Care Programme Approach in Mental Health Care: past, present and future – time to move on?

Thursday 1st November 9.30am - 4.00pm
Venue: City, University of London
Passionate about collaboration: For more information, etc. please contact us…

Tel 020-76554000
Medical Director: frank.rohricht@nhs.net
Head People Participation: paul.binfield@nhs.net
IT clinical champion: graham.fawcett@nhs.net
The Care Programme Approach and community mental health services – where are we headed?

Professor Tim Kendall
National Clinical Director for Mental Health, NHS England & NHS Improvement

ELFT & City University: From Care Programme Approach to Recovery Care Approach - Time to Move on?
City University, 1 November 2018
<table>
<thead>
<tr>
<th>Priority</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>70,000 more children</td>
<td>will access evidence based mental health care interventions.</td>
</tr>
<tr>
<td>At least 30,000 more women</td>
<td>each year can access evidence-based specialist perinatal mental health care.</td>
</tr>
<tr>
<td>The number of people with SMI</td>
<td>who can access evidence based Individual Placement and Support (IPS) will have doubled.</td>
</tr>
<tr>
<td>280,000 people with SMI</td>
<td>will have access to evidence based physical health checks and interventions.</td>
</tr>
<tr>
<td>Inappropriate out of area placements (OAPs)</td>
<td>will have been eliminated for adult acute mental health care.</td>
</tr>
<tr>
<td>New models of care for tertiary MH</td>
<td>will deliver quality care close to home reduced inpatient spend, increased community provision including for children and young people.</td>
</tr>
<tr>
<td>Intensive home treatment</td>
<td>will be available in every part of England as an alternative to hospital. ( Older People )</td>
</tr>
<tr>
<td>10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 2017. ( Older People )</td>
<td></td>
</tr>
<tr>
<td>Increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year. ( Older People )</td>
<td></td>
</tr>
<tr>
<td>No acute hospital is without all-age mental health liaison services, and at least 50% are meeting the ‘core 24’ service standard. ( Older People )</td>
<td></td>
</tr>
<tr>
<td>Increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year. ( Older People )</td>
<td></td>
</tr>
<tr>
<td>60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks including children.</td>
<td></td>
</tr>
<tr>
<td>There will be the right number of CAMHS T4 beds in the right place reducing the number of inappropriate out of area placements for children and young people.</td>
<td></td>
</tr>
</tbody>
</table>
‘the traditional divide between primary care, community services, and hospital...is increasingly a barrier to the personalised and coordinated health services patients need...the NHS will increasingly need to dissolve these traditional boundaries’.
Community Mental health Services: where do they fit in?

- Community mental health services provide the bedrock for secondary mental health care with over 90% of service users supported in community settings.
- While the Five Year Forward View for Mental Health (FYFVMH) focussed mostly on addressing significant specialist treatment gaps, community services are central to the delivery of the ambitions the FYFVMH and to ensuring that local services are sustainable.
- The need to optimise core community-based care is more important than ever, particularly with the Mental Health Act Review currently underway.
- We want to reduce (avoidable) levels of pressure on acute mental health services, reduce reliance on the MHA, reduce relapse and (re)admission rates.
- Particular issues around access and quality – and where system-wide issues are most likely to either manifest or originate.
Community Mental health Services: Objectives

- Ensure people are receiving **consistent, timely access to evidence-based care in the community**
- Ensure people receive **holistic, person-centred and recovery-orientated support** with improved care planning and co-ordination
- Triple integration:
  1. **Primary** and **secondary care**
  2. **Health, social care, voluntary sector** and **community networks**
  3. **Physical** and **mental health**
- Improve the level of support that people with mental health needs are able to access in or via **primary care**, to ensure that:
  - People who are **not served by the current set-up of services** (IAPT services/secondary care mental health services) receive the right care;
  - People are supported **within their communities** to sustain recovery following discharge from acute mental health care.
- Significant **inequalities** in relation to access, experience and outcomes associated with community mental health services are addressed
Community Mental Health Services Framework: What are we proposing?

A radical change in the approach towards the delivery of community mental health care (NHS, social care, VCS, public health, communities) – to be responsive, proactive, flexible:

- An integrated model of community based mental health care for adults (including those over 65), from less complex to complex mental health needs
- Bridging the primary-secondary care divide, pulling CMHS ‘into’ primary care to provide a broader, revived and integrated ‘core’ MDT offer to people including those with complex SMI and co-morbidities:
  - Organised at the local community level for a population of around 30,000 - 50,000 people (approximately 5 to 12 practices i.e. Primary Care Network footprints)
  - Linked closely with wider community services (populations typically of 150,000 - 200,000) that focus on the most complex needs where services are provided by more specialist mental health MDTs – building up to an STP/ICS footprint
  - Local needs, local geography and current provision will determine how systems do this
- Provision of specific psychological, pharmacological and social interventions as a core part of the service
- Ability to step care up and down based on need and complexity, and ensuring that those no longer in need of more intensive support will still receive a level of ongoing care and support
- Making more effective use of community assets and resources, including housing, debt advice, employment services, social connections

The framework is being drafted and developed over 2018/19
Community Mental Health Services Framework: Where does the CPA fit in?

- The key elements of CPA i.e. care co-ordination and care planning remain relevant but need reinvigoration, modernising and linking to the drive around personalised care.
- Anecdotally the consistent message is that the CPA has stopped being a tool to deliver quality care for those who need it most and has become a bureaucratic process.
- There is also limited scope to understand the quality of a person’s CPA care plan and consistently-reported issues with patients being unaware of their care plans and wholly uninvolved in their design.
- It appears that the CPA has become linked to ‘risk management’ in the community rather than focused on recovery and utilising community resources and assets.
- The CQC reported in their 2017 Community MH Survey statistical release that ‘there is a large variation in the proportion of people on the CPA between trusts, which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy’, with figures in their 2016 report that ‘ranged across trusts from a low of 3% of respondents on the CPA to a high of 73%’.
- The framework will effectively become an alternative to the CPA in the context of community mental health services.
Risk

Big question to ask about risk aversion – have we created the right culture?

• “Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.”
• “Risk is not a number, and risk assessment is not a checklist.”
• “There is a growing consensus that risk tools and scales have little place on their own in the prevention of suicide.”
• “The management of risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone.”

Need a cultural shift towards proactively addressing individual need and focussing on safety instead of myopic focus on risk – which is relatively poorly-understood, dynamic and subjective – as a proxy to determine access and intensity of input.
Honest reflections

• The CPA feels **dated and increasingly irrelevant** – a lot has changed in the last decade since the 2008 guidance from DH

• While measurement is important, centrally-mandated, prescriptive policies sometimes rob clinicians of **the initiative to do things intuitively well** and can be used defensively

• We want a **new approach to clinical practice in community mental health services** to grow from the bottom-up with **genuine co-production** instead of paternalism at its heart

• The MHA and the CPA drive a lot of **behaviours in secondary MH care** – both are rightly undergoing serious examination
Sidney Millin

Me and my Care Plan!
This Is Me
This Is Me

Zimbabwean

Father

Journalist

Sports fan

Activist

Sometimes an inpatient
This is NOT Me

<table>
<thead>
<tr>
<th>Care Plan</th>
<th>Date of review:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parametric</td>
<td>Username</td>
</tr>
<tr>
<td>Gender</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>ID Number</td>
<td>NHS No.</td>
</tr>
<tr>
<td>Diagnosis(s)</td>
<td>ICD-10 Code(s)</td>
</tr>
</tbody>
</table>

**East London NHS Foundation Trust**

**Care Plan**

- **State of Current Situation and Identified Needs**
  - (Including self-directed support plan)

- **Intervention/Actions**
  - (Including self-directed support plan)

- **Responsible Person/Agency**
- **Thesedate**

**Risk Issues:**

<table>
<thead>
<tr>
<th>Physical Health:</th>
<th>Ongoing</th>
</tr>
</thead>
</table>

**Crisis, Relapse and Contingency Plan (Including advance directive)**

- Early warning signs, relapse indicators, triggers, location of any advance statements, whom to contact
- Service response, including arrangements for children

**Agreed action/plan/intervention frame**

<table>
<thead>
<tr>
<th>Relapse Indicators/Warning Signs</th>
<th>Responsible Person/Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CM/Global</td>
</tr>
</tbody>
</table>

**Summary and Location of Advance Directives:**

- None at present

**Crisis Plan:**

<table>
<thead>
<tr>
<th>CM/Local care coordinator</th>
</tr>
</thead>
</table>
What matters to me?

