National CAMHS Support Service

THE CHOICE AND PARTNERSHIP APPROACH

(CAPA)

IN A SPECIALIST COMMUNITY LEARNING DISABILITY CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

The Northumberland Child and Adolescent Learning Disabilities Team

Background to the Team

The Northumberland Child and Adolescent Learning Disability Team are a specialist community multi disciplinary service. We are part of the comprehensive specialist CAMH services in Northumberland provided by Northumberland Tyne and Wear Foundation NHS Foundation Trust.

The county of Northumberland has a population of approximately 310,000 (ONS 2007) and is a predominantly rural county with a more urban conurbation to the south and east. The county borders Scotland to the north, Cumbria to the west, North Tyneside and Newcastle to the south. The team work to four geographical locations across the county and provide a locality based outreach service currently operating out of 6 bases.

The multi-disciplinary mix of the team consists of

- Nursing
- Occupational therapy
- Psychiatry
- Psychology

The nurses are based in each of the 4 localities and are supported by a psychologist.

The psychiatrists and occupational therapist provide a service across the whole county, as does the Autism Spectrum Co-ordinator. The Community Support Worker primarily works in the west of the county but does have some capacity to work into all areas. There are 14.68 whole time equivalent staff in the team:

- 1.0 Team Co-ordinator (Nurse) – band 7
- 4.68 Community Nurses – band 6
- 2.0 Community Nurses – band 5
- 0.8 Community Support Worker – band 3
- 0.2 Autism Spectrum Disorder Co-ordinator – band 4
- 1.0 Consultant Psychologist – band 8c
- 1.5 Psychologists – band 7
- 1.0 Assistant Psychologist – band 5
- 0.5 Occupational Therapist – band 6
- 1.0 Consultant Child LD Psychiatrist.
- 1.0 Locum Psychiatrist - Staff Grade (At the time of writing this paper)

Administrative time within the team is provided by:

- 1.0 Medical Secretary – band 4
- 1.0 Admin Assistant – band 3
- 0.56 Nurse Secretary – band 3

The team are proactive and committed to raising all aspects of the quality of the service it delivers. Team away days are regular features throughout the work year to give the team dedicated time to plan and develop as well as to address issues and agree solutions.

The team are registered with the Quality Network for Multi-Agency CAMHS (QINMAC) and have achieved accredited status. The QINMAC LD standards describe the quality of service operations and processes and are based upon national standards from the National Service Frameworks, Every Child Matters Outcomes and Standards for Better Health.

Even though the service has achieved accredited status there is recognition that there are still improvements to be made with particular emphasis on improving the service user experience.

Eligibility Criteria

The key referrers to the team are special schools, paediatricians, disabled children's social work team, special school nurses and specialist CAMHS.

The service has explicit referral criteria. Referrers are requested to submit a referral on the service referral form and to supplement the referral with specific information which indicates that the young person does have a learning disability. The information requested by the service is as follows:

- National Curriculum Attainment Levels– need to be functioning at least 2 levels below expected level of achievement for chronological age
- The minutes of the last 2 reviews of the statement of special educational need
- Evidence of the levels of social and independent functioning
- Speech and Language therapy reports (if available)
- Any other medical/psychological/developmental history reports
- Copy of the CAF (to support assessment information)

Referrals are received at a central point where admin staff can process each one in line with the organisation's electronic patient information system (RIO). There is a weekly referral meeting where cases are allocated according to locality in the first instance and then clinician.

The demand for the service is measured by the amount of referrals accepted on an annual basis and this has remained fairly static for the last few years.

The team receive approximately 110 referrals per year and accept about 90 of those referrals. This equates to an uptake of 82%.

Whole time equivalent staff are running with caseload numbers of approximately 35-40.

This implies that cases are open for an average of 4 years (35 case load x 12 WTE = 420 cases at 100 per year = 4 + years) as a minimum. This is an estimated figure as it has been difficult to accurately measure the length of time a case is open due to inconsistency in Psychiatry over the last 3 years as a result of staff sickness and locum cover.

As the team operate an outreach model of service delivery there is a comprehensive Lone Worker Policy in place that requires two staff to undertake initial contact visits.

Current Referral and Allocation Process

When a referral is received into the team it is registered immediately onto the patient information system (RIO) by admin staff.

There is a weekly referral meeting involving representatives from Nursing, Psychology and Psychiatry to ensure that the eligibility criteria have been met via the service referral form and the supplementary information required.

If referrers do not send the required evidence of learning disability then the referral does not progress any further until that evidence is available. Referrers will be requested in writing to forward on the required evidence. However the team are aware that some referrers may not have ready access to specific evidence and will seek out that evidence ourselves e.g. G.P.'s are unlikely to have copies of National Curriculum Attainment Levels.

If all the referral information is not available the referral is 'discharged' from the RIO system, as an incomplete referral, until it is available.

Referrers are informed in writing and a copy of the letter is also sent to the family to let them know the status of the referral.

When all the required referral information is present the referral panel will look at the reason for referral and allocate the case. Cases are allocated based on the locality where the young person lives in the first instance. The reason for referral then indicates which team member working in that locality would appear to be the most appropriate and who has capacity.

Admin staff will register the case to the allocated clinician on the RIO system.

The referral information is then sent to the clinician for them to contact the young person and their family to arrange an initial contact appointment within the organisation's waiting time targets (18 weeks). Once the referral has been allocated the identified clinician would set the timescale for their first contact with the young person and their family.

The clinician will telephone the family to arrange a mutually convenient date, time and venue (as all work is outreach this is usually in the young person's home or school). The clinician will also need to organise for another staff member or the referrer to accompany them on the initial contact visit in line with the organisation's Lone Worker policy.

At the initial contact visit the clinician will talk to the young person and their family about the service and provide a copy of the service information booklet. They will discuss the reason for referral and ensure that the young person and their family are in agreement with the referral. If not then the clinician will discuss with them what they see as the priority for them and if necessary any other service that would be most appropriate to meet their needs. The clinicians would then signpost/refer the young person on.

If it is agreed that the service is appropriate and can meet their needs then the clinician will start the assessment process building on the information they have about the young person and their family from the referral information. The clinician will also start to look at risk factors to inform the risk assessment.

The clinician may also begin to provide initial intervention advice at this stage suggesting things to try, reading information and websites to access. The date, time and venue of the next appointment are arranged before the clinician leaves.

The clinician will undertake a care co-ordination assessment with the young person and their family using the referral information they have and through interview with the family. The assessment process is not intended to be a finite process and can be built upon during engagement with the family. However when the necessary information has been gathered in relation to the presenting issues then an agreed action plan and risk assessment are completed leading on to intervention.

If the clinician at any time during involvement with the family wanted to utilise the skills of another clinician within the team then they would have a discussion with that team member and follow this up with a written referral to the referral panel, creating an internal referral system. The referral would then be allocated via the panel to the clinician concerned. The rationale behind this is to enable each clinical lead within the different professions in the team to monitor referral capacity and also provided a way of monitoring requests for specific work. Skills were seen as quite separate within each profession.

The clinician will continue to work with the young person and their family implementing the agreed intervention reviewing progress every six months as a minimum.

Cases usually stay open to clinicians for long periods of time and discharging cases can be difficult as families are not keen to disengage from the service. The rate of discharge from the team does not match the rate of referrals and year on year this results in ever increasing caseload numbers for every clinician in the team.

Although there are few evidence based interventions recommended when working with young people with learning disabilities the team deliver a wide variety of intervention that are founded on practice based evidence. There is much diversity within the team in the delivery of interventions based around the skill, knowledge and experience of individual team members.

The current system is not efficient for both the service users and the service itself. Consequently there are a number of issues that the team need to address:

- Not accurately aware of the capacity of the team – mismatch in referral and discharge rates/high caseload numbers
- Delaying the take up of new referrals until the last week possible within wait times – up to 18 weeks
- Families not knowing when they will be seen until the clinician contacts them
- Families not having information about the service, advice about possible things to try whilst waiting for clinician involvement
- Internal waits for specific intervention/specific clinicians
- Ensuring that new referrals to the team are shared out equally among all team members
- Consistent service delivery throughout the team – clear referral, initial contact appointments, assessment and intervention pathways
- Having a strategy for managing capacity and demand - low discharge rates compared to referrals/ever increasing caseload numbers
- Providing meaningful data on capacity and activity to both management and commissioners
- Clear recognition of skills within team to provide a range of interventions at all levels
- Planning or preparing families for discharge from the service at an early stage

THE CHOICE AND PARTNERSHIP APPROACH

The Choice and Partnership Approach (CAPA) is a clinical system informed by Capacity and Demand Theory. It includes 7 Helpful Habits which support services to build capacity to meet referral demand. They are based on demand and capacity theory and integrated with clinical and theoretical experiences from a CAMHS perspective.

