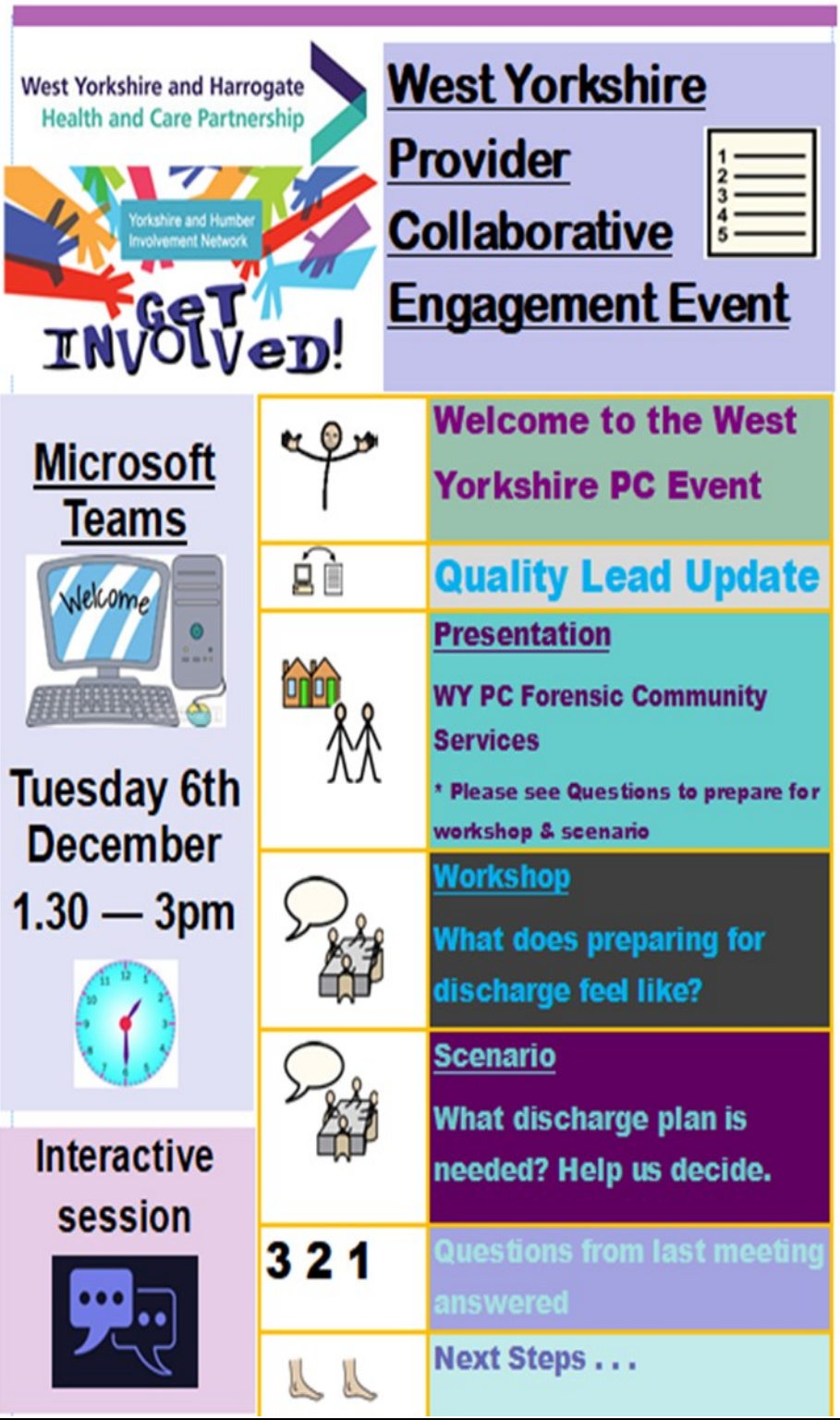
WEST YORKSHIRE PROVIDER COLLABORATIVE

NEWSLETTER 8 December 2022



Welcome to the Newsletter from the latest West Yorkshire Event – December 2022.

We had an update from the Commissioning Hub about quality, including updates and priorities for improvements.