- My Mental Health
  - Achieving my goals (write a book)
  - Challenging stigma in our community
  - Personal development and growth
  - My physical health (trying to stop smoking)
  - Liverpool FC
  - Work - get back into meaningful work
  - Family - most important thing of all
  - Money (do I have enough)
History of the Care Programme Approach

David Kingdon

*Senior Medical Officer, DH (1991–4)*

Professor of Mental Health Care Delivery UoS

Clinical Director (Adult Mental Health Services)
Two years ago this woman was discharged from mental hospital. But she still desperately needs skilled care. Instead she spends her days lying in bed in a hostel for homeless women. Our investigations reveal that she is one of thousands of victims of a worthy idea that went wrong.
1985 Banstead relocates patients & closes
1986 Closure of Saxondale Hospital, Nottinghamshire
1988 Report of Spokes Inquiry
1990 CPA circular
1991 CPA to be implemented
1992 Health of the Nation
1994 ‘Community care has failed’


The origins of the care programme approach (CPA) can be traced back to the Spokes Inquiry into the Care and After-care of Sharon Campbell (DHSS, 1988). This concluded that there had been a breakdown in the delivery of services effectively resulting in the death of Ms Campbell’s social worker. It recommended that the Secretary of State issue to health and local authorities a written summary clarifying their statutory duties to provide after-care for former mentally disordered patients, and that the Royal College of Psychiatrists publish a document on good practice for discharge and after-care (Royal College of Psychiatrists, 1991). Research demonstrating the relatively high levels of psychotic illness among the homeless and in the criminal justice system also reinforced the need for improvement in the organisation and delivery of services.
After the Asylums

The local picture

Trish Groves

Mental health services in Bassetlaw

All areas covered by
- Community psychiatric nurses
- Social services mental health team
- MIND befriending scheme

- Outpatient clinic
- MIND support group

- District general hospital including:
  1. Acute admission ward
  2. Day hospital
  3. Outpatient clinic
  4. Community psychiatric nurses (base)
  5. Hospital hostels
- Social services day centre
- Local authority cluster flats
- Refuge flat
- Turning Point hostel
- MIND centre, shop, and coffee bar
- MIND support/TRANX group

- Outpatient clinic
- Community psychiatric nurse clinic
- Social services mental health team (base)
- MIND support group
- TRANX group
- National Schizophrenia Fellowship group

- Outpatient clinic
- MIND support group
Care programme approach
Recent government policy and legislation

David Kingdon

Principles

The care programme approach involves:
(a) assessment of health and social care needs
(b) a key worker to coordinate care
(c) a written care plan
(d) regular review
(e) interprofessional collaboration
(f) consultation with users and carers.
Care programme approach

Recent government policy and legislation

David Kingdon

Targeting of resources on severely mentally ill people is specified in the circular as community mental health teams have been prone to move away from care of the severely mentally ill (Weaver & Patmore, 1990).

Psychiatric Bulletin (1994), 18, 68-70
A specific definition of severe mental illness has never been given because of the complexity of specifying a point on the continuum of ‘illness’ that is relevant to individual patients who have widely varying needs and services which have varying levels of resources. However in ‘Building Bridges’ (1994) a framework for developing such criteria and making decisions about resource allocation was proposed. This involves consideration of:

- Safety
- Need for Informal or Formal care
- Diagnosis
- Disability
- Duration of illness
Making care programming work
David Kingdon

- Detailed guidance: care plans, key working (to become care coordination), prioritisation, social care – care management
- Health and social care
- Providing ‘safety net of care’
- ‘Standard’ and ‘Enhanced’ care:
  - Care coordinator
  - More than one practitioner – multidisciplinary/multiagency
- Also Health of the Nation key area handbook, leaflets, circulars
Reclaiming the care programme approach

David Kingdon

The bureaucracy that has developed in some trusts, ostensibly because of the CPA, is overwhelming. Why has a clinical system been subverted to such an extent?
Abstract
The care programme approach (CPA) has become an accepted part of clinical practice, despite the continuing lack of strong direct evidence of its value. Guidance from the Department of Health has refined the original requirements, which were to ensure health and social care assessment, discharge from hospital to appropriate accommodation with necessary support, appointment of a mental health professional to draw up a care plan, and coordination of its implementation with necessary follow-up. The CPA now specifies that care plans include provision, as necessary, for risk assessment and management, employment, leisure, accommodation and plans to meet carers’ needs. Levels of care have been simplified to ‘standard’ and ‘enhanced’. In future it will need to incorporate issues arising from the development of specialist teams as part of the National Health Service Plan, concern about the physical healthcare of those subject to it and the continuing development of psychosocial interventions.
In 2008, the CPA was refocused on the enhanced level, although the previous requirements remained for all those under mental health services. The impetus for this ‘refocusing’ came from the recognition that allocation to CPA was inconsistent, and that there was a need to improve care coordination and reduce bureaucracy. A set of criteria were introduced to determine eligibility for ‘new CPA’, and principles for working with patients on CPA were described in detail.
Characteristics to consider when deciding if support of (new) CPA needed | Table 2

> Severe mental disorder (including personality disorder) with high degree of clinical complexity

> Current or potential risk(s), including:
  - Suicide, self harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
  - Self neglect/non concordance with treatment plan
  - Vulnerable adult; adult/child protection e.g. financial/sexual
  - Financial difficulties related to mental illness
  - Disinhibition
  - Physical/emotional abuse
  - Cognitive impairment
  - Child protection issues

> Current or significant history of severe distress/instability or disengagement

> Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability

> Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies

> Currently/recently detained under Mental Health Act or referred to crisis/home treatment team

> Significant reliance on carer(s) or has own significant caring responsibilities

> Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities
  - Physical health problems/disability
  - Unsettled accommodation/housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Ethnicity (e.g. Immigration status; race/cultural issues; language difficulties; religious practices; sexuality or gender issues)
NHSI/E targets

- CPA 12 month care plan review
- CQUIN physical health (EIP, IP & CPA)
NHSI/E targets

- CPA 12 month care plan review (perverse incentive?)
- CQUIN physical health (EIP, IP & CPA)

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Mental Health Trusts in England
- Southern Health NHS Foundation Trust

Trend line not drawn when $R^2$ is below 0.15 ($R^2 = 0.04$)
Care programme approach
Recent government policy and legislation

David Kingdon

Principles

The care programme approach involves:
(a) assessment of health and social care needs
(b) a key worker to coordinate care
(c) a written care plan
(d) regular review
(e) interprofessional collaboration
(f) consultation with users and carers.

Psychiatric Bulletin (1994), 18, 68–70
Care programme approach – time to move beyond?

David Kingdon¹

¹University of Southampton
Correspondence to David Kingdon (dgk@soton.ac.uk)

First received 20 Apr 2018, final revision 15 Jul 2018, accepted 3 Aug 2018

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The Care Programme Approach (CPA) has been instrumental in embedding principles of holistic collaborative assessment and management into mental health care. Initially, its implementation was assisted by targeting those at greatest need. However dichotomising patients into more and less severe is now considered unhelpful and has been demonstrated to be unreliable. Division of patients into severe and not severe categories is no more logical than such a division of patients with physical health problems. CPA principles are now applied to all patients in mental health services and practice needs to move to individualised care, focusing on meeting quality standards and achieving positive outcomes. A system based on evidence-based clinical pathways and reliable measures of severity and need should replace the current approach.

Declaration of interest  None.

Keywords  Community mental health teams; outcome studies; risk assessment; service use; economics.
Risk management

Risk summary:
- Based on weighting risk factors (DH, 2008)
- Using national risk ranking

My Safety & Crisis Plans
- Medium/high risk
- Borderline/emotionally unstable personality disorder
- Inpatients
Diagram 1: Care programme approach

Individual with mental health problems

CPA

Non-CPA
Rathod et al. (2015). Pathways to recovery: A case for adoption and implementation of systematic pathways in psychosis and Schizophrenia. Jointly produced by Imperial College Health care partners and Wessex Academic Health Sciences Network.
Diagram 2: Pathways, outcomes & standards

Individual with mental health problems

- Psychosis
- Borderline personality disorder
- Affective disorder
- Eating disorder
- Organic disorders

Individual outcome & standard measurement

- HoNOS
  - Substance use
  - Psychosis
  - Depression
  - Other symptoms
  - Cognition
  - Physical health
  - Occupation
  - Accommodation
  - Relationships
  - Self-harm
  - Agitation
  - ADL

- DIALOG
  - Satisfaction with:
    - Mental health
    - Physical health
    - Employment
    - Accommodation
    - Leisure
    - Family
    - Friendships
    - Personal safety
    - Practical help
    - Medication
    - Consultations

- STANDARDS
  - NIHCE standard for each outcome area, e.g. psychological and family work, physical health, medication.
  - Standard met/in progress/unavailable/declined

‘Mental health pathways’
Condition Pathway Assessments - Summary

Select a Pathway
All

Select an assessment period
01/11/2017 to 31/10/2018

Condition Pathways HoNOS assessments completed

- Psychosis: 1,714 (16%)
- Borderline pd: 917 (8%)
- Affective disorders: 2,564 (23%)
- Eating disorder: 447 (4%)
- Other: 4,334 (39%)
- Organic: 1,007 (9%)
- Null: 2 (0%)

Total: 10,985 (100%)

Condition Pathways DIALOG assessments completed

- Psychosis: 1,049 (28%)
- Borderline pd: 449 (12%)
- Affective disorders: 988 (26%)
- Eating disorder: 3 (0%)
- Other: 733 (20%)
- Organic: 537 (14%)

Total: 3,750 (100%)
## What outcomes?