CAPA incorporates the Habits into the clinical system to give:

- a new approach to clinical skills and job planning
- methods for increasing service capacity
- active involvement of young people and their family

The benefits of following the 7 Helpful Habits and CAPA for services are:

- the reduction of waiting periods and DNAs
- the establishment of clear working goals with clients and their family
- the use of clinicians with the appropriate clinical skills

CAPA is focussed on the young person and their family. The stance is collaborative and provides choices. For the clinician there is a shift in position from an 'expert with power 'to a 'facilitator with expertise'.

The service still needs to apply eligibility criteria for access although the threshold of acceptance needs to be low if information in referral letters is lacking. The aim is to find out from the family whether CAMHS has anything to offer, rather than trying to guess this from the letter.

The model is based around **4 Big Ideas**:

1. Choice

When their referral is accepted, the young person and their family are given the opportunity to book an appointment at a time [and ideally a place to suit them]

The first contact is in a Choice appointment. The initial aims of the Choice appointment are to build therapeutic alliance.

During the Choice Appointment they may choose:

- That they can get back on track and do not need to return
- To be put in contact with a different agency more suited to help
- To return to CAMHS

The style of Choice is conversational, relaxed and not following a rigid semi-structured 'interview'. This is much easier when clinicians remain curious rather than trying to complete an 'assessment'. The clinician needs to be considering possible diagnoses and risks in their head as they go along. The skill is to 'park' these ideas and return to them as the Choice appointment progresses.

If the young person and their family decide to return they will be able to choose an appointment with a clinician in the service who has the right skills to help them. This will have been discussed with The Choice clinician before completion of the Choice appointment. The young person and their family will have reached a joint formulation with the choice worker as to roughly what is going on and have been helped to make an informed choice about the next step. This is called the **Choice point.**

2. Core & Specific Work

This is about separating out the clinical work into two streams of work Core & Specific (or Specialist)

Core

- Bulk of work, uses range of skills, involves liaison with the system & other psycho-social interventions.
- Shouldn't be seen as the least skilled area.
- Highly flexible & experienced clinicians.

Specific (or specialist)

- Using a particular assessment or therapy to complement core work
- Maybe of short duration
- Or more intensive
- Clinicians offering specific services may have done more training in this area

3. Selecting clinician for partnership

A key of CAPA is matching the young person and family's choice of goals to a clinician with the right extended core skills to help them with these. This means choosing a Core partnership clinician at the end of the choice appointment for the young person to work with in partnership. Selecting clinician ensures the person with the right skills will do the partnership work.

The traditional CAMHS model of service delivery means that there is a rather hit and miss process whereby the clinician that the family first sees is the one they continue with. This does not guarantee this clinician has the right skill set to facilitate the change process.

The Core Partnership Appointment
The next appointment will be the start of the Core Partnership work with one or more clinicians with a wide range of extended clinical skills. Most people will find this is enough to achieve their goals. For some, more specialist [specific] work may be added to the core work. The core partnership worker remains the key worker during the pathway.

Specific or Specialist Partnership Work
Specific partnership work is implemented when clinicians use a particular assessment or therapy skill in a pure way to complement core work. It may be of short duration e.g. psychometric testing, or longer term, more intense therapeutic work. A family accesses these specific skills by the Core Partnership worker asking someone to add in a specific assessment or therapy skill. It is an adjunct to the Core work.

4. Job Planning

Before CAPA can be implemented Job Planning must be done which includes defining the activities and capacity for individual staff and the team which is simple knowing what you can do within the resources you have. This then allows you to move around your capacity to meet demand.

The 11 Key Components of CAPA
There are also 11 key components and for CAPA to have the maximum impact it is important that key components are considered. Where possible these key components need to be implemented because evidence has shown that the more components in place, CAPA is more likely to be successful for both the service and young people and their families. The key components are:

1. Leadership
2. Language
3. Handle demand
4. Choice Framework
5. Full booking to partnership
6. Selecting Partnership clinician by skill
7. Extended clinical skills in Core Work
8. Goal setting & care planning
9. Job plans
10. Peer group supervision
11. Team away days

The following aspects of this paper focus upon how the Northumberland LD CAMH team set about incorporating all the components and principles of CAPA into practice.

PLANNING FOR THE IMPLEMENTATION OF CAPA

Using the 11 key components as a guide to the implementation of CAPA in the Northumberland LD CAMH service there was a need to ensure there was full commitment from everyone including senior management. The organisation and particularly the Director of Children's Services had already made the commitment to implement the CAPA model of service delivery across all the Tier 3 CAMH services.

The team were unsure how the key components of CAPA could be incorporated into a model of service delivery which is almost entirely out reach. The LD team had recognised that they were implementing some of the CAPA principles already but there was an urgent need to address the identified issues and to test out whether the 4 big ideas and all the key components could be applied to improve the efficacy of the service delivery.

Those key components that the team were already putting into practice included peer supervision which occurs at least on a monthly basis and team away days which happen up to 4 times per year. The team also felt that they were very near to the guidance around the language used with young people and families as well as the framework around the Choice appointment. However as identified above there were inconsistencies with this.

Therefore the team agreed to apply all the CAPA principles to practice and see if this would improve the service delivery for both the young people and their families and the team as a whole.

The first step was required a review of the existing caseloads by every clinician within the team. This was followed by job planning with all staff and the identification of the skills and competencies across the team.

Reviewing the Existing Caseload

Traditionally, in learning disability services, young people and families have remained for a number of years on staff caseloads and some right up until they needed to transfer into adult services. These young people would go through cycles of needing concentrated input by the team to having relatively little involvement at times. It was acknowledged by the staff that this cyclical pattern of activity often created more difficulties in terms of managing capacity in caseloads than anything else. The anticipation that the young persons' needs would escalate and require their involvement when dealing with several other complex cases created pressures in itself. On top of this was the need to undertake multi-agency, multi-disciplinary reviews on a regular basis with young people where there was little input. In addition staff acknowledged that they kept cases open because they found that families wanted the safety net of having the service available as they required. Also staff often stated that it was easier to keep the case open than having to undertake the paperwork needed to discharge a young person.

Whilst the demand for the service has been measured by the amount of referrals accepted on an annual basis and this has remained fairly static for the last few years there is a huge problem around the imbalance between referral and discharge rates. The team receive approximately 110 referrals per year and accept about 90 of those referrals. This equates to an uptake of 82% (with DNA rate running at around 3%) the discharge numbers were approximately 30 per annum. This has resulted in staff continually absorbing new cases onto ever increasing caseloads. Staff frequently stated that they were at capacity in terms of case load numbers which were up to 40 for whole time equivalent staff. Part time staff were often working at even higher capacity for the hours they were employed to do. Staff stated within clinical supervision sessions how stressed and overwhelmed they were feeling about workloads.

It has been difficult to accurately measure the length of time a case is open due to inconsistency in Psychiatry over the last 3 years as a result of staff sickness and inconsistent locum cover. However using the following calculation based upon caseload numbers, whole time equivalent staff within the team, the number of cases open to the whole team and the number of referrals per annum we have been able to estimate the average length of time a case is open for at 4+ years as a minimum (35 case load x 12 WTE = 420 cases at 100 per year = **4 + years).**

For a period of about 6 months, during individual supervision sessions, each member of staff undertook systematic reviews of the work they were undertaking with young people and families. They were asked to review with young people and families all care plans and ensure there were clear goals, agreed with the young person and family, about their involvement and the intervention they were providing, including a plan for discharge.

For those young people where the goals were less clear discussion was held with that young person and their family about discharge. However families were reassured that they could access the service again without the need to wait for lengthy periods of time. Staff also looked at support networks and services for families prior to discharge and as part of the discharge process were signposted and or referred into these services and networks.

The outcome of this work for the team resulted in a significant number of discharges from the staff caseloads reducing active case numbers down to 20-25 for whole time equivalent staff. Part time staff are also working with case numbers pro rata to whole time staffing.

Identifying Skills And Competencies across the Team

The second stage in the planning before being able to implement CAPA required the team to identify the work skills for every member of staff. The level of skill was also identified to allow for differentiation between core threshold skill and specialist skill level.

