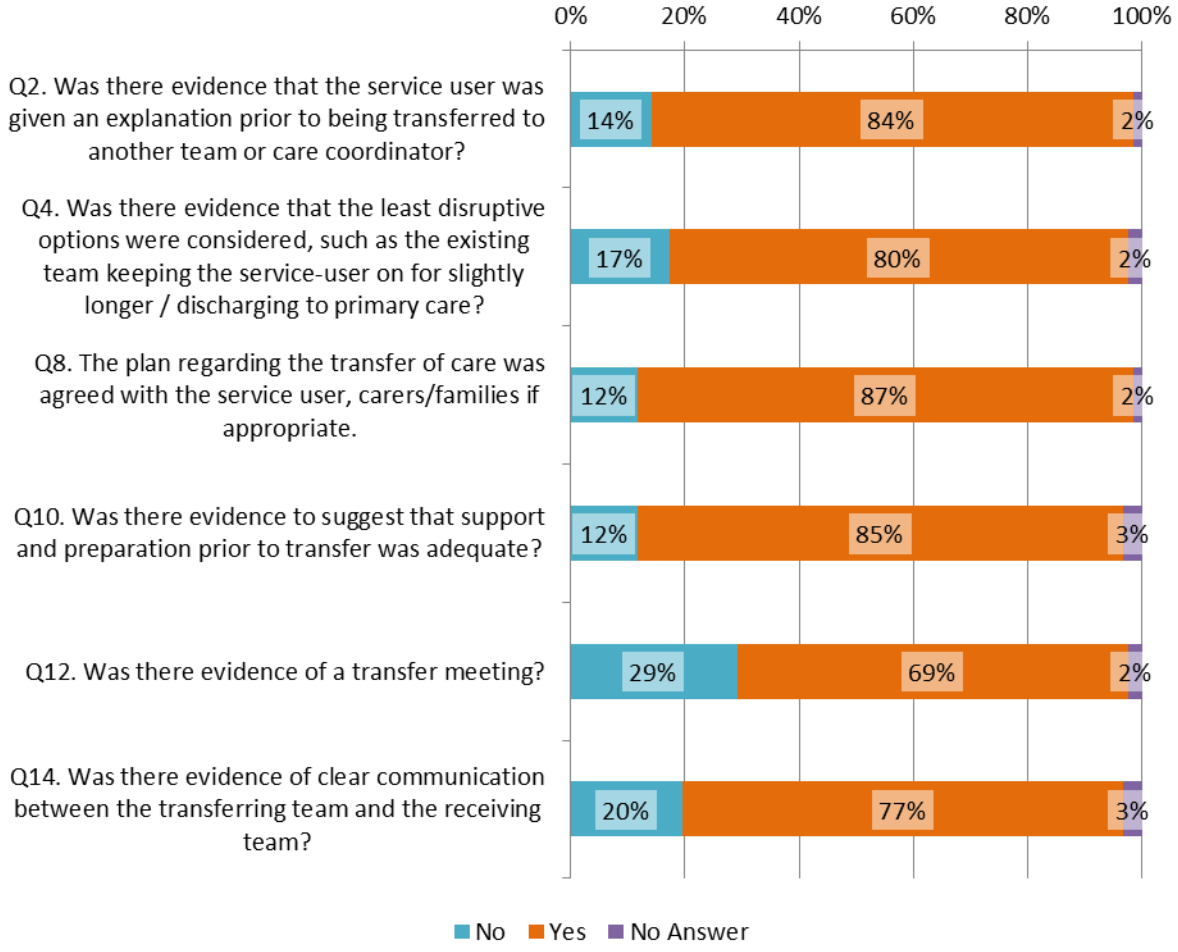

Figure 1: Questions relating to the Triangle of Care

Table 1: Summary of Results

Question	No (% (n/N))	Yes (% (n/N))	No Answer (% (n/N))
Q2. Was there evidence that the service user was given an explanation prior to being transferred to another team or care coordinator?	14% (18/127)	84% (107/127)	2% (2/127)
Q3. Was the timeliness of the transfer appropriate (during a period of relative stability)?	6% (7/127)	92% (117/127)	2% (3/127)