We then had a presentation from Amanda as lead for the Community Workstream. We workshopped questions asking you about discharge planning including a scenario.

We also answered some of the unanswered questions from the 3 2 1… presentations from the last event.

Thank you for joining us!

Contact Charlotte, Jo or Holly for more information:
Hnf-tr.involvement.network@nhs.net

www.yorkshireandhumberinvolvementnetwork.nhs.uk

West Yorkshire and Harrogate Health and Care Partnership

Cygnet Health Care

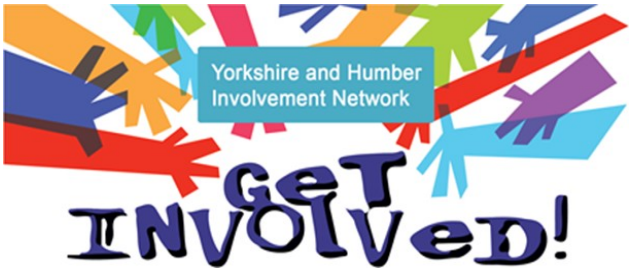
NHS South West Yorkshire Partnership NHS Foundation Trust

inmind HEALTHCARE GROUP

Newton Lodge
Bretton Centre
Newhaven
Cygnet Bierley
Moorlands View
Waterloo Manor
Newsam Centre
& All guests

NHS Leeds and York Partnership NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust



WY PROVIDER COLLABORATIVE COMMISSIONING HUB

Updates from October – November 2022

- We have implemented a new lead case manager model

- Over the last three months we have significantly increased the frequency of face-to-face 6-8 week reviews with service users

- We have started to make better links with advocacy services to ensure this intelligence is used to inform our commissioning activity

- We have strengthened our position within the WY ICB system

- We have started to develop a process for collecting family and carer feedback within the Annual Quality Review process

- We have launched a Deep Dive component to the quarterly contract review meetings with providers

Priorities for improvement in December 2022

- On 22/12/22 we will review our Quality Review process to ensure it is effective, efficient and meets the needs of services users and staff

- We are finalising our Quality Assurance Framework

- Our new out of area service user 6-8 week case manager review process will be submitted to Board for review and sign-off

Commissioning Hub Update

In October, we implemented a new model of case management, a lead case manager model.
What used to happen was a case manager would have service users in lots of different hospitals at once. That made it really difficult for case managers to work closely with the clinical teams on the wards or to see service users on a regular basis because it was traveling all around West Yorkshire.

In COVID case manager's started to rely on remote working and 'virtual visits' too.

The new lead case manager model is where one case manager would work very close with one or two services. This would help them to see service users more regularly, to spend more time on the ward and to have more consistency with those clinical teams around communication and developing relationships.

We set an ambition for ourselves that we will do better at this, we'll see more people face to face and we'll see people more often.
There has been positive initial feedback and we've seen a significant increase in the six-to-eight-week reviews completed.

The case managers and Quality Team also have Quality Reviews with each service every year, we look broadly at everything quality related, look for areas of good practice, areas of potential improvement, listen to service users and staff about their experience and then work with the providers to kind of develop an action plan to improve.

Advocacy was a real gap in that process. We have mapped out who our advocate services are, who are advocates are, and we're going to use them within that quality review process as an extra kind of layer of information around themes to do with quality.

Our goal is to regularly and routinely share and receive information with advocacy services because they pick a lot from speaking with service users and they support very good work.

Our vision is to involve families and carers within our quality review process too, something that traditionally wasn't done by NHS England before the introduction of provider collaboratives and something we've not done yet. It's something we need to refine. It is another really another valuable perspective on service users experiences of being in hospital.

We've launched a deep dive component to our contract monitoring with providers; that's at the quarterly contract review meetings where we review quality and performance. We're now ask providers to give us a bit of a deep dive, a closer look at some of the good work happening or areas of challenge.

We have plans to Improve the quality reviews and also make it easier for providers to facilitate our annual review process.

Over the last year since go live! we've been developing our individual components of how we quality assure and monitor quality; we now want to formalize that and pull it all into one overarching framework. So, we're currently in the process of writing that.