Staff were asked to identify what they felt were the key skills and knowledge needed by any member of the team to work with young people with learning disability. The Skills and Competencies table (Appendix 1) shows the outcome of that exercise within the Core Work column. The exercise has also been useful in that it has provided the team with an agreed list of training that any member of staff working in the team can expect that will be identified within Personal Development Plans.

Identifying the skill levels resulted in some team thinking. Some staff had extended knowledge, skill and experience in some areas and were keen to be able to practice at a higher level knowing that they would have dedicated time to do so.

All members of the team are expected to engage in group work with both young people and carers and parents. It was agreed within the team that there needed to be dedicated time for all staff to undertake group work and that such work requires specific skills around presenting, managing group dynamics and meeting individual needs within groups. In addition staff felt it important to have dedicated time to prepare for group work too. As such all group work is identified under specific partnership work.

Job Planning

Within the team job planning was already in place for both Psychology and Psychiatry but not for Nursing, Community Support Worker, the Autism Spectrum Link Worker or Occupational Therapy. Job planning across the whole team was essential to enable us to calculate individual clinician and whole team capacity.

The team undertake a variety of group work with both young people and parents and carers. Everyone acknowledged that group work is an essential part of intervention delivery and was very aware of the benefits to young people and their families. However they often found themselves struggling to commit to group work due to the need to prepare adequately and balance this with the demands for outreach work. Staff also felt that the more specialist skills they had were underutilised and they struggled to carve out time in their busy work schedules to put these skills into practice.

Staff were asked to identify their individual, typical work commitments over a month. This enabled us to identify regular team commitments as well as being aware of individual commitments within localities.

There is now a team job plan which is informed by each member of staff's individual job plan.

Nursing staff, in particular, are now able to acknowledge the benefit of having a job plan and how this has enabled them to build in dedicated time through specific partnership work to utilise skills which were previously dormant due to pressures of work. Staff are also more aware of the range of skills and expertise within the team.

Staff also have recognised training and CPD time as well as time to commit to the training of universal and targeted services as per the service specification.

Examples of job plans in Appendix 2.

PUTTING CAPA INTO PRACTICE

Having undertaken the key preparatory work the team were just about at the point of putting the CAPA system into practice. However it was necessary to calculate the number of CHOICE Appointments and CORE Partnership Appointments that the team could accommodate in relation to the capacity identified via the individual and team job plans.

In addition it was also necessary for the team to identify clear intervention pathways to follow on from the work undertaken to identify core threshold and specific partnership skills.

1. CHOICE APPOINTMENTS

How many CHOICE appointments do the team provide?

The average accepted number of referrals the team receives each year is approximately 90.

A CAPA year is set over a 10 month period (holidays taken into account).

There are 9 staff who are able to undertake CHOICE Appointments.

This means that each eligible member of the team, in theory, will take on 1 CHOICE Appointment per month.

The staff identify within their job plans 2 CHOICE Appointment times they are able to offer for a month and submit this to the administrator to enable a team CHOICE diary to be accessed. This is because 2 people do Choice Appointments together to meet lone working safeguards.

Staff are asked to submit 2 CHOICE Appointment times to enable a variety of dates and times to be offered to young people and their families.

However staff will only be required to fulfil one of these appointments and this is managed by the team administrator.

There is a need for 9 slots with 2 people in each to accommodate for lone working requirements.

The CHOICE Appointment

When a referral is accepted the first consideration is given to the geographical location where the young person lives. This determines who the team members are working within that locality and can offer CHOICE Appointments.

Consideration is also given to the referrer's reason for referral as if the referral is clearly linked to medication issues then a CHOICE Appointment with the Psychiatrist would be the preferred route. However all band 6 and above staff within the team undertake CHOICE Appointments with young people and their families.

All team members who undertake CHOICE Appointments submit their availability to the team administrator offering 2 CHOICE Appointment slots in their locality each month. The team administrator contacts families by phone to offer them the opportunity to book into the available slots. This is followed up in writing to families, referrer and other involved parties.

Two members of the team undertake the CHOICE Appointment ensuring compliance with the Lone Worker Policy for an outreach service (second member of staff usually below band 6 or the referrer).

The CHOICE Appointment focuses upon the following:

1. Discussion about the reason for referral to gain family and young person's (if appropriate) views

2. Elicit family and young person's expectations of the service

3. Discussion about whether the service is able to meet the family and young person's expectations

4. Discussion about possible signposting to other services if appropriate

5. If service input is required the service information booklet is provided

6. Discussion about the most appropriate team member to meet the needs of the family and young person (within the limitations of the service geographical area).

7. Identify what the family and young person want to work on, how they want to do this, and how things will look when they reach their goals

8. Suggestions (behaviour management) to try at home/school/other environment are provided during initial contact appointments and risk elements including any safeguarding issues are taken into consideration

9. Provide written information about issues and solutions in relation to learning disabilities and mental health, as well as other sources of help such as other agencies and websites.

10. Begin assessment including risk factors.

Young people and their family can access up to 3 CHOICE appointments (Choice Plus) to ensure that all of the above has been addressed and agreed i.e. reach a Choice point.

2. CORE PARTNERSHIP ACTIVITY

Within CAPA the CORE PARTNERSHIP work capacity is calculated in relation to the average number of sessions each family access from the service. The team have not been able to accurately calculate the average number of sessions a young person accesses within the service. As such there is agreement within the team that if each team member is undertaking one CHOICE Appointment per month then they will also commit to one new CORE PARTNERSHIP Appointment per month.

Each member of the team submits 2 CORE PARTNERSHIP Appointments per month to the team administrator to allow young people and their families a wide variety of appointment times and dates.

Not all staff will fulfil their CORE PARTNERSHIP Appointment availability as there are additional staff below band 6 who can also provide these appointments.

The team administrator manages the allocation of appointments with each member of staff only required to undertake one of the appointments offered each month.

Booking of Core partnership appointments

At the end of the CHOICE Appointment the young person and their family are offered a CORE PARTNERSHIP Appointment with the appropriate clinician.

If it is agreed that the member of staff undertaking the CHOICE Appointment is the appropriate person to continue with CORE WORK then they will agree the next available date and time with the clinician who will notify the team administrator to record the appointment allocation.

All clinicians have access to the availability of CORE PARTNERSHIP Appointments. If it is found that the clinician undertaking the CHOICE Appointment(s) is not the most appropriate to meet the needs of the family then engagement with a clinician with particular skills to meet their needs can be accessed through the next available CORE PARTNERSHIP Appointment for that clinician working into that locality.

Staff have the opportunity to delay the agreement of the CORE PARTNERSHIP Appointment until they have had the opportunity to discuss the case with the proposed clinician if there are some uncertainties about the presentation of the case. However they must agree a time frame with the family to inform them of the CORE PARTNERSHIP Appointment.

3. CARE BUNDLES/INTERVENTIONS

The team have identified a number of intervention pathways (Appendix 3).

The intervention flowcharts are shared with families and young people helping to explain the intervention pathway process. They identify additional specialised assessments to be undertaken and the suggested intervention strategies to be implemented, and help young people and their families, together with the clinician, to set realistic goals from the outset.

These intervention pathways enable open and transparent care planning with all parties and ensure a consistent care approach is followed by all team members enabling equality of care and intervention.

Development of intervention pathways and particularly care bundles continues within the team. The focus is also upon developing care clusters for LD CAMH service provision.

IMPLEMENTING CAPA IN AN OUTREACH SERVICE – THE FINDINGS

The team implemented CAPA from the beginning of September 2010 and have been able to review the use of the approach at the beginning of December 2010.

The review of the CAPA system as a model of delivery in the service has shown up some difficulties for the team.

A fundamental issue for all team members is the geography of the county and the need to deliver a locally accessible service across both urban and very rural areas. Staff work into determined localities to develop sound multi–agency partnership working, mirroring how partner agencies deliver services across the county.

Delivering locality based services results with a limited number of staff working into each locality limits the skill mix.

Also impacting on the effective implementation of CAPA within an outreach service is the need to adhere to the lone working policy. Lone working requires 2 staff to attend the CHOICE Appointment and this demands that Band 5 and 3 staff (of which there are 4 in the team) have to match up CHOICE Appointment slots with staff who undertake CHOICE Appointments.

The spread of referrals is uneven across the 4 localities with higher demand in the more urban areas. The need to deliver cost effective and efficient services also supports the need for staff to work into localities i.e. it is not cost effective for staff based in the north of the county to drive 60 miles to undertake a CHOICE Appointment in the more urban areas to support the CAPA system.