<table>
<thead>
<tr>
<th>Outcome at 12 months/discharge</th>
<th>DIALOG</th>
<th>HoNOS</th>
<th>Input</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery</td>
<td>Satisfaction with mental health</td>
<td>Symptom scores &gt;3 (mild)</td>
<td>Low (past 6–12 mth?)</td>
<td>Self-determination</td>
</tr>
<tr>
<td>Improved</td>
<td>Improved MH satisfaction &amp;/or</td>
<td>Key item improved &amp;/or</td>
<td>Reduced or stable</td>
<td>Increase in input balanced by &gt;1 point change?</td>
</tr>
<tr>
<td>Stable</td>
<td>No change (0–1 point)</td>
<td>Key item – no change</td>
<td>Change balanced by input</td>
<td></td>
</tr>
<tr>
<td>Deteriorated</td>
<td>Reduced &amp;/or</td>
<td>Reduced &amp;/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Died</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Self-discharged</td>
<td></td>
<td></td>
<td></td>
<td>Policy followed</td>
</tr>
</tbody>
</table>
CPA – moving on..

- Principles stood the test of time for clinical processes .. but apply to all patients
  - Care planning is a universal need
  - Physical health issues apply to all

- SMI too broad a concept to use categorically
  - Allocation to NICE broad pathways possible
  - Use of PROMs & CROMS can be used to assess level of need
CPA

Back to the future
or
Be careful what you wish for

Tom Burns
CPA Original purpose

To ensure:
Allocation of key-worker (later case manager)
continuity of care
effective coordination

For all specialist MH patients

Simple effective communication
  Within team and between teams
### ENHANCED CPA/SECTION 117(2) REVIEW (delete as applicable)

**Patient’s name:** Jonathon P  
**Address:** 15 Sudbury Walk, Battersea.  
**Phone:**

**CMHT:** ACT  
**TEAM:**  
**Phone:** 020 8877  
**New patient:** NO  
**If NO, date of review:** …17/4/01…….  
**Date of birth:** 12/10/65  
**GP:** Givens  
**Phone:**

### You must consider the following:

1. Mental health, including indicators of relapse;  
2. Physical health;  
3. Medication;  
4. Daytime activity;  
5. Personal care / living skills;  
6. Carers, family, children and social network;  
7. Forensic history;  
8. Alcohol or substance misuse;  
9. Cultural factors;  
10. Housing/finances/legal issues;  
   and  
   a) make sure a risk assessment is done;  
   b) include:  
      1) a crisis plan;  
      2) i.e. what should be done if part of the care plan can’t be  
      be provided (e.g. the care co-ordinator is on leave or ill)

### Assessed needs or problem

<table>
<thead>
<tr>
<th>Psychotic experiences mainly paranoid.</th>
<th>Intervention</th>
<th>Respo.df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain on Risperidone 4mg nocte.</td>
<td>CNS</td>
<td></td>
</tr>
<tr>
<td>Monitor compliance openly and collaboratively.</td>
<td>CNS</td>
<td></td>
</tr>
<tr>
<td>Monitor mental state at each visit. Observe for relapse signature signs of suspicion, unusual beliefs and hostility. Repeat BPRS at 3 monthly intervals.</td>
<td>CNS</td>
<td></td>
</tr>
<tr>
<td>Relapse plan negotiated that if Jonathon believes his brother or other member of his family has been substituted again then Jonathon will accept increased dose of Risperidone up to 8 mg nocte.</td>
<td>CNS</td>
<td></td>
</tr>
<tr>
<td>Ongoing weekly CBT sessions aimed at modifying beliefs of Capgras’ syndrome.</td>
<td>CNS</td>
<td></td>
</tr>
<tr>
<td>Low threshold for joint visits. See risk assessment and contingency plan.</td>
<td>CNS</td>
<td></td>
</tr>
</tbody>
</table>

### Risk of aggression when acutely paranoid.

### Professionals involved in care:

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>CP</th>
<th>OT</th>
<th>S</th>
<th>Ward</th>
<th>ACT</th>
<th>Support</th>
<th>Worker</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Present at planning meeting:

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>CP</th>
<th>OT</th>
<th>S</th>
<th>Ward</th>
<th>ACT</th>
<th>Support</th>
<th>Worker</th>
<th>Other</th>
</tr>
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</table>

### Plan discussed with the patient?

<table>
<thead>
<tr>
<th>Copy given to patient?</th>
<th>Copy sent to GP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

### Care co-ordinator

- **(print):** Alison  
  **(signature):** Clinical Nurse Specialist  
  **Phone:** 020 8877  
  **Date of next review:** 17/10/04

### On Supervision Register?

- **NO**

### On Supervised Discharge?

- **NO**

### Care management?

- **NO**

### Risk history completed?

- **YES**

### Relapse + risk plan required?

- **YES**
• Endless meddling
• Requirements to confirm a range of needs assessed
• List needs even if not being addressed
• Demographics for reporting for planning
• Obligatory risk assessment
  – Possibly structured
• Evidence of co-production
• Subversion of status to electronic records
# C&I Care Program Approach

**Downtime Form**

<table>
<thead>
<tr>
<th>Client NHS or Carenotes ID (if known)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Title</th>
<th>Client First Name</th>
<th>Client Surname</th>
<th>Client Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Postcode</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>GP</th>
</tr>
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## CPA Details

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## Outcome and Next Steps

*(please tick only one box below)*

**Outcome:**

- Service user attended, CPA completed
- Service user DNA, CPA completed in absence
- Service user DNA, CPA re-booked
- CPA cancelled by Service user
- CPA cancelled by clinician

**Next Steps:**

*(please tick only one box below)*

- Continue care under CPA
- Discharge from CPA, continue care under non-CPA
- Discharge from CPA and discharge from service
- CPA Transfer
### Steps:

- Continue care under CPA
- Discharge from CPA, continue care under non-CPA
- Discharge from CPA and discharge from service
- CPA Transfer

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### Additional Information

#### of Latest Risk Assessment:

- 0: Variance
- 1: Common Mental Health Problems (Low Severity)
- 2: Common Mental Health problems (Low Severity with greater need)
- 3: Non Psychotic (Moderate Severity)
- 4: Non-psychotic (Severe)
- 5: Non-Psychotic Disorders (Very Severe)
- 6: Non-Psychotic Disorder of Over-valued Ideas
- 7: Enduring Non-Psychotic Disorders (High Disability)
- 8: Non-Psychotic Chaotic and Challenging Disorders
- 9: First Episode Psychosis
- 10: Ongoing Recurrent Psychosis (Low symptoms)
- 11: Ongoing or recurrent Psychosis (High Disability)
- 12: Ongoing or Recurrent Psychosis (high symptom and disability)
- 13: Psychotic Crisis
- 14: Severe Psychotic Depression
- 15: Dual Diagnosis
- CPA Transfer
- 16: Psychosis and Affective Disorder - Difficult to Engage
- 17: Cognitive Impairment (low need)
- 18: Cognitive Impairment or Dementia Complicated (Moderate Need)
- 19: Cognitive Impairment or Dementia Complicated (High Need)
- 20: Cognitive Impairment or Dementia (High Physical or Engagement)

#### of most recent cluster:

- CPA Transfer

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<tr>
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<tr>
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<tr>
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<tr>
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<td>□ Night shelter/emergency hostel/Direct access hostel</td>
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<td>□ Sofa surfing</td>
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<td>□ Placed in temporary accommodation by Local Authority</td>
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<td>□ Staying with friends/family as a short term guest</td>
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<td>□ Foyer - accommodation for young people aged 16-25 who are homeless or in housing need</td>
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<td>□ Detention Centre</td>
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<td>□ Other accommodation with criminal justice support such as ex-offender support</td>
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<td></td>
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<td>Smoker - Advice given, cessation services declined</td>
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Cross-national comparative mixed-methods case study of recovery-focused mental health care planning and co-ordination: Collaborative Care Planning Project (COCAPP)

Alan Simpson, Ben Hannigan, Michael Coffey, Aled Jones, Sally Barlow, Rachel Cohen, Jitka Všetečková and Alison Faulkner
Conclusions: First paragraph (p148)