Some of the learning from Edenfield and Panorama was about how we monitor the quality of care and the pathways of our out of area service users, this can be a challenge along with maintaining close contact due to distance. This is a priority we are working on.

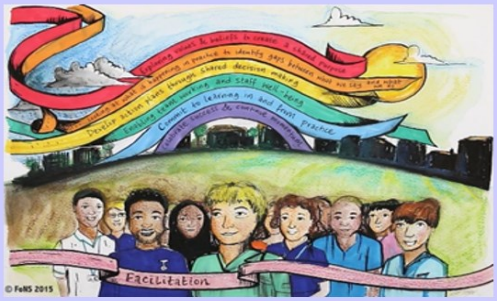
HELLO MY NAME IS Amanda Barker

I am currently working as Project Lead for the Provider Collaborative leading the Community Workstream.

I'll be talking to lots of staff and Service Users about secure care community services and how we can enhance them.

I enjoy spending time with family and friends. When I have time to myself I like to read.

I am also a Foundation of Nursing Studies Fellow and am passionate about Creating Caring Cultures and supporting the FoNS work. I will be using this collaborative approach whilst working with everyone on the Community Workstream.
Tools And Resources (fons.org)



WHAT DO WE WANT OUR SECURE COMMUNITY SERVICES TO LOOK LIKE?

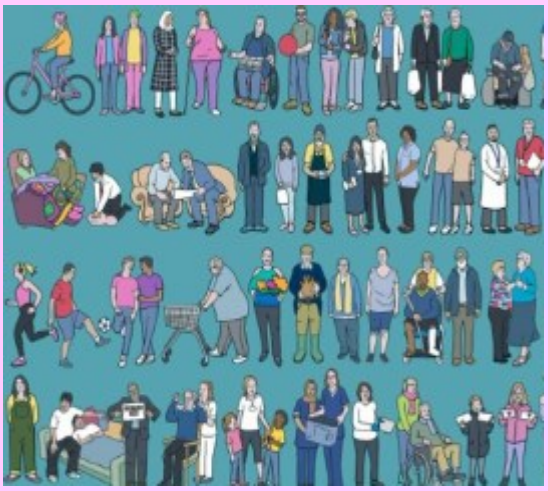
Providers with a Community Team currently:

West Yorkshire Provider Collaborative Forensic Community Services

Bradford District Care NHS Foundation Trust

South-West Yorkshire Partnership Foundation Trust

Leeds and York Partnership Foundation Trust



Leeds is trying to do some in reach into the inpatient wards but do have quite large caseloads of people in the community and mainly work in the Community.

The team in based in Wakefield, at the Bretton Centre, who are the forensic community transition team (FCTT) at the moment cover service users from Calderdale and Kirklees, but not Wakefield. So that's a bit of an anomaly. They also do some in-reach into the wards as well but have a case load for people that have moved out into the community.

Bradford is actually an inpatient service. So, the transition team in Bradford mainly work with people that are still in hospital but what they do is they facilitate and support people through the transition points- From war to ward, and then the transition through discharge from hospital into the community. They had been doing some community support as well, really through goodwill rather than what they're commissioned to do, but they've had to pull back on that a little bit just because the demands of the impatient work.

So, depending on where you live, you get a very different service. What we need to do as part of this work is try and look at how we make sure that all service users are getting the same or a similar offer really and they're not getting something different than someone that lives in the next city.

I am working with all providers, staff and service users and am on my way round to visit and ask the following questions to support future community provision:

Who do we want in our community teams?

At the moment, the team in Wakefield have got a bit more of a mix of staff in their team, so they've got different professionals. But in Bradford and Leeds it's mainly nurses.
Who do we need in those teams to make them successful and to be able to support people in the best way that we can?

What do we want the for the forensic community teams to do?

This is a big focus of the work to do.
What interventions would we like to see in the Community teams and what support would be really beneficial to service users when they're moving from a hospital site to the community.

Question 1:

What does preparing for discharge feel like? What support is needed?

It can feel scary, some of the girls that are with me have been like let down. It can feel quite scary that there might be let down again. But it can also feel exciting.