Although there is a higher number of staff in the more urban area of the county the number of referrals received across this area is also high. Implementing a full CAPA system, particularly full booking to CHOICE Appointment, has resulted in longer waiting times than we originally had and a lack of flexibility around appointment dates and times for children, young people and their families. CHOICE Appointments are now being booked up more than 2 months in advance giving waiting times of almost 12 weeks where previously they had been responded to within 8 weeks. As referrals keep coming in staff fear that waiting times will increase even more.

The team are currently operating with 2 WTE staff down due to staff being on secondment, long term sick and maternity leave. There has been a significant impact on the availability of staff, particularly in the urban areas, to ensure that a fully operational CAPA system can be implemented.

The lack of flexibility in dates and times for families has occurred because staff are being asked to book out identified CHOICE Appointment slots in their diaries. The majority of these slots were not at convenient dates and times for families resulting in admin having to ring around all staff to ask about changes to diaries to accommodate families' needs.

The work undertaken by the team to identify care pathways has been extremely beneficial to the whole team and has provided consistency in terms of delivery of interventions. The team are more confident in discussions with young people and their families about the care pathway and the expectations for all parties involved in the intervention.

THE CONCLUSION AND SOLUTIONS – THE SYSTEM NOW!

Discussions with the authors from the outset suggested that the there were significant elements of our operational systems that were already following the principles of the Choice and Partnership Approach. However we acknowledged that there were also elements that could be changed and improved on.

The CAPA system can be applied to most services but we have found the need to adapt the system to meet the needs of delivering an outreach service within the geography of the county. We were able to identify the aspects of CAPA that help us to improve the delivery of our service.

1. Continuing to Meet Demand and Capacity

Staff are agreed that they still need to commit to one CHOICE Appointment per month. Allocation of referrals will still be made on the basis of where a young person lives, in the first instance, and then allocated to any member of staff who works into that locality. This will be monitored at the weekly referral meetings to ensure that each member of staff shares the responsibility of taking on new referrals.

2. Booking CHOICE Appointments

The team agreed that we needed to follow the principles of a CHOICE appointment but that the allocation process needs to be revised. We agreed in principle that when a case was allocated that the clinician would contact the family and arrange a suitable appointment with them (just like we used to do). This enabled families to have the flexibility of dates and times to meet their needs and it fits better with clinician time.

3. The Initial Telephone Contact with Families

Families are often referred in to the service with little information or knowledge about who and what the service provides for. The team agreed that the service information booklet will be sent out with the CHOICE Appointment confirmation letter to enable families to familiarise themselves with the service provision prior to meeting staff. However, the team are conscious that information in a written format is not always appropriate for some carers and advice will be sought from referrers.

It was also agreed that verbal consent to seek and share information about the young person will be gained in the initial telephone contact with the family and/or young person. This can then be confirmed in writing at the CHOICE Appointment.

4. No Internal Waiting Lists

The use of CORE Partnership appointments has been a significant improvement to the service particularly for referrals within the service. CORE Partnership work is requested through initial discussion between colleagues and documented on Rio. Staff allocate CORE Partnership slots in their diaries to accommodate such requests. The demand and capacity issues that can occur for staff are monitored via clinical supervision.

5. Case Discussion

The team have a monthly slot in the diary for peer supervision where the focus is on case studies/management and the sharing of skills, knowledge and experiences. This also allows the team to discuss demand and capacity issues, CORE and SPECIFIC Partnership work.

6. Core Team Base

Whilst the team continue to work through the issues above one of the key problems for the service has been the fact that we are split across six sites throughout the county. Whilst the team need to retain bases in the north and west of the county as these are the more rural areas we have only recently secured a core team base in the more urban south and east area. Having a core team base allows for a more co-ordinated administrative system to operate.

There is now a core of staff across the disciplines based together and this facilitates improved communication. In addition having a number of staff in one place enables referrals to be considered on a daily basis in line with the eligibility criteria for emergency and urgent referrals.

Another benefit of this is that there is improved co-ordination of staff diaries particularly electronic diaries as all staff can now access the same electronic systems.

7. Use of Clinic Based Service Delivery

The team are aware that there are still potential issues with the principle of each eligible member of staff undertaking only one CHOICE and CORE Partnership appointment per month, as well as the added complication of 2 staff needing to undertake the CHOICE Appointment to conform to the Lone Working Policy.

Consideration has and will continue to be given to the possibility of setting up clinic based CHOICE Appointments which will at least eradicate the need to commit 2 staff to each CHOICE Appointment.

These ‘clinic based’ CHOICE Appointments would need to be arranged within the special schools or some other children’s service facility in the county.

Northumberland CALDT will continue to review and develop the efficiency and effectiveness of the service delivered. The team will implement and test out the changes above ensuring that the children, young people and their families receive the best quality service to meet their needs.

Julie Curtis

LD CAMHS Development Worker

NCSS North East

Team Co-ordinator

Northumberland Child and Adolescent Learning Disability Team

Shirley Green

Acting Team Co-ordinator/Community Nurse

Northumberland Child and Adolescent Learning Disability Team

Ann Jones

Regional Development Worker

NCSS North West

November 2010

Appendix 1 Skills & Competencies for Client Work

Core Partnership Work	Specific Partnership Work
Care Co-ordination Assessment	IABA Behaviour Management
Risk Assessment	Non Aversive Managing Challenging Behaviour – general/sleep/toilet (Group)
Safeguarding & Protection of Vulnerable Adults	Massage (Nurse - CC)
Non Aversive Management Challenging Behaviour – general/sleep/toilet (1:1)	Autism Assessment & Diagnosis (including ADOS)
Basic Sensory Assessment/Intervention	ADHD Clinics (Psychiatry and Nursing)
KBIT –	Play Therapy (Occupational Therapy)
LD Screener Questionnaire	Family Therapy (Psychology)
TEACCH Principles	Sensory Profiling & Intervention (Occupational therapy)
Social Stories	Neuro-psychological Assessment e.g. cognitive assessment (Psychology)
PECS	Psycho-therapeutic Approaches (Psychology)
About Me/My Books	Cognitive Behaviour Therapy
Solution Focussed Approach	Attachment
Cognitive Behaviour Approaches	Epilepsy (Psychiatry)
Attachment	Tourette's Syndrome
Personal, Sexual and Relationships Education (1:1)	Anger Management
ADHD Assessment	Physiological Assessment (Psychiatry)
Systemic Work	Personal, Sexual and Relationships Education - Group
Psycho-educational Work	Specific Risk Assessment (Psych)
	Complex Systemic Work

TEAM JOB PLAN

WEEK 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Discipline Meetings	Core Work	Core Partnership Appointment	Training/CPD	Specific Partnership/Group Work
PM	Team meeting/Referrals	Core Work	Core Work	Core Work	Admin
WEEK 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Choice Appointment	ASD Specific partnership work	Training/CPD	Core Work	Specific Partnership/Group Work
PM	Core Work Referrals		Core Work	Core Work	Admin
WEEK 3	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Core Work	Core Work	Supervision	Core Work	Specific Partnership/Group Work
PM	Multi-Agency Meetings Referrals	Core Partnership Appointment	Core Work	Training/CPD	Admin
WEEK 4	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Core Work	Core work	Choice Appointment	Core Work	Specific Partnership/Group Work
PM	Supervision Referrals	Core Work	Training/CPD	Admin	Consultation Tiers 1 and 2 Training for others