The results of this cross-national, multisite, mixed-methods study suggest that there is a gap between the macro-level national policy aspirations for recovery-focused, personalised care planning and co-ordination and the meso-/micro-level ‘street-level’ practices and everyday experiences of service users, carers and care co-ordinators. Of particular concern was evidence of a perhaps widening discrepancy between policy and practice and the indications of an emergent cynicism among participants as recovery concepts and ideals are subverted by higher order organisational needs, directives and ends.
From this....
To this....
CPA’s Achievements

why we should cherish it
Community care: Loss to follow up 18/12
Peter Tyrer, Lancet 1995

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<td>Lost to fu</td>
<td>40 (20.4%)</td>
<td>64 (32.5%) (26.5%)</td>
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(Suggested higher rate of admission for CPA)
**OCTET 36m follow-up 2015**

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**Disengaged (>90 days)**

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<tr>
<td>Disengaged (&gt;90 days)</td>
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**Discontinuities**

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<td>187/327</td>
<td>(57%)</td>
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<tr>
<td>One</td>
<td>66/327</td>
<td>(20%)</td>
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Conclusions

CPA an excellent clinical tool

Achieved its end of sustaining community contact

Overburdened by multiple expectations and meddling

A trusty servant at risk of becoming a tiresome master
Thanks for listening
The CPA – What does/does not work: Lessons from two cross-national studies of care planning & coordination (COCAPP/A)

Professor Alan Simpson
a.simpson@city.ac.uk
City, University of London
Acknowledgements

■ Colleagues and collaborators at City, Cardiff, Swansea and beyond

■ The projects were funded by the National Institute for Health Research Health Services and Delivery Research Programme (HS&DR 13/10/75 and HS&DR 1/2004/12).

■ Views and opinions expressed are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.
## Brief background to studies

### COCAPP (Community)

- No research focus on relationships between care planning and coordination and recovery outcomes
- Findings from early studies of the CPA pointed to:
  - Excessive bureaucracy
  - Limited opportunities to provide therapeutic interventions
- Audits suggest that care planning and coordination are subject to:
  - Significant local variation
  - Limited involvement of service users and carers

### COCAPP-A (Acute)

- Annually around 112,000 people are admitted to mental hospitals; about 40% of them detained under MHA
- Care planning in inpatient settings is intended to be personalised, focused on recovery and undertaken in collaboration with service users
- National surveys and audits identified serious concerns about care planning and called for measures to ensure that acute inpatient services are more personalised to promote recovery
Aims

- To identify factors facilitating or hindering recovery-focused, personalised care planning and coordination in community and acute inpatient mental health settings.

Teams/Wards

- COCAPP in 20 CMHTs
- COCAPP on 19 Wards

Location

- Six NHS Providers
- Four NHS Trusts in England
- Two Local Health Boards in Wales
- Sites were identified to reflect variety in geography, population and setting (inner city, urban, rural)
Design

- Cross-national comparative study, employing a concurrent transformative mixed methods approach with embedded case studies.

- The study emphasises connections between different ‘levels’ of organisation (macro/meso/micro)
  - In-depth micro-level case studies of ‘frontline’ practice and experience with detailed qualitative data from interviews and reviews of individual care plans and care review processes.
  - Larger meso-level survey datasets and policy reviews to provide potential explanations and understanding.
  - At the macro-level the national context was considered through a meta-narrative review of national policy and relevant research literature.
Quantitative measures (*used in both studies)

- Surveys of service users (n=749), ward staff/care coordinators (n=491) and carers (n=28).

We used the following measures:

**Views of Inpatient Care scale (VOICE)**
- A patient-reported outcome measure of perceptions of acute mental health care,
- completed by service users.

**Recovery Self-Assessment scale (*RSA)**
- Measures the extent to which recovery-oriented practices are evident in services;
- completed by all.

**Scale to Assess the Therapeutic Relationship (*STAR-P/C)**
- Assesses therapeutic relationships;
- completed by service users and staff.

**The Empowerment Scale (*ES)**
- Measures empowerment, strongly associated with recovery;
- completed by service users.

**Analysis:** Descriptive statistics alongside reference values (build ‘recovery profiles’ of the sites). Across site comparisons using one-way ANOVAs and post-hoc Tukey tests. ANCOVAs to adjust for confounders and correlations to identify relationships between measures.
Qualitative methods

• We used a range of qualitative methods

Semi-structured interviews
• 69 service users (combined with care plan review)
• 59 multidisciplinary staff
• 39 managers/senior practitioners
• 26 carers

Structured care plan reviews (using template)
• 84 additional care plans were reviewed

Non-participant observations
• 12 care plan review meetings

Analysis: Framework method used to explore the relational aspects of care planning and coordination; the degree to which service users and carers participated in care planning processes and decision-making, and the extent to which practitioners were oriented towards recovery and personalised care.
COCAPP: Care plans and relationships

- Care plans seen as irrelevant by most service users who rarely consulted them
- Were seen as a useful record but an administrative burden by care coordinators
- Relationships with care coordinators, support workers, family were seen as far more important to recovery than care plans
- Large positive correlation ($r = 0.61$, $n = 409$, $p < 0.001$) between the recovery and therapeutic relationship scores
COCAPP: Risk and safety

- Risk was a very significant concern for clinicians, yet did not appear to be openly discussed with service users (or carers) who were often unaware that risk assessments had taken place.

- “...[the risk assessment is] one thing... you never discuss with service users just in case it alarms them” [B-SM-001].

- This appeared to limit their involvement in exploring and managing their own safety and prevented positive risk-taking from becoming a part of people's recovery.
COCAPP: Service context

- **Austerity and re-structuring** (upheaval, uncertainty)
  - Cuts and merging of services, increased workloads
  - Integration of health and social care services; refocusing of services
  - Increased use of third sector/voluntary services – added complexity

- **Common organisational factors** (all reported previously)
  - Administrative burden (increasing!), inflexible IT, unwieldy documentation, little training in coordinator role/recovery approaches, high caseloads preventing recovery-oriented work, etc

- **Contradictory initiatives/targets skew priorities**
  - Some developments appeared counter to recovery focus (e.g. Clustering, Payment by Results, Community Treatment Orders)
  - Others, e.g. increased personal budgets, aided recovery-focus
COCAPP: Recovery

• Lack of shared understanding of the concept of recovery
• Staff had a good understanding of personal recovery
• Service users focused on returning back to who they were, independent of services (clinical recovery)
• Carers referred to both personal and clinical recovery
• Some staff and service users were opposed to the terminology
• There were mixed views on how or whether care planning supports recovery
For service users we found a strong correlation between the:

- RSA and VOICE scales \( (r = -.70, p < 0.001) \)
- When recovery-orientated focus was high, the quality of care was viewed highly

- STAR-P and VOICE scales \( (r = -.64, p < 0.001) \)
- When therapeutic relationships were scored highly the perception of quality of care also scored highly

- RSA and the STAR-P scales \( (r = .61, p < 0.001) \)
- When services seen as recovery-focused, the quality of therapeutic relationships was rated positively

Across all sites staff rated therapeutic relationships significantly more positively than service users on the Scale to Assess Therapeutic Relationships.
Comparisons between COCAPP-COCAPPA studies

For service users ratings on:

The recovery-focus of services
- There were only small differences between total RSA scores across sites, which can be considered equivalent.

Therapeutic relationships
- Relationships are rated more positively in community services. The overall difference in total score varied across sites from 2.74 to 8.49 points lower. (Range 0-40)

Empowerment
- Service users scored empowerment higher overall in the acute study than in the community study.
COCAFFA: Care planning and collaboration

Staff spoke about:

- The importance of collaborative care planning and the value of plans being kept up-to-date with service users actively involved

- Plans being used to pull together multidisciplinary contributions and to help transitions between hospital and community

- Difficulties created by rapidly arranged discharges and protracted admissions (lack of accommodation)

- Service users’ unwillingness or inability to collaborate

- Barriers brought about by the introduction of electronic records

Service users and carers:

- Service users frequently drew attention to receiving good quality care

- Evidence of a widespread commitment to safe, respectful, compassionate care underpinned by strong values

- But staff accounts of routine collaboration with service users in care planning contrasted with service user accounts and care plan reviews which pointed to lack of involvement or ownership

- Carers reported low levels of formal involvement but also high quality care being provided
COCAPPA: Care plan reviews

- Staff described formal multidisciplinary ward rounds as key events where progress and plans could be reviewed involving service users and carers wherever possible.

- Service user views and experiences of these differed, within and across sites.
  - For some they were helpful, providing opportunities to catch-up with psychiatrist/team.
  - Some service users/carers described support to plan and prepare for participation.
  - Others spoke of limited time to fully consider needs and issues, of excessive jargon being used and inflexibility over scheduling.