It's important to be able to visit placements to know where you're actually going to. And to have overnight visits too.

Clear communication between teams and between you as well. You want to be informed of what's happening. It's your discharge, it's your next steps.

A discharge plan.

Having a structured day. Knowing what's available once you're discharged, you know you don't just want to be kind of left to your own devices and fall back into hospital.

Direct and reliable contacts- there are times when people have needed to speak to someone, and they get responses like 'we're busy at minute. Can you ring this number up?' 'You should have rung the day team we're the night team.' Not an actual identified person that can help in a time of crisis.

The discharge process is very scary and very awkward as well, but the support I've got from the SCFT team has been very strong. It was smooth process for me because they're supported me with my overnights, with cleaning my flat up and everything. I think if you have the right support and the right team and pretty much everyone is on the same page the doctors, the nurses, it can be a real smooth process.

The support that's needed is to prepare the person not to come back to hospital at all. To support them to take medications and support them with their problems like family, drugs, alcohol. Loneliness can be a big problem when you have a mental health issue, you might lose friends, family.

Practical support of getting linked in with places and people and groups and activities in the community seems to be a common theme and starting that before discharge so people are familiar with what's out there and what they can be engaged in once discharged.

To know that somebody has time to spend with you to go out into the community and find things of interest to you and what you need to know.

Consistency is important.

Having access to people when you when you need them.

Finding things to do within the community whilst the support is there- It's hard to find activities for those with forensic background. It can be difficult to volunteer or get a job because of histories, and to manage expectations of this and let people know it can take time to find something or you may face more discrimination. Support is needed and taking time with the person is also needed as well.

Feelings you might have at discharge could be like anxiety, a fluctuation in your nerves and positive attitude, excitement, readiness. Worry about alone time and having to sort things out on your own.

Some of the things you need to think about pre discharge is positive behaviour, taking your medication, staying settled. Work with teams by doing your therapy. Eat. Drink and take care of yourself. Make sure you've got positive influences in your life. Go out on leave and shop.

People said about feeling lonely and not knowing again what's going on with your community team or what's going on with your support. And I just think that both Inpatient transition and community have got different kind needs for communication, but they're all really important.
Having some kind of communication strategy at each stage so that everybody knows what to expect and they're not left wondering.

Opportunity for Peer Support is something that has been discussed already with the teams too. The SCFT have got a peer support worker and they speak really highly of that role and how valued it is by the service users that they work with.

Often hear stories about people's frustrations and experiences are of waiting long times for discharge. And the lack of community mental health service is to support the discharge process in terms of getting involved and at the right time. Is there an option that the inpatient services created roles to support transition, not just community team reliant then?

All options are sort of on the table at the moment, but we would like to see Community services are enhanced. And have the right work for sure, right? People in the and the right and a clinical model that would be able to support discharge effectively.

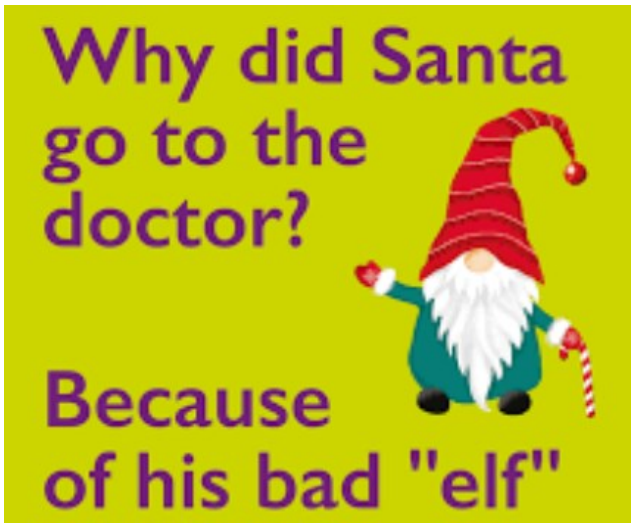
If/when we get further down the line, it's not working it we probably will need to think innovatively won't we? What is what can we do other than this to try and improve things.