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AUTISM SPECTRUM DISORDER CO-ORDINATOR JOB PLAN

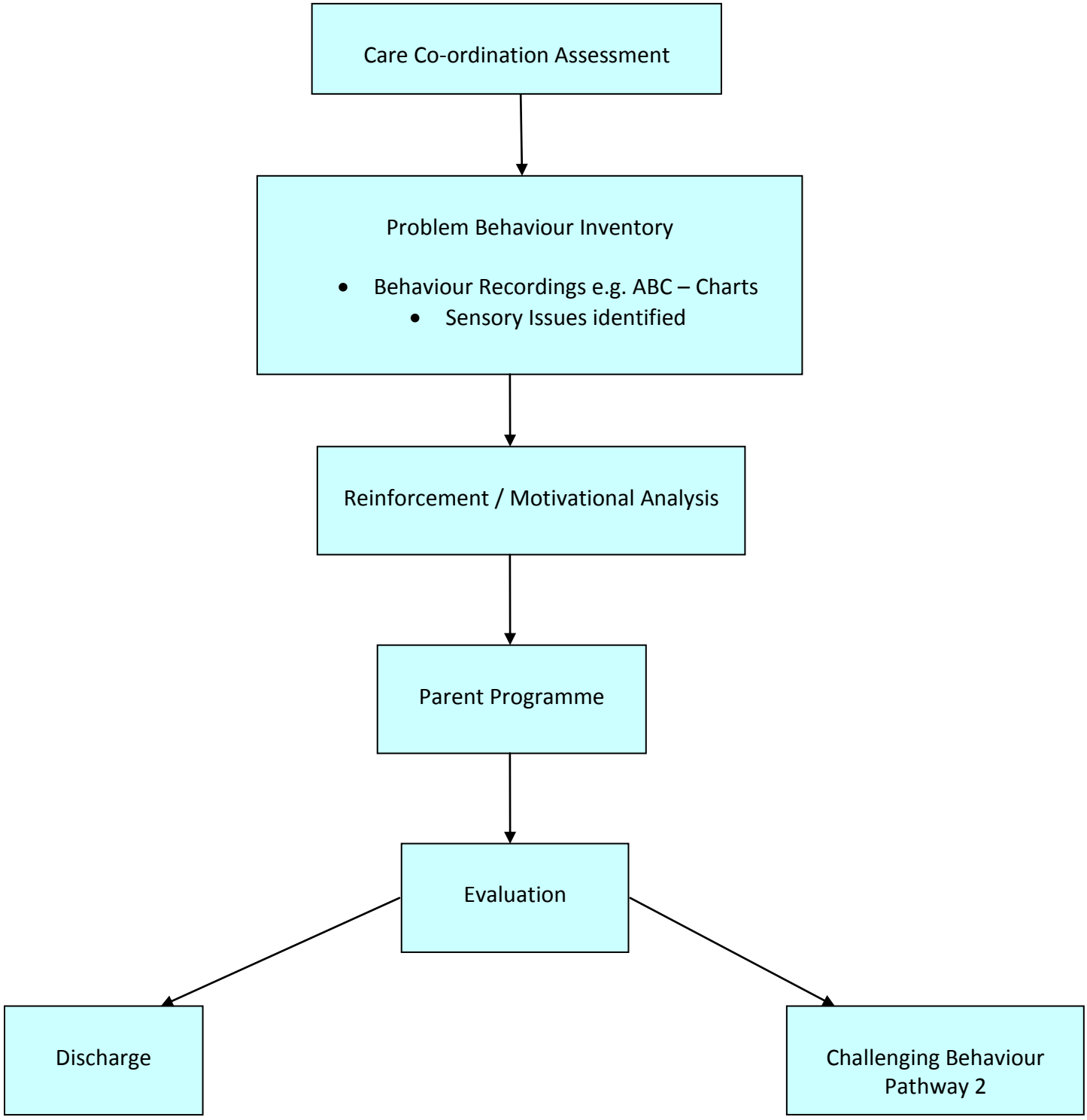
Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
AM	CALDT Nurse Meeting	CHAD Team Meeting	Core Work – Paediatricians / Linhope	Core Partnership Appointment - CALDT	Group Work
PM	CALD Team Meeting & Referral Feedback - CALDT	Core Work – CHAD Assessments	Specific Partnership Appointment – ADOS Assessment	Core Work - CAMHS	Admin.
Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Core Partnership Appointment - CAMHS	Core Work – CALDT	Core Work – Paediatricians / Linhope	Admin.	Group Work
PM	Admin.	Joint Rating	Specific Partnership Appointment – ADOS Assessment	Core Work - CAMHS	Admin.
Week 3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Referral Feedback CALDT	Core Work – CAMHS	Core Work – Paediatricians / Linhope	Core Partnership Appointment – CAMHS	Group Work
PM	Core Work – CAMHS	Core Work – CHAD Assessments	Core Partnership Appointment - CALDT	Core Work – CAMHS	Admin.
Week 4	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Training	Core Work – CAMHS	Core Work – Paediatricians / Linhope	Core Work – CAMHS ASD Clinic	Group Work
PM	Admin.	Core Work – CHAD Assessments	Specific Partnership Appointment – ADOS Assessment	Core Work – CAMHS	Admin.

PART TIME BAND 6 NURSE JOB PLAN

WEEK 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	Nurse meeting	Core work	Specific Partnership/Group work	Admin	
pm	Team Meeting/Referral feedback	Core Work	Multi-Agency Meeting/ Training and Consultation Tiers 1 and 2 Training/CPD		
WEEK 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	Choice Appointment	Core work	Specific Partnership/Group work	Admin	
pm	Core work	Core work	Core work		
WEEK 3	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	Core work	Core work	Specific partnership/Group work	Admin	
pm	Training/CPD	Core Work	Core work		
WEEK 4	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	Core Work	Core Partnership Appointment	Specific Partnership/Group work	Supervision	
pm	Training/CPD	Core work	Core work		

