Assertive Outreach Team's experience of CPA

Introduction

Assertive Outreach Team (AOT) are making CPA work. A group of three care coordinators (case managers), the team manager and the CPA development manager met on 2/10/13 to critique CPA by addressing the following:-

- How does CPA works within the team?
- Why does CPA works within the team?
- What could be better?

There had been a team discussion about CPA earlier; this informed the information brought by the group members. Overall the comments were that there was 'no great criticism' of CPA; that staff understands the rationale of the areas but that the document is 'very big'.

How CPA works within the team

Care Plans – The team identified that most people do not want a copy of their care plan. Conversely, the crisis plan element of the care plan was reported to be generally useful, one person had it displayed prominently in their lounge. There was discussion around how clinicians use the CPA care plan; there was variation and the discussion itself served to share practice eg. numbering where there are multiple actions to one goal, then linking to numbering the 'who' and 'time-frames'.

Reviews - Service user interest in CPA was reported to be varied; ranging from 'something to be endured' to being 'very keen'. In response to this, there is variation in the way that reviews are facilitated by the care coordinator; largely in response to service user preference. Reviews are often held as a range of smaller meetings, with liaison with others involved rather than as a room full of people. AOT report that some service users will not tolerate a large meeting for a number of reasons.

Inpatient CPA reviews – It was identified that a lot of work towards developing the CPA care plan happens when the person is in hospital. The actual CPA Review in hospital is not always conducive to formulating a full CPA plan – there is not enough time allocated; it is often focussed on mental state/health and medication, there is a sense of impatience when going through/reviewing the other elements; there are times when there are people in the review that don't need to be there. In reality, the ward CPA review is brief; the care plan is elaborated upon when written up after the review. Wards often call the meeting a CPA review when it is a regular ward round/MDT.

Documentation – Clinicians vary in the way that the documentation is completed; the guidance was that if no 'goal' was identified, then there was no requirement to care plan for it. Experience following CIR's is that where there is no goal identified, the clinician is left feeling as though they have to explain. This has resulted in the documentation completion being very thorough, leaving no areas out. This is not necessarily to benefit the service user, but is to protect the clinician. This was described as an organisational culture issue. It was identified that there have been care plans where the person's mental health needs were not described.

Why CPA works within the team

Flexibility - The team's ability to be flexible was identified as the key reason why CPA works within AOT. This ability to be flexible was attributed to a number of factors – experienced care coordinators - a prerequisite to working within AOT; a good understanding of care managing/planning; proactive engagement with service users and also partner agencies. The flexibility is evident in the creative ways of working –for example, more flexible CPA reviews.

Capacity – It was acknowledged that it takes quite a while to put together a good CPA care plan, but that once this is done, then reviewing and updating it is made easier by the copy facility on PARIS. The group reflected that they are able to spend time putting the care plan together as they have a lower case load (typically 12) compared to that of the CMHT's (up to around 50) albeit, the time spent with their service users is likely greater with added complexity.

Scrutiny – The number of people subject to a Community Treatment Order (CTO) is significant, currently around 40-45% of case loads. This means that the scrutiny of the care plan and review is greater due to the safeguards. Clinical Audit was also cited as reason to be thorough with documentation.

What could be better?

Inpatient reviews – should be as flexible as community based ones; should have enough time allocated and not be medically focused.

Summary – a one page summary of the care plan providing a succinct overview would be useful to other clinicians – own team, out of hours teams etc, may be an option for the service user who cares not for a lengthy detailed care plan. Could be compiled by 'pulling through' from a section of the care plan. Would be useful at the start of assessment as the current CPA care plan doesn't capture initial plans "misses it by a mile".

Documentation – Sections in the care plan 'work/training/education' and 'meaningful activity' could be combined as they are similar. 'Mental Health' should be followed by 'Medication' as a more logical sequence, also reads better for the service users care plan. The document is big, it's very 'nursey' and 'O.T.'y' in language, eg. goal's – the language could be simpler. The questions at the start of the CPA documentation should be reviewed – are they still necessary? Green Light and Section 117 were discussed but the remaining questions should be reviewed.

Discussion

The characteristics of AOT appear to be particularly compatible with CPA. There are clear areas where CPA should be at least reviewed as there are areas identified that could be improved. The service user and carer voice need to be heard to bring together a fuller picture of CPA in AOT.

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