- Reviews of care plans and observation of care plan meetings suggested mainly limited levels of genuine involvement.
COCAPPA: Risk and safety

- Assessing and managing risk were central to planning and providing care, with formal ward rounds being named as places for risks to be discussed although not necessarily in the presence of service users.

- Discussions in relation to medication, risk and decision-making with service users who were detained can be particularly challenging.

- Risks mentioned by staff included those to self and others, with some also noting dangers of over-estimating risks and importance of attending to strengths and positive risk-taking.

- Most service users talked of their safety having been attended to, sometimes giving specific examples (e.g., through removal of objects and the use of observations).

- But risk assessments and management plans were rarely actively discussed with them.

- Others, however, talked of feeling unsafe in hospital and of asking for more staff.
COCAPPA: Recovery and personalised care

Definitions and understandings of recovery varied, as did views of the role of hospitals in promoting recovery.

Most service users saw admission and medication as helpful in their recovery.

Whilst some staff talked of inpatient care as person-centred there was also widespread recognition of the challenges in providing this.

Within and across sites there were differences in service user views and experiences of individually tailored care.

- Some were clear that hospital had been pivotal, and that personal needs and wishes had been attended to.
- Others were equally clear that care had not been personalised, or said that care at home was more personalised.

Carers gave positive accounts of care provided.
Key Findings from the COCAPP studies

- Excessive time on inflexible care plan documents and IT
- Care plans not important (most service users)
- Low levels of collaboration & involvement of service users (& carers) in planning of care & recovery goals
- Service users and carers excluded from discussions of safety and risk & involvement in managing safety
- Personalised care often provided but little clarity & agreement about recovery
Recommendations

■ Investigate how best to build and support positive therapeutic relationships as they are key to recovery

■ Explore how to improve service user experiences of and involvement in care planning and reviews

■ Develop shared decision-making in risk assessment and management

■ Training in recovery-focused care planning and coordination may be insufficient to bring about the necessary changes unless wider contextual factors are addressed

■ Investigate approaches to freeing up staff to increase contact time with service users, carers and social networks to promote recovery
Thank you!

Email: a.simpson@city.ac.uk
CPA and improving quality of life

Stefan Priebe
Unit for Social and Community Psychiatry
(WHO Collaborating Centre for Mental Health Service Development)
Queen Mary, University of London
CPA

• Care-coordinator and care plan
• CPA meetings for monitoring, coordinating and planning
• How to make these meetings therapeutically effective in themselves?
• Can they improve patients’ quality of life?
DIALOG - questions

• “How satisfied are you with your…”
  mental health       physical health
  job situation       accommodation
  leisure activities   partner/family
  friendships         personal safety
  medication          practical help received
  meetings

• Rating of each domain:
  1 (totally dissatisfied) to 7 (totally satisfied)

• ‘Do you need more help in this area?’
DIALOG trial

• Randomised controlled trial
• >500 patients with psychosis in 6 European countries
• On average used 4 times over 12 months
• Improved quality of life!!!
• Small effect size

Priebe et al., British Journal of Psychiatry, 2007
DIALOG+

- Quality of life research
- Concepts of patients centred communication
- IT developments
- Solution focused therapy
How satisfied are you with your mental health?

1. totally dissatisfied
2. very dissatisfied
3. fairly dissatisfied
4. in the middle
5. fairly satisfied
6. very satisfied
7. totally satisfied

Do you need more help in this area?  Yes  No

Physical health
Job situation
Accommodation
Leisure activities
Partner / family
Friendships
Personal safety
Medication
Practical help
Meetings
Mental health
Physical health
Job situation
Accommodation
Leisure activities
Partner / family
Friendships
Personal safety
Medication
Practical help
Meetings

Review  Select  Discuss  Action Items  Finish Session
Medication

Step 1  Understanding
- Why this rating and not a lower one?
- What is working?

Step 2  Looking forward
- Best case scenario?
- Smallest improvement?

Step 3  Considering options
- What can the patient do?
- What can the clinician do?
- What can others do?

Step 4  Agreeing on actions
DIALOG+ trial

- Cluster randomised controlled trial
- 40 clinicians with 180 patients
- DIALOG+ versus active control
- 6-month intervention period
- Outcomes assessed at baseline, 3 months, 6 months and 12 months

Priebe et al., Psychosomatics Psychotherapy, 2015
Results

• Better quality of life throughout
• Effect size at least as large as for CBT
• Lower levels of general symptoms throughout
• Better objective social situation after one year
• Cost savings over one year

Priebe et al., Psychosomatics Psychotherapy, 2015
Patient experience

“The questions ... made me look and reflect on my life... I’d never addressed some of the issues that I came across in [DIALOG+].”

“You start improving yourself because you’re aware of it now... It made me realise what I needed to do.”

“[DIALOG+ was] more structured, more professional, more focused ... Constructive things were being done about certain issues.”
Clinician experience

“It was structured, it was easy for them also to follow what we are talking about.”

“I got so much more information out of him.”

“I found it the most empowering tool in the 10 years I have been qualified as a clinician. By far.... It definitely changed our therapeutic relationship... By the end really he was very very much in control of his own care.”
Why so effective?

• Addressing patient concerns
• Empowering patients
• Help with communication
Implementation

- All information on dialog.elft.nhs.uk
- Free Apps for all steps of DIALOG and DIALOG+
- For iPad and Android platforms
- Tested/implemented >15 countries
- Clear core principles
- Intentionally brief manual
DIALOG+ for CPA

• DIALOG+ makes CPA:
  - patient centred
  - useful, as it delivers assessment, planning, intervention and evaluation in one procedure
  - therapeutically effective

• Improves patients’ quality of life
CPA Redesign: a “recovery care” process - the journey so far...

Frank Röhricht
- Medical Director Research, Innovation & Medical Education
Paul Binfield
- Head of People Participation
Graham Fawcett
- Consultant Clinical Psychologist
Simon Fewer
- Clinical Systems Manager
The method & the mission

- Started from scratch (blank sheet)
- Started with a vision (endpoint in mind)
- Radical Co-production (Service users, Clinicians, IT experts, Local Authority)
- Objectives: Empowerment, Focus on Quality of Life, simplify processes, foster therapeutic relationships
Why we changed the process - Main Drivers & background

- The new Care Act (2014)
- Change focus of clinical practice re recovery-focused process
- Efficiency/productivity: service user-focused, staff user-friendly (bureaucracy)
- Opportunities arising in the context of new RIO open system
The national agenda: Challenges with current delivery of CPA

- Significant **administrative and data burden** on staff that is frequently associated with CPA delivery
- **Lack of flexibility** in relation to workforce models
- Service users report that experience of CPA is **not recovery focussed**
- Ensure services can **maximise efficiencies** and improved outcomes
- Need to update to bring in line with **opportunities of digital technology**
- Challenges around **integration and joint working** with primary care, social care and housing
- Tensions with discharging duties under the **Care Act**
- Need to better **support co-production** with people who use services, shared decision-making and **recovery-focused care**.
Consultation main findings

- Triangulating National & Local audits & literature with Workshops, common themes:
  - Duplication
  - Value of ‘non-essential’ documentation?
  - Use of electronic systems needed
  - Lack of recovery care focus
  - Care quality issues
  - Staff generating ideas on training
  - Needing service user focus
  - Lack of transparency
How did we start?
- Setting out principles

• Service user expressed needs = priority for care planning
• Clinical documentation / forms should drive good clinical practice
• Assessment process should identify service user skills / capabilities and start with screening for significant health/social/risk management needs
• Care plan with emphasis on self-management
Early decisions taken:

- Use DIALOG PROM as screening tool to guide care planning according to needs identified
- Replacing the concept of “risk” management by “safety plan” and “care plan” by “My recovery plan”
- Mental & Physical health & Safety as mandatory domains, other domains according to individual needs
- To avoid duplication: utilise as screening tool (opening up care planning boxes as required)
- Transparency in documentation re `areas of disagreement (“override”)

We care  We respect  We are inclusive
Building new process: Learning/Adaptation/Transformation

• Starting point: self-defined recovery goals, service user’s strength and capabilities and “What matters to me” question
• Care planning according to structured and service user led needs assessment
• Utilising solution-focused therapy approach as developed in DIALOG+ (plan for action)

- Focus is on the client’s desired future, not their past problems or current conflicts
- Clients are encouraged to increase doing things which are useful (empowerment)
- Small increments of change will lead to larger increments of change (realistic/hope)
- Personalised and outcome driven
Who needs to be involved?