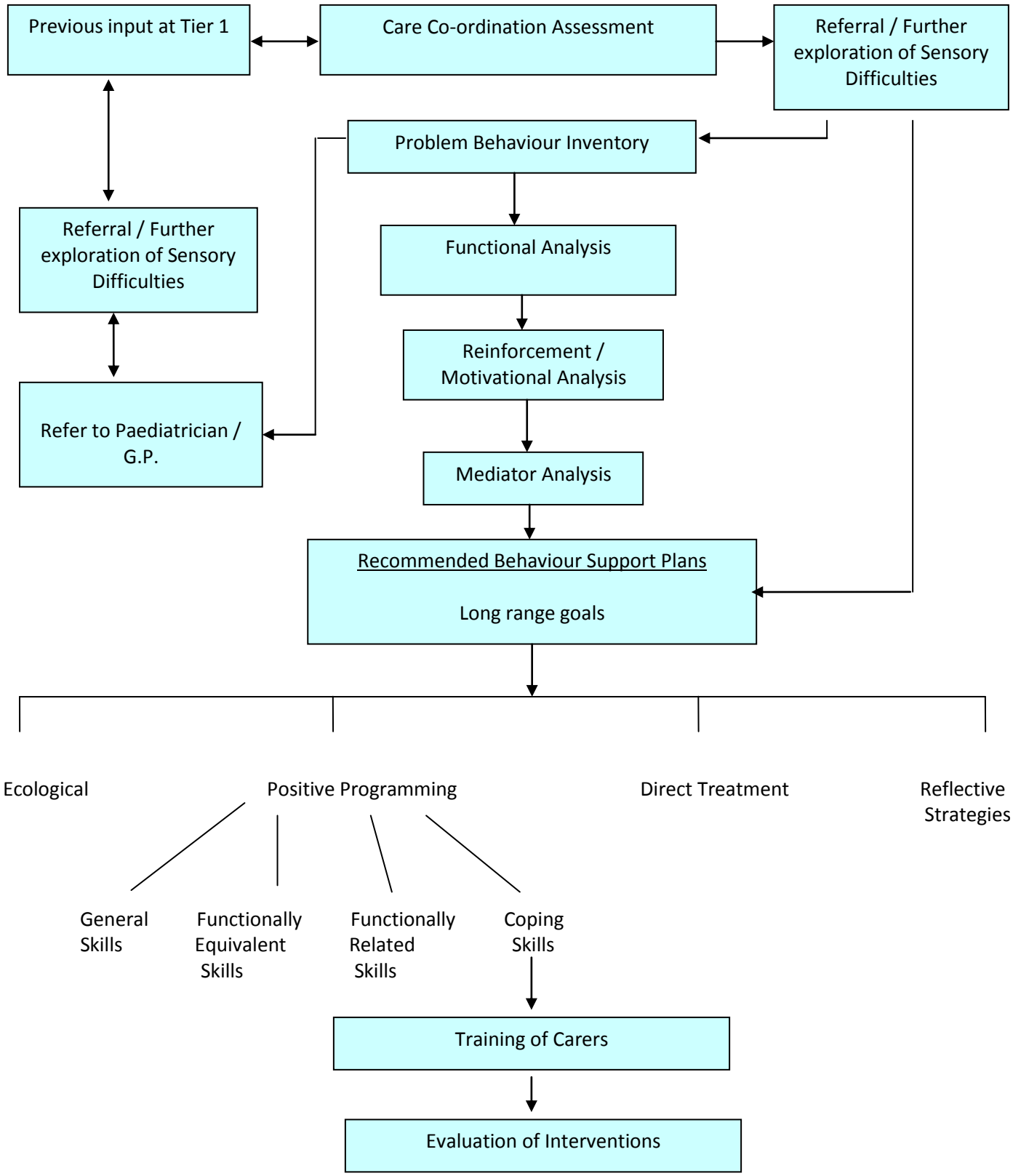
Appendix

Non Aversive Challenging Behaviour Pathway 1



Appendix

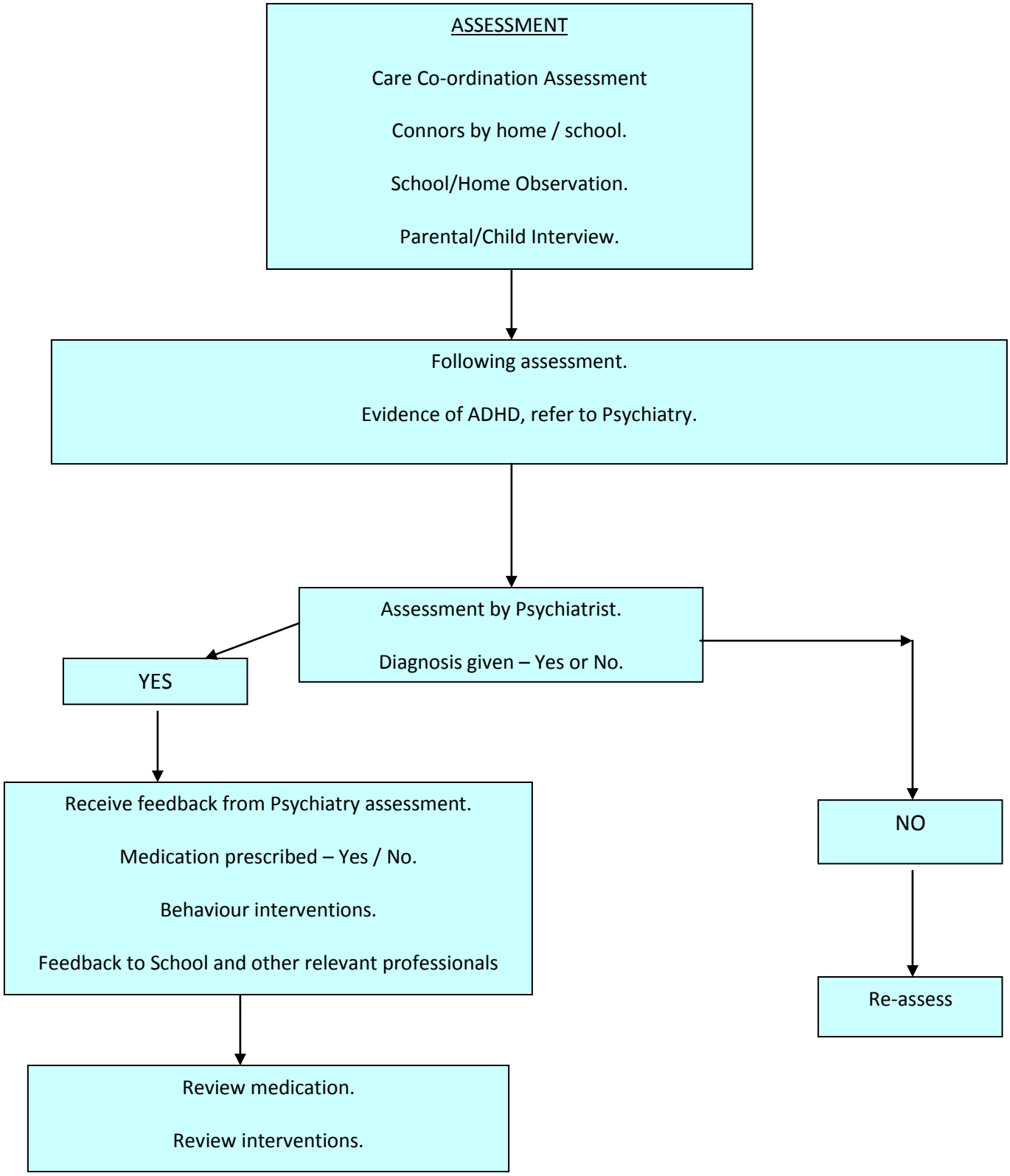
Non Aversive Challenging Behaviour Pathway 2



(Based on Willis & LaVigna model of Assessment and Analysis of Severe Challenging Behaviour)