Question	No (% (n/N))	Yes (% (n/N))	No Answer (% (n/N))
Q4. Was there evidence that the least disruptive options were considered, such as the existing team keeping the service-user on for slightly longer / discharging to primary care?	17% (22/127)	80% (102/127)	2% (3/127)
Q5. Was there evidence that the service user was actively involved in discussions around their transfer plan of care?	19% (24/127)	80% (101/127)	2% (2/127)
Q6. Were carers (with service user consent) involved in decisions around transfer plans?	52% (66/127)	43% (54/127)	6% (7/127)
Q7. Were other involved professionals included in decisions around transfer plans?	9% (11/127)	88% (112/127)	3% (4/127)
Q8. The plan regarding the transfer of care was agreed with the service user, carers/families if appropriate.	12% (15/127)	87% (110/127)	2% (2/127)
Q9. Was there evidence that appropriate support was offered to the service user during the transfer of care?	9% (11/127)	88% (112/127)	3% (4/127)
Q10. Was there evidence to suggest that support and preparation prior to transfer was adequate?	12% (15/127)	85% (108/127)	3% (4/127)
Q11. If any issues arose around the transfer of care, was there evidence that attempts were made to resolve these issues?	9% (12/127)	88% (112/127)	2% (3/127)
Q12. Was there evidence of a transfer meeting?	29% (37/127)	69% (87/127)	2% (3/127)
Q13. Did the transfer meeting include the service user and both the new and transferring teams?	38% (48/127)	59% (75/127)	3% (4/127)
Q14. Was there evidence of clear communication between the transferring team and the receiving team?	20% (25/127)	77% (98/127)	3% (4/127)

For Question 5 (Was there evidence that the service user was actively involved in discussions around their transfer plan of care?), if staff answered “No” they were asked why. Responses varied from the service user deemed to not have capacity to poor engagement with CMHT. The full list of responses is provided below, grouped by the overarching theme:

Theme 5.1: Service User Engagement Issues

“Attempted but service user refused”

“Service user does not have the capacity to engage with discussions.”

“Service-user failed to attend the planned transfer meeting”

"The service user is in an out of area placement and notes suggest this person is very unwell."

Theme 5.2: Operational Issues

"Not a straight forward transfer from CMHT to CMHT; The service user was being transferred from acute care to CMHT, was originally referred to one locality but it became apparent that the service user had recently registered with GP in different catchment. No need to have a handover. Care transferred from acute care to CMHT."

"Poor engagement with CMHT, did not engage with transfer meeting, then was discharged by one team due to non-engagement, then allocated to new team when relapsed and admitted (within the same month)."

"Service user was not reallocated to a new care-coordinator or team and was discharged from care-coordination months after service changes had occurred."

"Care coordination ended but psychology input was still required."

"Explanation given over phone, minimal documentation around this."

"It was an internal team transfer. Only a medic involved at first until care coordination was indicated then they were allocated thereafter."

"The notes do not reflect a thorough discussion about the transfer but that the service user has been informed that it is happening."

For question 6 (Were carers (with service user consent) involved in decisions around transfer plans?), if staff answered "No", they were asked to provide a reason. For nine service users it was reported that no evidence was available in the notes, for six the service user was reported as not having any carers and one did not want their carers involved. The remaining responses were:

Theme 6.1: Lack of/poor evidence of engagement

"Carers are involved but I could not find any discussions or letters about this on the electronic record."

"No evidence"

Theme 6.2: Carers not involved

> *"No identified carer, service user declines to give information to staff about who he spends time with"*
>
> *"Service user did not want them involved"*
>
> *"Service user did not have carers."*

Theme 6.3: Operational Issues

> *"Service user was not reallocated to a new care-coordinator or team and was discharged from care-coordination months after service changes had occurred."*

The final question gave staff the opportunity to provide any other information. The full list of comments is in Appendix 1. Some comments are:

> *"Good attempts made to transfer smoothly but service user unable/unwilling to engage in the process."*
>
> *"Good example of a transfer that was well planned, communicated and completed in a person centred way."*
>
> *"Unable to find documented evidence where reason for transfer was explained to service user."*

Overall the results were positive regarding the transfer of care post-community redesign. For 84% of cases there was evidence that the service user was given an explanation prior to transfer, and for 92% the transfer timeliness of the transfer was deemed appropriate. There were other areas with lower levels of adherence, for instance only in 43% of cases were carers involved; although there are some explanations for the lack of carer involvement. For 38% of cases the transfer meeting did not include the service user and both teams (new and old).