User reference groups:

- 104 members of operational staff have agreed to be part of staff user reference group
- frontline staff as part of Design & Development Group
- IT champions for co-production process
- Recovery Care Plan developed with service user group, based upon EPC template
Back to front: the power of reverse thinking
OUTPUTS FIRST

My Recovery Care Plan

Date: 2 Sep 2016  My Name: Ms Dummy Patient ZZTEST  NHS Number: 999 991 7690

Who gets to see my plan?

Remember 5 ways to mental health & wellbeing:

- Connect - stay in touch with family / friends
- Get active
- Take notice - be more aware of the present
- Keep learning
- Give to others

What Recovery means to me? My long term goals! What I would like to achieve in 12 months time...

- This is my long term goal. I would like to achieve in 12 months
- This is my long term goal. I would like to achieve in 12 months
- This is my long term goal. I would like to achieve in 12 months

What matters to me

- This is test data - for what matters to me
- This is test data - for what matters to me
- This is test data - for what matters to me

My skills, strengths and experiences that will help me achieving my goals:

- This is test data - for my skills, strengths and experiences that will help me achieve my goals
- This is test data - for my skills, strengths and experiences that will help me achieve my goals
- This is test data - for my skills, strengths and experiences that will help me achieve my goals

My key contacts

Care Coordinator:
Alison Naughton
Phone Number:

My emergency contacts:
Discussions and Actions

Date: 2 Sep 2016       My Name: Ms Dummy Patient ZZTEST       NHS Number: 999 991 7690

Mental health discussion and actions

Mental Health discussion and actions
A discussion and action plan for mental health issues.
This is a plan.

Physical health discussion and actions

Physical Health discussions and actions
- Really satisfied with physical health action plan after discussion

Accommodation discussion and actions

Accommodation discussion and actions. Accommodation needs attention - plan for move in autumn.
- Would like to move area away from parents

Leisure activity discussion and actions

Need to be more active.
- Discussion around gym membership.
- Need to decide how often to attend and which classes to join
My Safety Plan

Date: 2 Sep 2016  My Name: Ms Dummy Patient ZZTEST  NHS Number: 999 991 7690

Triggers

| These are the triggers for when I become unwell |
| Remember these triggers |

Action Plan

| This is the trigger action plan that needs to be in place |

Early Warning Signs

| The early warning signs for when I become unwell are....... |

Action Plan

| I need an action plan for the early warning signs |
| This action plan will help me when ................................. |

When Things are Getting Worse

| When things become far worse I will ............. |

Action Plan

| This action plan helps when my symptoms become worse ................. |

How can I best be contacted

| I can be contacted on my mobile phone or at home |

Who can be contacted if I can't be reached

| Please contact my parents when needed, but do not contact my sister |

How will I know when I am out of crisis

| I know I am out of crisis when .......................... |
Testing Process: Piloting the approach

- Identified 8 pilot sites across ELFT (different directorates and clinical settings)
- Pilot from Oct – Dec 2016
- Questionnaire before the pilot regarding staff views about the current CPA process
- Survey Monkey quick feedback during the pilot about experiences using new eCPA
- Evaluation report - Dec
Pre-pilot survey

• shows strong frustration among staff of the existing CPA process, with two thirds (66%) of staff sitting dissatisfaction with current process vs 19% post pilot.
Is the new CPA process and 'My Recovery Plan' an improvement on the old Word CPA Template?

- 60%: Substantial improvement
- 13%: Improvement
- 13%: The same
- 13%: Worse
- 4%: Somewhat dissatisfied
- 19%: Old CPA
- 20%: New eCPA
- 4%: Very satisfied
- 18%: Somewhat satisfied
- 13%: Neither
- 6%: Somewhat dissatisfied
- 0%: Somewhat dissatisfied
Training and rollout:
Key Areas for Implementation

1. Education and Training
2. RiO
3. Comms (patient and staff engagement)
Education and Training

Stage 1 Training – Principles of Recovery (Jan – March/April)

- Co-produced and delivered
- Team based where possible
- Half day to include principles of recovery, principles of a solution-focused approach, overview of the new CPA process and service user journey
- Podcasts of service user experience

Stage 2 Training – RiO process (Feb – March)

- Approx 8 sessions to be delivered to admin leads, performance managers, one local practitioner champion
- ‘Train the Trainer’ approach to support local champions to deliver team based local training (1 hour sessions)
- RiO user guide already developed for pilot
Building the infrastructure

- Open RIO as electronic records platform
- Creating an accessible, user-friendly interface
- Creating hyperlinks for ease of reference and to support work-flow
- Thinking about user-friendly output throughout the design process
RiO Live DIALOG+ Screenshot
Additional benefits

• Aligning care planning and outcome measurement (avoiding duplication)
• Map resource, capacity and skills around DIALOG domains
• Dynamic, intrinsic outcome measuring with a QoL PROM
• Gathering information: why do people come to us for help
Indicative data for services

Pareto: Dialog Dissatisfaction (1-3) scores first point of contact
Closing the loop: independent service evaluation

- Developed in close collaboration with one of ELFTs academic partners: City, University of London

- Project design: evaluation of care planning in community mental health services pre and post introduction of a new recovery care focused process

- Mixed methods: PROMs, process measures, qualitative interviews (staff & service users), ratings of care plans.

- Data collection is on-going – preliminary results.
Evaluation of care planning in community mental health services: a mixed-methods evaluation of a new recovery-focused care planning process

Alan Simpson, Martin Cartwright, Sally Barlow, Graham Fawcett, Frank Rohricht, Paul Binfield
Acknowledgements

- Grace Wood
- Felicity Stocker
- Safdar Shah
- Jaleel Mohammed
- Georgia Templeton
- Talana Adams
- Josef Schwaerzler
- Chris Albertyn
- Anna Verey
- Namita Srivastava
- And everyone else that provided information and help
Mixed methods

• Pre- and post-intervention service user survey, qualitative interviews (staff & service users), ratings of old and new care plans
  – investigating experiences and outcomes

• Process of implementation evaluated using the i-PARIHS framework (Harvey & Kitson, 2016)
  1) the characteristics of the innovation;
  2) the context or settings for the innovation;
  3) the level and nature of engagement of the recipients implementing the innovation;
  4) the facilitation provided to support implementation; and
  5) the outcomes of the implementation.

• Data collection is on-going – preliminary results

• Discuss challenges in evaluating innovative service developments
Intervention

- Revised version of the CPA care plan process
- Incorporates DIALOG+
- Intended to be more person-centred
- Seeks to promote personal recovery
- Focuses on person’s own goals and strengths
Preliminary findings – Staff interviews

12 staff interviews so far… more underway

Sex: 6 Males, 6 Females

Professional Role:
- 7 - Community mental health nurses
- 1 - Team manager
- 2 - Psychosocial Intervention Practitioners
- 1 - Forensic Outreach worker
- 1 - Senior nurse practitioner

Borough:
- 5 - City & Hackney
- 1 - Tower Hamlets
- 4 - Newham
- 1 - Bedford
- 1 - undisclosed

Analysis: Framework analysis – utilising the Integrated-Promoting Action on Research Implementation in Health Services’ (i-PARIHS) Framework
## Sample Interview Questions

### Training, support & facilitation

Can you tell me about how the new CPA was introduced?

Why do you think they introduced the new CPA process?

What sort of support was offered?

### Experience & outcomes

Can you tell me about your experience of using the new CPA process & documentation?

Impact on service users?

Impact on staff?

Impact on carers?

### Contextual factors impact implementation

Are you aware of anything that has helped or hindered the implementation of the new CPA?

- Anything affecting the team?

- Organisational issues?