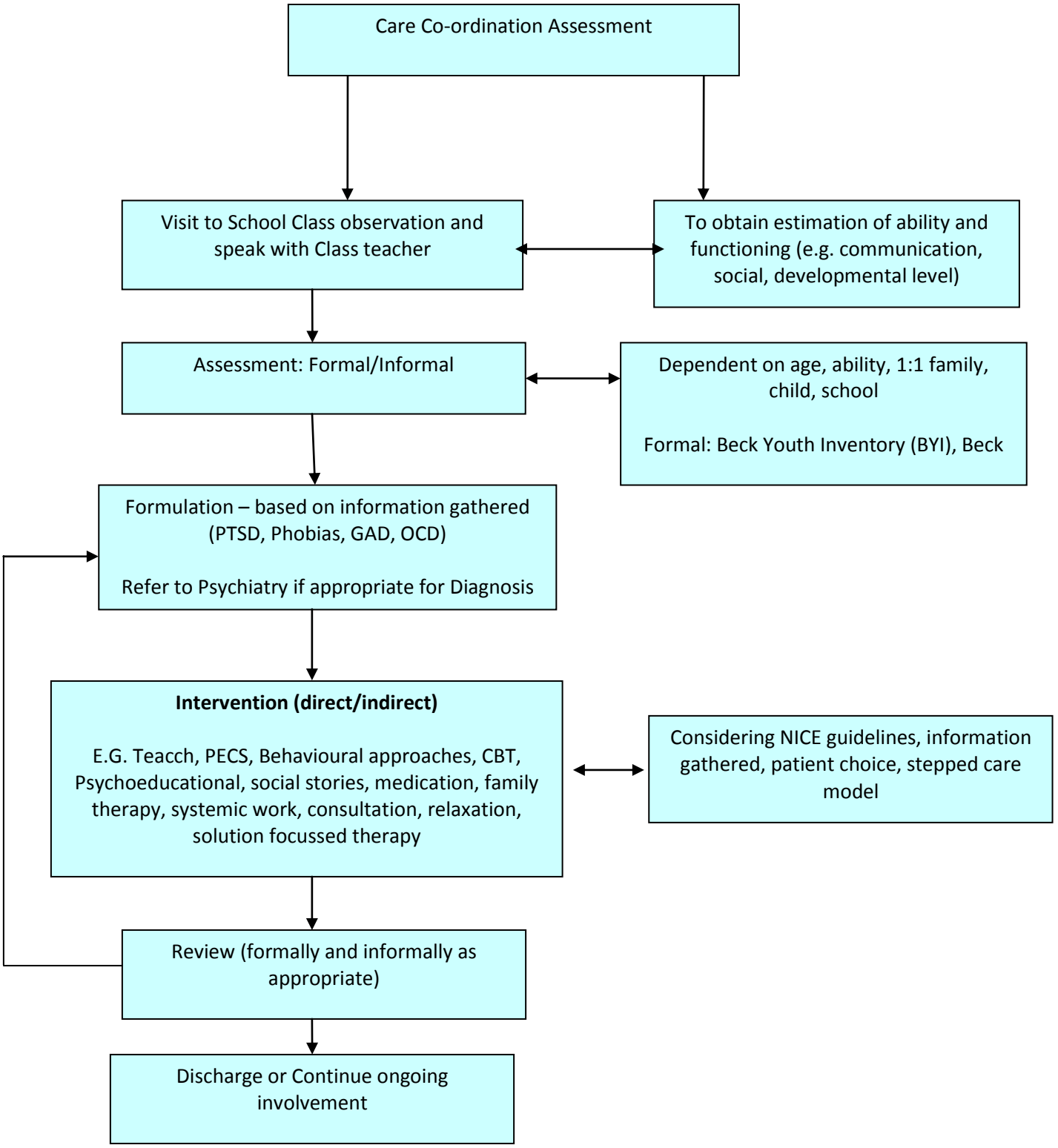
Appendix

Attention Deficit Hyperactivity Disorder Pathway



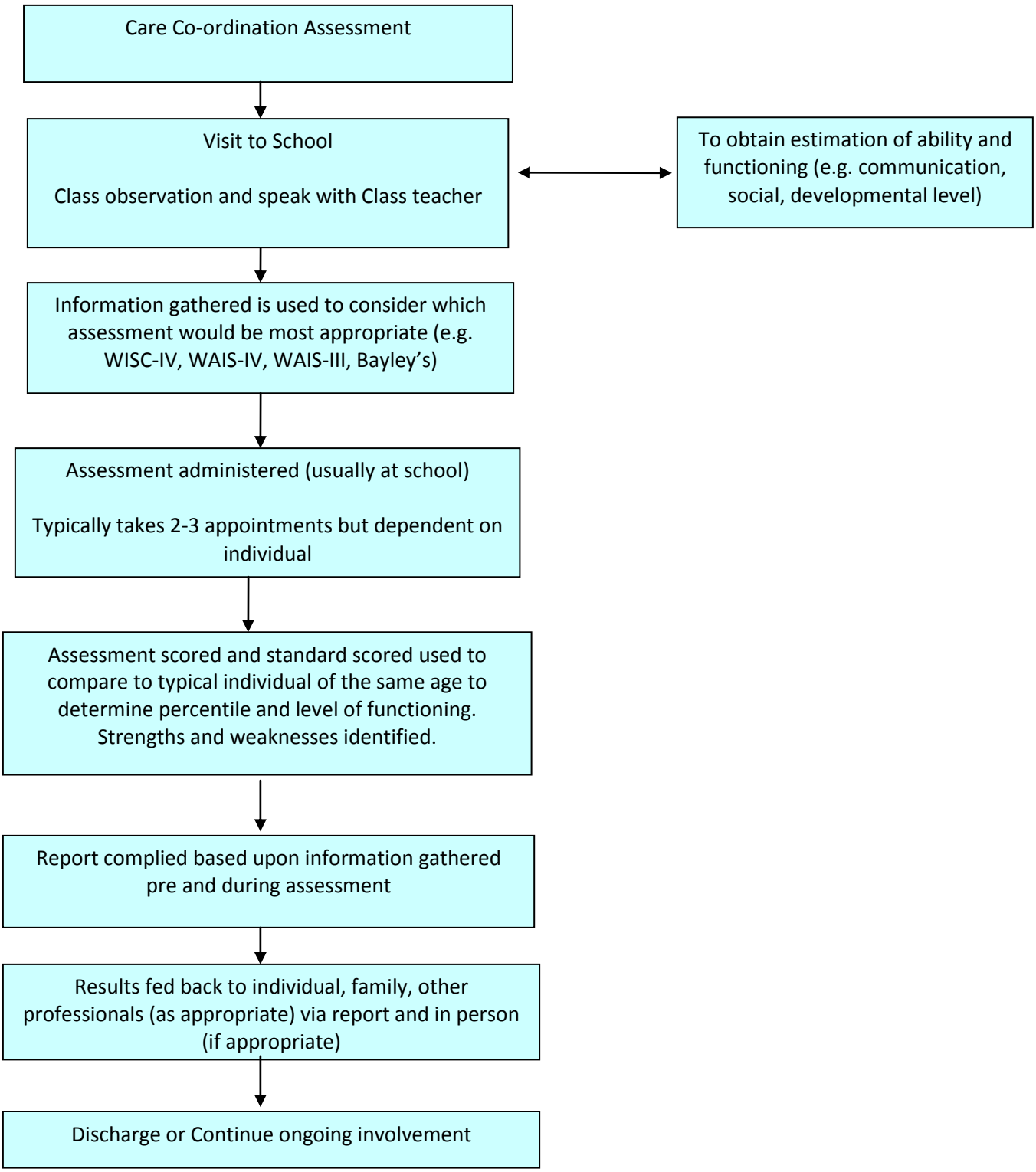
Appendix

Anxiety Pathway



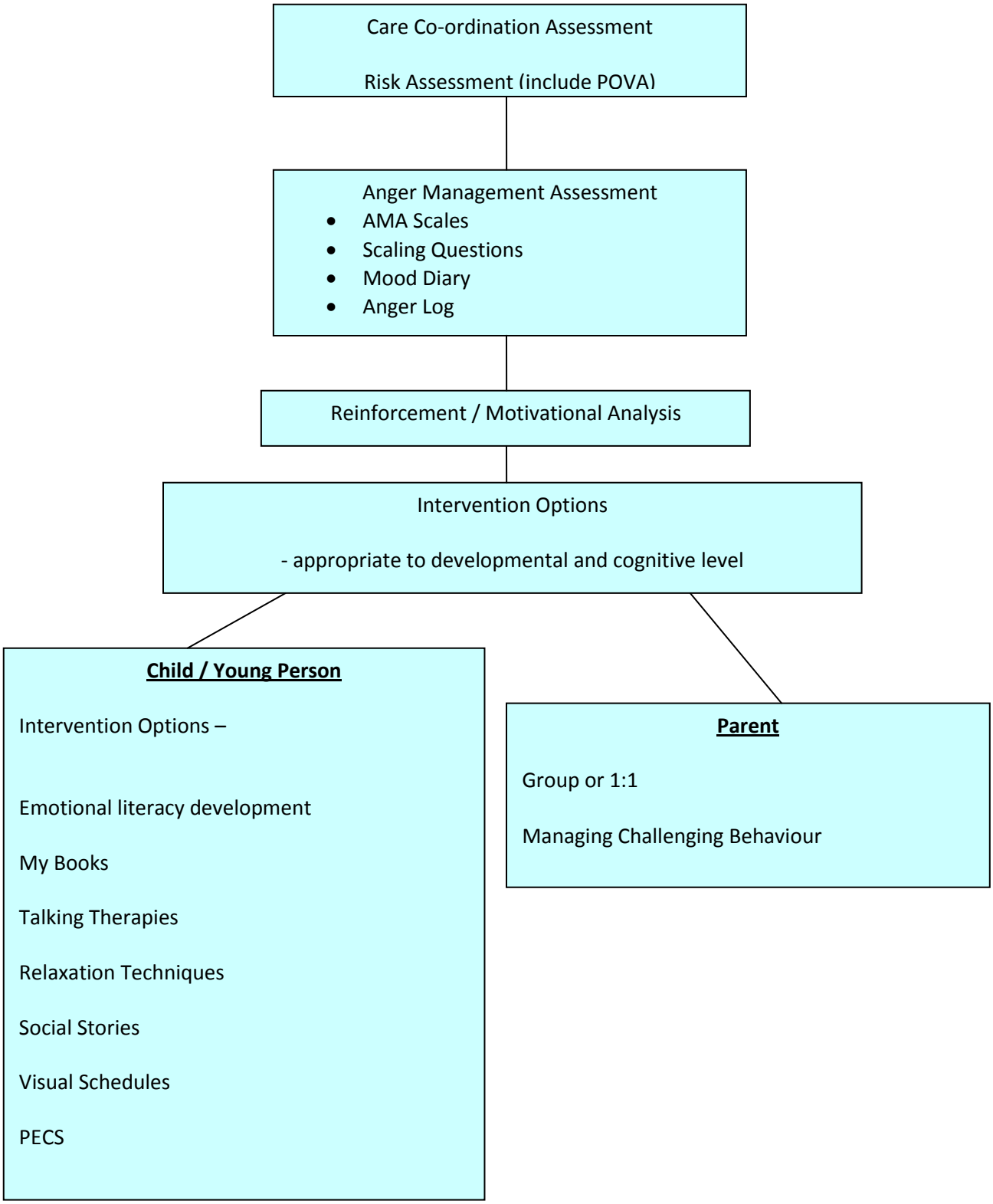
Appendix

Cognitive Assessment Pathway



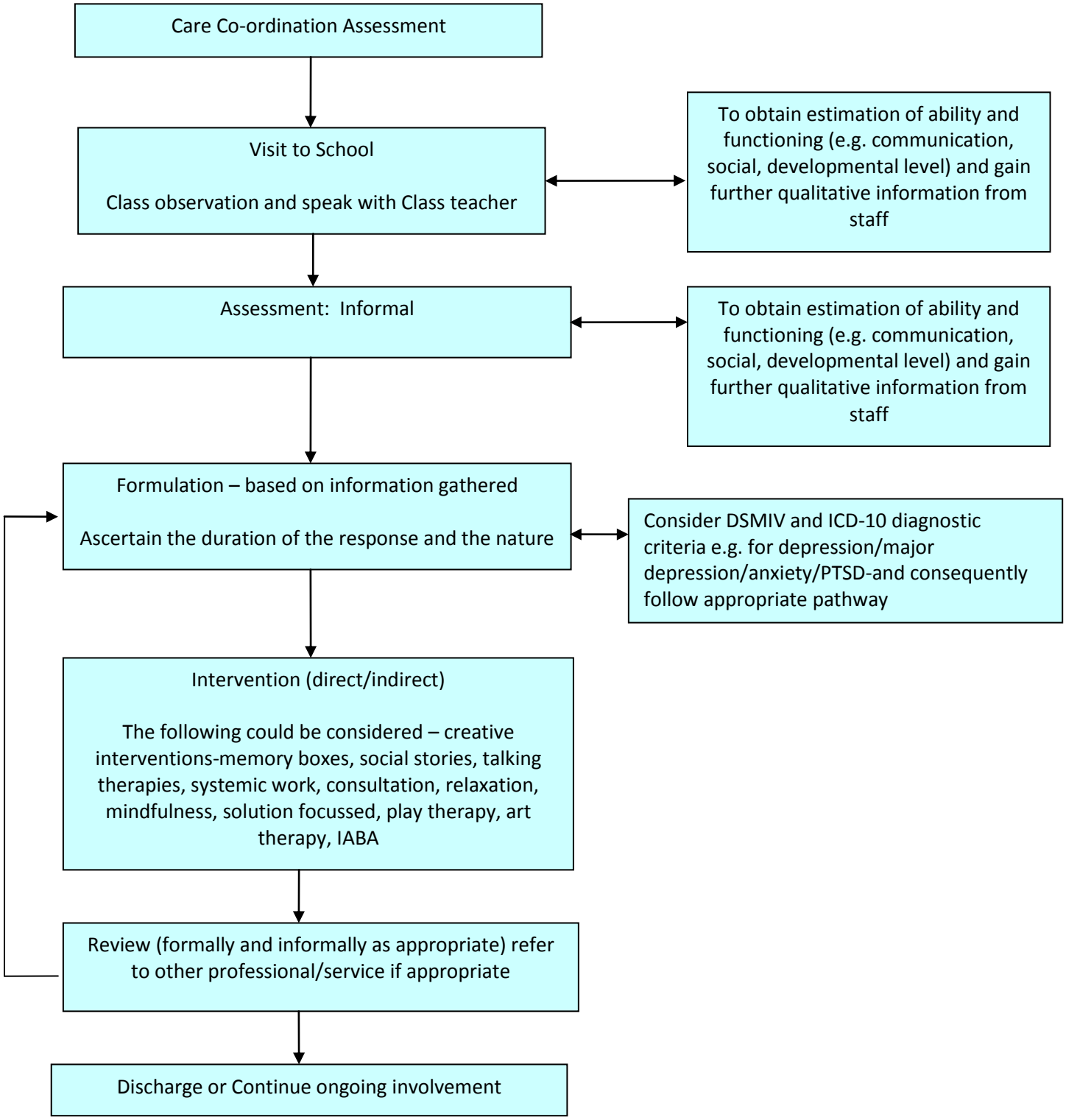
Appendix

Anger Management



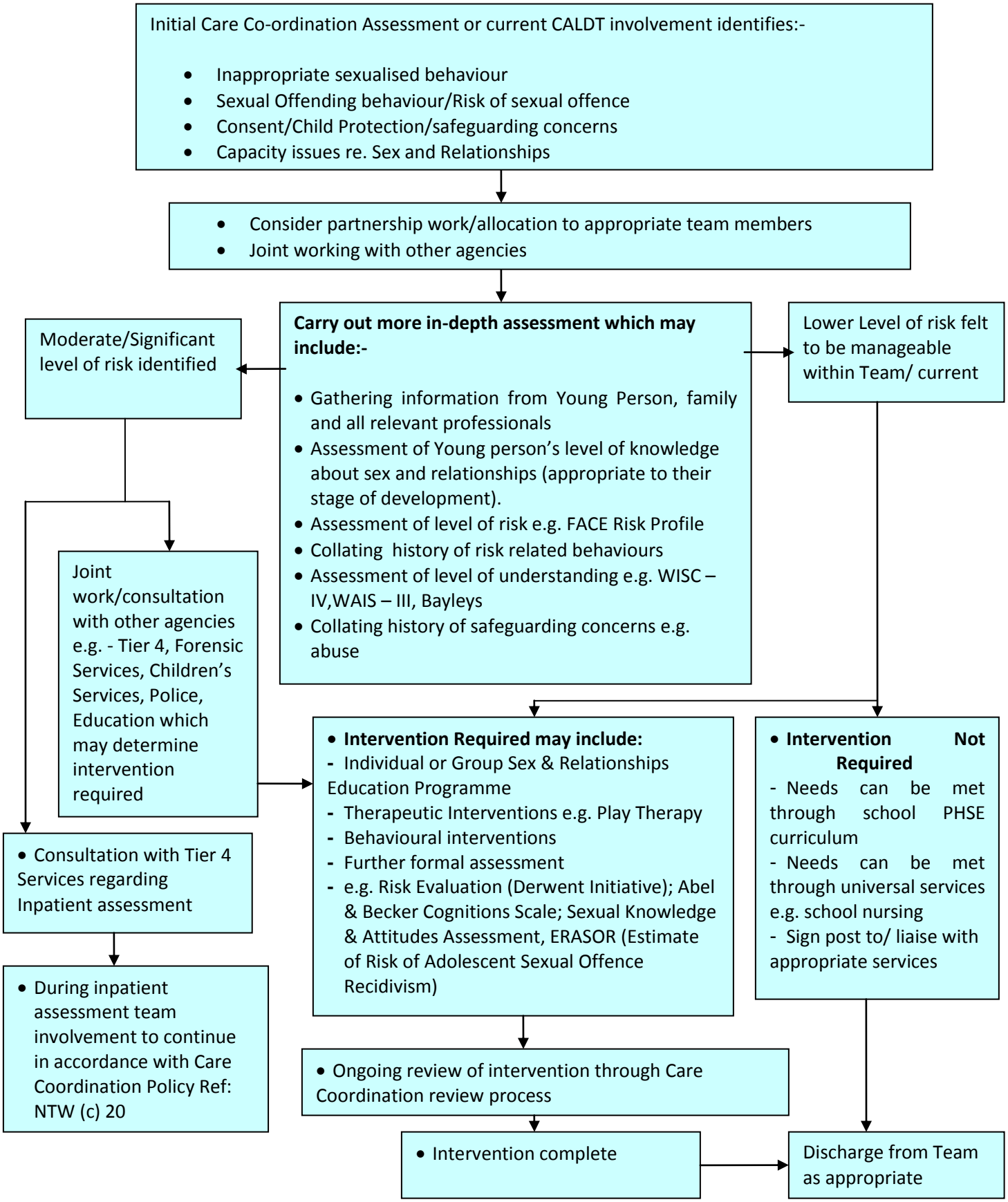
Appendix

Bereavement Pathway



Appendix

Inappropriate Sexualised Behaviour Intervention Pathway



Appendix
Transition into Adult Services

New referral to the team Young person is aged over 14 yrs

Young person currently receiving services from the team reaches 14 years of age/Yr 9

Gather information from Yr 9 Transitional School Review & subsequent reviews as part of Care Co-ordination assessment process

Attend/Contribute to Yr 9 Transitional School Review process & subsequent review as appropriate

Young Person reaches 16 Years of age

- Consider whether young person will require health provision/social care support in adulthood.
- Through discussion with young person/family
- Through information provided by Yr 9 & subsequent reviews/agencies currently

NO

YES

Provide intervention as identified on young person's care co-ordination care plan

Continue to review interventions through Care Co-ordination review process

Identify appropriate adult service e.g. Adult LD, Adult Mental Health, Adult Psychiatry, Adult Psychology

NO

YES

Seek consent from young person/family to send brief transition information to identified adult service

If response received indicates that service felt to be inappropriate consult with NCALDT team co-ordinator

Discharge young person back to G.P. (review form & discharge letters to young person, family, G.P. and relevant professionals)

Discharge from RIO as appropriate

Young Person reaches 17 and a half years.

Care Co-ordinator to update Care Co-ordination assessment & Risk assessment

Seek information from any other CALDT team members involved.

Identifying possible future health care needs.

Seek consent from young person/family to send information to appropriate adult services to request service involvement

Young person reaches 17.

For transition cases to adult LD Team (as per service transfer protocol, April 2009) care manager is allocated.

Work alongside care manager during transition process.

Attend Person Centred reviews as appropriate.

Team members to work alongside adult services professionals up to young persons 18th birthday to ensure a gradual transition to adult services.

If response received from adult services indicates that service is felt to be inappropriate consult with NCALDT Team Co-ordinator

Carry out Care Co-ordination discharge review prior to young person's 18th birthday.
Transfer input to adult service workers at Child's 18th Birthday.
Discharge – Care Co-ordination review form & letter to G.P., young person/family and all relevant professionals
Discharge from RIO

Appendix

Sensory Intervention Pathway