Discussion and Conclusion

After the Community Redesign it was noted that there were a number of risks associated with the large scale transfers that occurred. Therefore it was important to understand the impact on service users from the transfers. An audit was conducted of 127 service users who experienced a transfer of care. The results indicated that overall the transfers of care were well documented and resulted in minimal disruption to the care received by service users. For a few questions, particularly related to the involvement of carers, a lower adherence level was observed. However, review of the comments indicated that in many cases the service user did not have any carers or did not want their carers involved in the process.

Strengths and Limitations

Some of the strengths associated with the audit are that all identified cases had an audit proforma completed, giving a 100% response rate. Secondly, the overall results were largely positive. There were a few limitations; there were limited views from other professionals as it was mainly nurses (3) who took part in the audit, although a doctor and an occupational therapist also contributed.

Recommendations for the service

Based on the results, the following recommendations are suggested:

- Review the results with the wider team and identify areas where there are gaps in the service which need to be addressed. This can be done in existing meetings or via a separate meeting.
- Follow up on service-users with delays in transfer to ensure continuity of care was maintained.

Conclusion

The project aimed to assess the impact of the community redesign on the transfers of care which took place. The results overall suggested a positive experience for service users, though areas of improvement and learning were identified. Based on the results recommendations have been made.

Acknowledgements

The Clinical Effectiveness Team for their support in designing the proforma, assistance with data collection, analysis and writing the report.

Josef Faulkner (Operational Manager), Community Practice Development Leads and Dr. Blessing Alele supported the information gathering part of the audit process.

Appendices

Appendix 1: Questions included in the proforma

1. Was there evidence that the service user was given an explanation prior to being transferred to another team or care coordinator? Yes……No
2. Was the timeliness of the transfer appropriate (during a period of relative stability)? Yes……..No
3. Was there evidence that the least disruptive options were considered, such as the existing team keeping the service-user on for slightly longer / discharging to primary care? Yes……..No
4. Was there evidence that the service user was actively involved in discussions around their transfer plan of care? Yes……..No
5. Were carers (with service user consent) involved in decisions around transfer plans? Yes……No
6. Were other involved professionals included in decisions around transfer plans? Yes……..No
7. The plan regarding the transfer of care was agreed with the service user, carers/families if appropriate.
   Yes ……..No
8. Was there evidence that appropriate support was offered to the service user during the transfer of care? Yes……No
9. Was there evidence to suggest that support and preparation prior to transfer was adequate? Yes……..No
10. If any issues arose around the transfer of care, was there evidence that attempts were made to resolve these issues? Yes……..…No
11. Was there evidence of a transfer meeting? Yes…….No
12. Did the transfer meeting include the service user and both the new and transferring teams? Yes……No
13. Was there evidence of clear communication between the transferring team and the receiving team? Yes……No

Appendix 2: General Comments provided

“The service user was discharged from their CMHT and then taken up by ISS following a crisis. The SU was then discharged from ICS to a care care-coordinator who was already familiar with the case and so was happy for a transfer of care not to take place.”

“A telephone transfer meeting took place, which was agreed with the service-user, who felt she did not need to be part of a formal transfer meeting. The two coordinators reviewed the plan of care in detail following the telephone meeting, which was good practice.”

“Concerns that the exiting care coordinator has discharged the service-user in June, and the new care coordinator has not had any contact since. The new care coordinator was on long term sick during the transfer & due to return in one month.”

“CPA meeting to transfer held, however it is unclear if transferring care coordinator was present at the meeting as CC's name not documented at meeting.”

“Depot clinic entries predominantly, with very little description of service-user views.”

“Detailed and clear communication between service user and teams involved.”

“Evidence of excellent practice to support this lady with a transfer that she found difficult. Both care coordinators actively engaged with this lady to get to know her & minimise the disruption.”

“Evidence of good practice whilst supporting the service-user during the transfer process, particularly as she felt distressed about changing care coordinator.”

“Evidence of very supportive and sensitive approach with the service-user.”

“Excellent example of a transfer of care. Lots of preparatory discussion, evidence in the notes is clear and also documented in the CPA care plan. Service user anxieties about the process were well managed.”