Informed by the Integrated-Promoting Action on Research Implementation in Health Services’ (i-PARIHS) Framework
Introduction of the new eCPA: Training

The new eCPA was introduced via:

- Team/business meetings
- Emails before training events

- 9 out of 12 staff members attended training of some format:
  - Presentation on Information Technology (RiO)
  - Workshops on Recovery
  - Hybrid training – trialling the new forms with colleagues

- Self study materials available on the intranet
Experiences of Training

- Involvement of Service users
- Support with IT

- Trainer wasn’t a clinician
- Not delivered at right time
- Not enough focus on how to use the new CPA

‘it was good to have a play with it before it became live’ (ST14)

‘it was quite easy to understand but theoretical, when get to practice it’s harder to apply’ (ST3)
Move to the new eCPA: Support Available

Staff expressed that:

- **Technical support** was available – Staff made use of this for specific queries around data transfer
- **Supervision** was a place where they could request further support if needed
- **Colleagues** were other sources of support

‘We learnt how to use it with immediate colleagues’ (ST8)
‘We learnt via trial and error […] Took us some time’ (ST2)
‘Found our way through it’ (ST10)
Perceived reasons for the change to eCPA

1. **Make CPA process Service-user centred**
   - Enables more involvement (patient voice)
   - More collaborative & interactive (e.g. Develop goals)
   - ‘[people] take ownership of their own care and treatment’ (ST3)

2. **Streamline the CPA document**
   - ‘Was unwieldy process before…’ (ST10)
   - Simplify, more accessible
   - Reduce paperwork - digitalise

3. **Support transitions within the service**
   - Promote recovery – help people step down… and move on
   - ‘Ability to send the Care Plan to GP so continuation of care…’ (ST3)
Experience & Outcomes of using the eCPA

Experiences of using eCPA

• Overall, the views of using the eCPA were positive

• Staff spoke confidently about how they worked creatively with DIALOG+

• When speaking about the eCPA staff often referred to improvements made from the ‘old’ version. However, some staff missed some functions

• The format of the documentation was viewed positively when engaging with service user

‘It’s a different format. Print something off, go to the person and use the template to trigger discussions. I found it quite helpful really’ (ST1)
Experience & Outcomes of using the eCPA

Staff views of using DIALOG+

• Staff found DIALOG+ helpful for engaging people in prioritising their own care

‘DIALOG+ is helpful in what goals the person wants to focus on. How they want to do it’ (ST2)

‘DIALOG+ is the heart of the CPA’ (ST11)

• Some potential areas for adjustment were highlighted:
  • Merge domains - Repetition in some areas
  • Relevance to some populations (tailored to age)
  • Reformat questions to aid comprehension – e.g. identity question
### Experience & Outcomes of using the eCPA

#### Positives of the new eCPA

<table>
<thead>
<tr>
<th></th>
<th>Illustrative quotes</th>
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<tbody>
<tr>
<td><strong>Relational</strong></td>
<td></td>
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<tr>
<td>- Supports involvement</td>
<td>‘created more helpful conversations’ (ST9)</td>
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<tr>
<td>- Aids transparency</td>
<td>‘relational interaction is the huge benefit compared to how it was before’ (ST1)</td>
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<tr>
<td><strong>Improved format</strong></td>
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<td>‘reduced amount of paperwork, saves time’ (ST6)</td>
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<td></td>
<td>‘Find information want more easily, less messy, is accessible, more holistic, more user friendly for patients’ (ST10)</td>
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<tr>
<td><strong>Tracking progress</strong></td>
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<td></td>
<td>‘Goals and part of DIALOG+ makes it easier to measure themselves’ (ST2)</td>
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<tr>
<td><strong>Improved Risk assessment &amp; Safety documentation</strong></td>
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<td></td>
<td>‘Safety plan is a better document’ (ST3)</td>
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<td></td>
<td>‘[eCPA] saves things [risk] historically […] doesn't have to be duplicated’ (ST6)</td>
</tr>
</tbody>
</table>
### Challenges of the new eCPA

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Illustrative quotes</th>
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<tbody>
<tr>
<td><strong>Hard to engage some people</strong></td>
<td>‘can be hard for some service users to explain needs’ (ST9)</td>
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<tr>
<td></td>
<td>‘Still have problems when people don’t want to engage[…] I hear from a lot of people – not this again!’ (ST10)</td>
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<td><strong>Lack of integration</strong></td>
<td>‘[documents on RiO] separate to DIALOG+. There are lots of other bits […] so all a bit disjointed’ (ST4).</td>
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<td><strong>Technical glitches</strong></td>
<td>‘When the intranet goes down can’t access anything’ (ST3)</td>
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<td>‘RiO is slow’ (ST8)</td>
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<td><strong>Audit &amp; safety concerns</strong></td>
<td>‘If fill in half of CPA shows up as reporting as done - not accurate’ (ST4)</td>
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<td>‘Previous CPA signed off by consultant. This one doesn’t need to be signed off’ (ST6)</td>
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</table>
Staff Perceptions of Impact for Service Users

1. Realising potential for Recovery
‘Made client aware the CMHT not where they are forever, they can move on’ (ST3)
‘May help them achieve recovery earlier’ (ST5)

2. Engagement & ownership
‘more prone to engage with CPA process. Talk about why not happy with certain things […] improved the involvement’ (ST2)

3. Transparent: See Progress
‘ quantifiable way to see progress’ (ST4)
‘ Transparency and builds trust that we’re doing it for them […] clarify if right, they can see that it is represented in the document’ (ST14)
Staff Perceptions of impact for staff

1. **Process reflects or facilitates recovery-focused work**
   ‘I’ve been a very recovery-centred worker […] Paperwork is coming in line with my working process’ (ST1)

   ‘[DIALOG+] can be a good tool for communication. Talk about things wouldn’t usually talk about. Not nice talking about finances, it’s rude, but it gets you to do it’ (ST10)

2. **More meaningful process**
   ‘enjoy the process more. Like that it’s client led’ (ST7)

   ‘Allows client to make decisions themselves rather than ‘us’ making decisions’ (ST3)

   ‘It’s been a relief to people, not only admin wise – it has meaning’ (ST11)
Experience & Outcomes of using the eCPA

Staff perceptions of Impact for Carers

- Staff didn’t have much experience of interacting with carers for people on their caseload.

- Some respondents speculated what impact the eCPA could have on carers.

‘May be useful to have a copy of DIALOG+ and the safety plan, especially if they are new [to the service]’ (ST10)

‘Doesn’t reflect the carer views of need as well as the last one. Feels tokenistic, where it is in the plan – it was more visible in the old plan’ (ST4)
Broader contextual factors

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Hindrance</th>
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<tr>
<td>Redistributed workload and therefore lower caseloads, more time for clients</td>
<td>Time – initial time transferring forms and getting used to the system</td>
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<td>Present focus on integrated care</td>
<td>Increasing caseloads</td>
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<td>Focus on recovery</td>
<td>Reducing number of staff</td>
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<td>Support with IT - RiO champions</td>
<td>Not involved in the creation of eCPA</td>
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<td>Built into staff development - appraisal process</td>
<td>Technology – e.g. dongles</td>
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<td>Positive feeling in the team – Recovery Champions</td>
<td>Delay in operational policy</td>
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<td>Varied uptake of eCPA can affect transitions</td>
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Summary

- Staff reported that the new eCPA process supported service users in being more engaged with the care planning process

‘Allows client to make decisions themselves rather than us making decisions’ (ST3)

- For some the eCPA process has caught up with how they had been working

  Can’t say it has changed [approach to work] significantly – maybe formalised it a bit (ST7)

- For others the eCPA process provided some structure that they could use to engage with service users in different ways

  ‘[Speaking about DIALOG+] Brings things up, may not have otherwise.’ (ST1)

Interviews with Service Users will be commencing shortly...
Questionnaire Data

Design: Single-group pre-post study

Pre-implementation

Old CPA

Collect evaluation data

Intervention implementation

Post-implementation

New eCPA

Collect evaluation data
Questionnaire Data

Theory of Change

**INTERVENTION**

New eCPA care plan

**PROCESS**

Improved therapeutic relationships

Improved treatment / care

**MEASURES**

STAR-P (V)

Rating scales

**OUTCOME**

Improved personal recovery

RAS (V)
Questionnaire Data Measures

1) Scale to Assess Therapeutic Relationships (STAR-P)
   - Total score (12-items)
     - Positive Collaboration (6-items)
     - Positive Clinician Input (3-items)
     - Non-supportive relationships (3-items)

Questionnaire Data Measures

2) Single-item measures of service users’ perceived involvement in treatment and care plans

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<tbody>
<tr>
<td>1.</td>
<td>Do you feel your <strong>views</strong> about your care and treatment are considered?</td>
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<td>2.</td>
<td>Do you feel your <strong>views</strong> about your future goals are respected?</td>
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<td>3.</td>
<td>Do you feel your <strong>priorities</strong> for your care and treatment are respected?</td>
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<td>4.</td>
<td>Have you been <strong>involved in discussions</strong> about your care and treatment?</td>
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<td>5.</td>
<td>Have you been <strong>involved in decisions made</strong> about your care and treatment?</td>
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<td>6.</td>
<td>Does your <strong>psychiatrist understand you</strong> and is he/she engaged in your treatment/care?</td>
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<td>7.</td>
<td>Does your care coordinator <strong>understand you</strong> and is he/she engaged in your treatment/care?</td>
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<td>8.</td>
<td>Are relations with other staff members here pleasant or unpleasant for you?</td>
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<tr>
<td>9.</td>
<td>How <strong>satisfied</strong> are you with your care plan?</td>
<td></td>
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<td></td>
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</tbody>
</table>

**Not at all** 0 1 2 3 4 5 6 7 8 9 10 **yes entirely**
3) **Recovery Assessment Scale-Revised (RAS)**

- Total score (24-items)
  - Personal Confidence and Hope (9-items)
  - Willingness to ask for help (3-items)
  - Goal & success orientation (5-items)
  - Support from others (4-items)
  - Not dominated by symptoms (3-items)

