Transforming Care event for providers	
14.11.2016	
1	❖ **Present**
	NHSE, Providers, London ADASS, Commissioners
2	❖ **Feedback from 4 groups** *The groups were asked to consider the following:* • Could you provide a service for the case studies presented? • Barriers/opportunities for you as a provider to meet the needs of this group • Who needs to do what differently to make it work?
	<u>Case Study Feedback</u> ❖ Providers unanimously agreed that there is scope for service provision despite any complexity the individuals may present with. ❖ Highlighted the necessity for a good PBS plan developed in partnership. The presence of milestones and other assessments (environments, adaptations etc.) are also key. Environment to enhance sense of pride / achievement for the individual can positively impact the longevity of community placement. ❖ Design of care to be person centred and for provider staff to be thoroughly accustomed to the service user to organise a better transitional process where required. ❖ CCG/Commissioners to have transparent conversations with providers and vice versa. ❖ Providers to provide safe and robust service which is both economic and adhering to the transforming care agenda. ❖ Developing a cultural shift necessary in order to share responsibility for individuals. ❖ All concerned parties to genuinely involve family in care and planning of it. ❖ Effective and practical contingency plans to be in place as part of protocol. ❖ Emphasised the role of continuity and the benefits of a well-balanced team. ❖ Communication and building trusting relationships also plays a key role towards not losing sight of outcome. ❖ Landlord/ type of tenancy can impact on the security of placement.

Barriers

- Challenges around partnership working within multiple agencies.
- Time constraints when new speciality teams are assigned to support individuals with an unrealistic timeframe.
- Commissioner's challenges around time management around "getting to know the patient".
- Inconsistent care management / care co-ordination.
- Extensive list of providers given as choice – resulting in less specialist's service provision.
- Housing / Housing benefits / service design model/ inaccessibility due to costs and lack of funding.
- Care staff crisis/ competency and values to be refreshed and assessed.

What can be done?

- Workforce to have staff with the most appropriate skill set; responsive when presented with issues by the specific client group
- Clear escalation processes and crisis management strategies in place.
- Implementation of a preferred provider framework specifically for transforming care? This already happens in Surrey
- Preferable for providers to have 12-18 months run in if developing a new service for this group
- TCP grouped forums to achieve programmed support on commissioning, funding and escalation to overcome barriers.
- Clinical input to be lined up with community provision before transitioning into a community setting.
- Flexible staffing (2:1/3:1 etc.) according to needs and requirements of the individual.
- Not creating a 'hospital' from 'hospital'; needs of people in community settings should settle with time, use of assistive technology, savings from this should be passed to the commissioner
- Investments to be made for this to be actioned in a timely manner.
- Investment for this client group in community settings. Access and infrastructure to community professional teams.
- Shared expertise to aggregate specialism which can be generalised across the board.