“Medic to Medic Transfer”

“Original plan was to discharge back to GP but has subsequently been picked up by the new consultant as they were transferred over to the new team on PARIS in error."

“Minimal intervention during transfer (depot) and seen by numerous nurses for this.”

“New care coordinator often did not have capacity to see the service-user in the weeks following transfer.”

“No actual transfer meeting but the previous care coordinator went to visit the service user to explain the transfer had happened.”

“No clear documented evidence of a discussion taking place about transferring care on the actual day of transfer between the old and new care coordinators. CPA care plan notes the transfer will happen a couple of months prior to the transfer. No CPA transfer meeting.”

“No documented evidence of transfer meeting.”

“No evidence of informing the service user of the transfer and no evidence of informing the out of area placement about the new care coordinator.”

“Not a transfer between CMHTs. Was referred from SSE to SW CMHT internally. ?should this be included in the audit?”

“Service user comment made to new team that CMHT care used to be better pre all of the changes.”

“Service user did not attend the planned CPA transfer meeting. This delayed the process a little but the staff involved tried hard to include the service user in the process and to ensure they felt comfortable with it. Good efforts from staff involved.”

“Service user had difficulties engaging with the community team, so transfer of care to new care coordinator did not take place.”

“Service user unhappy about being transferred feels the old CMHT which was closer to home was more accessible and the new CMHT is miles away. Dissatisfaction expressed by service user.”

“Service user was not reallocated to a new care-coordinator or team and was discharged from care-coordination months after service changes had occurred.”

“Service-user agreed to discharge from care coordination but required psychology input still. The referral for psychology went to the East, West and eventually South team as there was confusion due to change of boundaries & data migration.”

“Service-user DNA's several appointments prior to transfer. Exiting care coordinator attended MDT meeting for new team & a decision was made to discharge from CMHT. Service-user turned up at the office distressed about being discharged. Exiting care coordinator met with him in response prior to discharging him.”

“Service-user has been psychotic during transfer period and became suspicious of exiting care coordinator. This made transfer difficult, however attempts to support the service-user by the exiting team were evident despite his difficulties.”

“SU was in ICS at time of transfer. Transfer was felt to meet the needs of the leaving care coordinator rather than the SU.”

“SU was transferred from the WnW team to the Ne (East) team. He however has not been assigned a care coordinator yet.”

“The care coordinator that was transferring clearly documented the plan during the transfer, and communicated this well with the MDT / carers.”

“The preparation for transfer was excellent, and whilst it was documented that a transfer meeting would take place, there was no evidence that this happened. Case notes by new care coordinator extremely brief.”

“The transfer has not yet happened. It is planned for the coming weeks. The service user has been informed that this is happening, no evidence of communication between health professionals involved in the transfer within the case notes.”

“There was a mistake with the taxi booking & the service-user attended the wrong base for the CPA meeting. Preparation around transfer had been good up until this point, however after the failed transfer meeting there was no contact with the service user for approximately 6 months & most recent contact was following the service-user calling SPA in crisis.”

“There was evidence that initial plans around transfer were clearly planned. However the service-user failed to attend the transfer meeting, the new care coordinator was off sick & the only contact for several weeks was reactive to duty workers who were unclear about the support plan.”

“This service user was referred for assessment and was not subject to care coordination, their referral was sent to the wrong locality which caused delays and there were some evidence of misinformation causing staff to close the referral which caused further delays. The service user made an informal complaint about the process and the time left waiting for support from CMHT.”

“Transfer has not yet taken place.”

“Transfer has not yet taken place as the SU is away for 2 months.”

“Transfer meeting not held. Old (Previous) care coordinator had only been caring for service user for a short time and had not formally met service user. Service user declined meeting old care coordinator, preferring to start off with the new care coordinator.”

“Transfer was from ISS to CMHT, not a transfer between CMHTs, should this one be included in the audit?”

“Unable to find documentation where explanation was given to SU regarding reason for care transfer. Transfer of care occurred during CPA wellbeing recovery plan.”

“Very good transfer, service user focused throughout.”

“Very poor transfer. Only reference in the notes of a transfer taking place was exiting care coordinator stated that he had phoned the new care coordinator as a handover.”