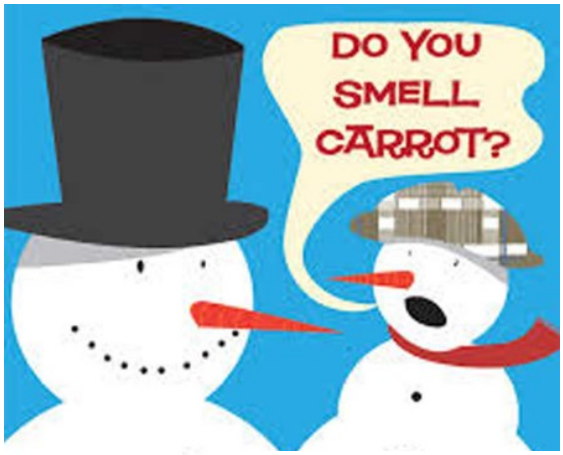
Recruitment is always going to be one of the challenges. We are keen to really think about who we want in these teams, you know be creative with that and really think about what is it that we want to offer and who can offer it rather than just thinking traditionally about more nurses or social workers, which of course we need, but who else could be in those teams that would support us?

I think the point around specialist knowledge around how to manage offence related issues and having more consistent relationships. I've seen 'flow teams' work okay, Some of the barrier is also in social care and mental health funding being separate which makes it hard for some of the gents to move on. It needs specialist knowledge from what I've observed

One of the biggest challenges in planning discharge we see in Leeds is the lack of suitable accommodation.

It would be amazing for consistency if service users were allowed to go to their own funding panels. I've had so many workers and care co-ordinators raise this





Why is it always cold at Christmas? Because it's in Decembrrrrrr

What Key is needed for a nativity?...
A Don-Key

Question 2:

What discharge plan and community support is needed?

33yr old male
Bi-polar disorder with episodes of psychosis
Has been in medium secure and then low secure care for the last 8 years
Not much family contact but does see dad
Was independent before admission to hospital but had more family support then and a CPN
Had casual work at a Car Valet station
Anxious about discharge

I would want to assess him myself, not just go on written report and visit regularly to check in.
Has he got the right medication and taking them?
Does he have support in place?
Is the housing right?
Right dietary needs?

Self-care and living skills? Cooking and cleaning.
House in order?
Does he need help in making an appointment?
The right coping skills?
Family support? Good relationships?

As an OT I would want to know what skills this person has already and see if we can help him to learn the skills that he needs and before he's discharged, so like things like paying bills and cooking.

Education around diagnosis.

Family therapy to help build relationships and have a network.

Living skills should be monitored, support a daily routine especially cooking and self-care, budgeting and shopping.

Explore why this person is anxious. Explain that it's ok to be anxious.

Support to continue his job. As it will build confidence.

Regular visits and contact. At least once a week.

Psychological therapy support.

Crisis support. Might need a bit more than the community team can offer.

How about using technology more innovatively to provide opportunities for extra support - like video calls and text messages to check in more regularly between visits. There's also what about crisis support if needed when first being discharged when feeling extra anxious if it leads to spiraling mental health distress. How would he access this...

everyone has there own expectations of life... what that person needs is to gather momentum and get back on board with something fulfilling

work with the person as a first point as no one size would fits all. Graded exposure (aka doing things step by step in a way that feels manageable to the person). See if they want to joint plan with family. They were independent before with more social support. do they want/need to reconnect with the community and social support but this hopefully should have already been happening on leaves. connection with work services. depends where you are on what's available. ideally there'd be some peer support or someone who's experienced it and made it. What time scales does he want? where does he want to be?

I was pondering a more bespoke plan of action for said discharged patient lets say for instance i was talking to someone earlier and they doubted they'll ever come off drugs i said to them that they need to replace it with maybe boxing training

Ideally its a balance of getting done what needs to be done and what someone wants to do- so ideally they get to spend most of their energy on doing what they want to do and maybe supported on what needs to be done. (If its needed)

it's important we have staff with time to provide alternative support and think about individual needs and creative ways of offering community activities and therapy

also that discharge plan should start from day dot! shouldn't be that discharge plan just starts- should always be happening

An Exciting New Role has been created in West Yorkshire by the Provider Collaborative, supported by the Yorkshire & Humber Involvement Team, as a 12 month pilot to work with and enhance the voice of family, friends and carers, this is thanks to your feedback through the SeQuln Tool. Here is some information:

Carer Experience & Engagement Coordinator

The Role will:

- Ensure the Carer Voice is heard
- Work with West Yorkshire services on Carer recommendations and standards
- Work across services to think what good looks like or feels like for Carers
- In-reach to support services on outcomes that relate to Carers
- Share Good Practice
- Strengthen relationships with Carers and offer opportunities for Carers to network across West Yorkshire

What questions should we ask at interview?

At our last event you asked us some questions during the 321 presentations, we have collected in some answers as follows:

321 Questions answered?

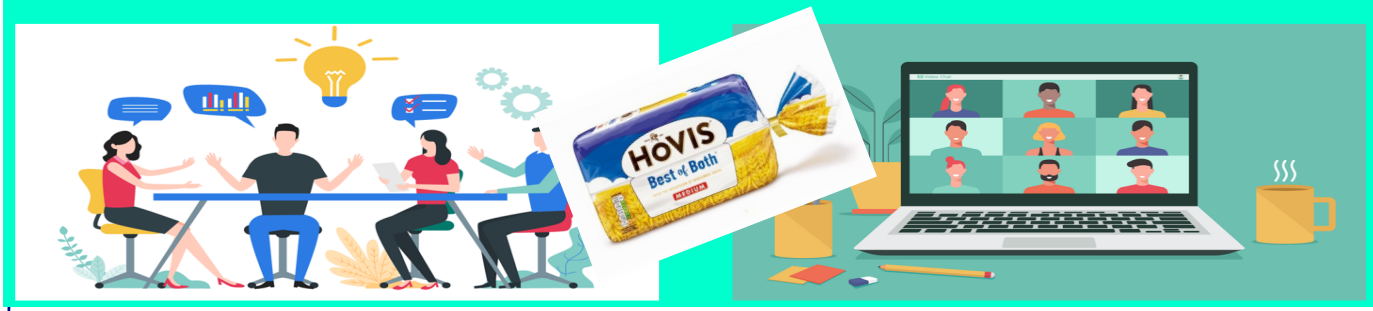
- **What Recovery College Courses on offer?**
  - NHS Humber Recovery and Wellbeing College (humberrecoverycollege.nhs.uk)
  - Leeds and York Partnership NHS Foundation Trust -About the Leeds Recovery College (leedsandyorkpft.nhs.uk)
  - What can we help you with today? - Wakefield Recovery and Wellbeing College (wakefieldrecoverycollege.nhs.uk)

- **Is there any information about the PC that is easy to understand? Branding is the first step in this process- ideas put forward at these events previously have been shared (Yorkshire rose, Rhubarb Triangle, Hands) and samples will come round for comment.**
- **When can we meet up again? March/April**

It has been a while since we have been able to meet in person as a West Yorkshire group due to keeping everyone safe during covid and as part of guidance and restrictions... We asked the question, on your behalf, to the West Yorkshire Provider Collaborative Clinical and Operational group (this is a meeting where every service is represented by managers) and the response was to let winter pass and plan for spring! So that is what we will do...

We will be organising a task and finish group in March in person and still offer a virtual meeting around the same time too—Best of both!

Next Meeting?



If you would like to answer any of the questions below or in this newsletter please send them to the Network email below, contact us through our website Yorkshire And Humber Involvement Network – Welcome or ask a member of staff to email us your responses! We can also pass on queries to the West Yorkshire Provider Collaborative too.

Yorkshire and Humber Involvement Network

GET INVOLVED!

Feedback December 2022

West Yorkshire Health and Care Partnership

What has gone well today and why?

What could have gone better and why?

What does preparing for discharge look like?

What support is needed for discharge?

Have you enjoyed it today and will you come again?

Contact Holly, Jo or Charlotte for more information
hnf-tr.involvement.network@nhs.net

www.yorkshireandhumberinvolvementnetwork.nhs.uk

Collaboration. Hope. Encouragement. Empowerment. Respect. Support. Fun