**Measures**

- I can handle what happens in my life (8)
- I'm hopeful about the future (13)
- I know when to ask for help (18)
- I ask for help, when I need it (20)
- I have goals in life that I want to reach (3)
- I believe I can meet my current personal challenges (4)
- Even when I don't care about myself, other people do (6)
- I have people I can count on (22)
- Coping with my mental illness is no longer the main focus of my life (15)
- My symptoms seem to be a problem for shorter periods of time each time they occur (17)

### Questionnaire Data

**Findings: Comparing completers to drop-outs**

<table>
<thead>
<tr>
<th></th>
<th>All T1 Qu responses</th>
<th>Completed only T1 Qu</th>
<th>Completed T1 &amp; T2</th>
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<td>N</td>
<td>Median</td>
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<tr>
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<td>RAS GSO</td>
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<td>16.0</td>
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<td>RAS ROO</td>
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Questionnaire Data

Findings: Comparing study sample to other studies
## Questionnaire Data

### Findings: Change over time

**Scale to Assess Therapeutic Relationships (STAR-P)**

<table>
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<tr>
<th>No. items</th>
<th>Time point</th>
<th>N</th>
<th>Median</th>
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<th>75%</th>
<th>Z</th>
<th>Sig.</th>
<th>99% CIs</th>
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<td>Positive clinician input</td>
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<td>9.5</td>
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<td><strong>STAR-P NSCI†</strong></td>
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† Higher score = better; adjusted α-level = .01
Questionnaire Data

Findings: Change over time

Scale to Assess Therapeutic Relationships (STAR-P)
### Questionnaire Data

**Findings: Change over time**

Single items assessing perceptions of treatment and care

<table>
<thead>
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<th>ITEM</th>
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<th>T2</th>
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<tbody>
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<td>N</td>
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<td></td>
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<td>9.00</td>
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<tr>
<td>Z</td>
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<td>99% CIs Lower</td>
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<tr>
<td>Upper</td>
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</table>

† Higher score = better; adjusted α-level = .01
Questionnaire Data

Findings: Change over time

Client Assessment of Treatment items
**Questionnaire Data**

**Findings: Change over time**

**Recovery Assessment Scale-Revised (RAS)**

<table>
<thead>
<tr>
<th></th>
<th>No. items</th>
<th>Time point</th>
<th>N</th>
<th>Median</th>
<th>25%</th>
<th>75%</th>
<th>Z</th>
<th>Sig.</th>
<th>99% CIs Lower</th>
<th>99% CIs Upper</th>
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<tbody>
<tr>
<td><strong>RAS PCH†</strong></td>
<td>9</td>
<td>T1</td>
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<td>Personal Confidence &amp; Hope</td>
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<td><strong>RAS WAH†</strong></td>
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</tr>
<tr>
<td><strong>RAS GSO†</strong></td>
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<td><strong>RAS ROO†</strong></td>
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<td>97.0</td>
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</table>

† Higher score = better; adjusted α-level = .01
Questionnaire Data

Findings: Change over time

Recovery Assessment Scale-Revised (RAS)
Questionnaire Data

Summary

- High attrition at follow-up
- No evidence of selection bias
- Powered to detect medium effects
- Baseline sample slightly worse than comparable studies

- Findings show no statistically significant changes for any outcome
- Magnitude of differences at follow-up were marginal
Interpretations

- Why didn’t we find significant **differences**?
  - Not sufficiently powered?
  - Small effects sizes?

- Why didn’t we find **improvements** at follow-up?
  - The intervention (eCPA) has no effect?
  - The intervention (eCPA) has no effect... yet?
  - The intervention (eCPA) was not properly implemented?
  - Unusual (biased) sample?
  - External antagonistic influences?
Care Plan Review

- **Broader goal:** To be able to reliably evaluate content of mental health care plans on a range of person-centred and recovery-focused characteristics

- **Study aim:** To develop an accessible tool to assess care plans and evaluate its reliability

- Worked with service users and clinicians

- Produced construct definitions and explanations

- Tested, revised, tested again

- Simplified scoring
Care Plan Domains

3 over-arching domains
- Recovery-focused goals
- Co-produced
- Strengths-based

5 specific domains
- Social networks
- Wider support
- Treatment
- Self-management
- Safety and risk management
Ratings Exercise

- Raters: 2 psychiatrists & 2 service users
- Discussion, training, practice, testing
- 40 paired care plans (old and new)
- De-identified
- Same order for each rater
- Test of inter-rater reliability
- Can different people make similar judgements on same care plans?
  - If yes, we can use the tool to evaluate care plans
  - If not, we need to think again…
### Ratings Exercise Results

#### ‘Old’ care plans

<table>
<thead>
<tr>
<th>Domain</th>
<th>Alpha</th>
<th>Lower</th>
<th>Upper</th>
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<tbody>
<tr>
<td>Recovery-Focused approach</td>
<td>-0.09</td>
<td>-0.25</td>
<td>0.07</td>
</tr>
<tr>
<td>Co-production</td>
<td>0.18</td>
<td>0.04</td>
<td>0.31</td>
</tr>
<tr>
<td>Strengths-based Assessment</td>
<td>0.02</td>
<td>-0.12</td>
<td>0.15</td>
</tr>
<tr>
<td>Social Networks</td>
<td>0.20</td>
<td>0.06</td>
<td>0.33</td>
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<tr>
<td>Wider Support</td>
<td>0.25</td>
<td>0.13</td>
<td>0.37</td>
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<tr>
<td>Treatment</td>
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<td>0.13</td>
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<tr>
<td>Self-management</td>
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<td>-0.03</td>
<td>0.25</td>
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<td>Safety and risk management</td>
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<tr>
<td>Overall rating</td>
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#### ‘New’ care plans

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<td>Social Networks</td>
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<td>0.39</td>
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<td>Treatment</td>
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<tr>
<td>Self-management</td>
<td>0.23</td>
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<td>0.36</td>
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#### 95% CIs

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<td>-0.25</td>
<td>0.07</td>
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<tr>
<td>Co-production</td>
<td>0.18</td>
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<td>Strengths-based Assessment</td>
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<td>Social Networks</td>
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<td>Wider Support</td>
<td>0.25</td>
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<td>Treatment</td>
<td>-0.03</td>
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<td>Overall rating</td>
<td>0.17</td>
<td>0.04</td>
<td>0.30</td>
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#### Criteria for current study = 0.70

---

**Value of Kappa**

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<tr>
<th>Level of Agreement</th>
<th>% of Data that are Reliable</th>
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<td>None</td>
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<tr>
<td>0.21–0.39</td>
<td>Minimal</td>
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<tr>
<td>0.40–0.59</td>
<td>Weak</td>
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<tr>
<td>0.60–0.79</td>
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<td>0.80–0.90</td>
<td>Strong</td>
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<tr>
<td>Above.90</td>
<td>Almost Perfect</td>
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</table>
Evaluation Summary

• Staff largely positive about the new CPA process

• Staff report:
  – DIALOG+ aids focus on service user priorities
  – Service user views more central to care planning
  – Helps with focus on recovery goals
  – Implementation/training could be tweaked

• Survey results found no change – too early? no impact?

• Quantitative rating of qualitative care plans remains a challenge

• Keenly await results of service user interviews
Community Recovery and Rehabilitation Services: a vision for the future

Dr Sridevi Kalidindi
“A whole system approach to recovery from mental illness which maximizes an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.”

(Killaspy et al, 2005)
A whole system approach to mental health rehabilitation services. Collaborative Care Planning with service users & carers at every stage.

**Referrals**
- Acute inpatient wards
- Forensic/secure services

**Inpatient rehabilitation units**
- High dependency units
- Community rehab units
- Complex care units

**Community services**
- Supported accommodation
- Residential care
- 24 hour staffed tenancies
- < 24 hour staffed tenancies
- Floating outreach
- Vocational rehabilitation
- CMHTs, Rehabilitation Teams, AOTs
- Primary care

**GIRFT**
GETTING IT RIGHT FIRST TIME
Rehabilitation Psychiatry

- 85% Psychosis – longer term conditions
- Treatment resistance
- Negative symptoms
- Comorbidities, psychiatric and physical health
- Functional impairments – Activities of Daily Living
- Challenging behaviour
- Difficult to engage
- Risk

(Holloway, 2005)

~14% of EIP require rehabilitation; earlier transfer better

Approx. 10-15% of those in secondary care, account for 25-40% of the annual UK mental health and social care budget (MH Strategies 2010 & Killaspy 2010)

The principles of rehab are relevant to all Mental Health services
14% of people newly diagnosed with psychosis will require rehabilitation services (Craig et al, 2004)

Long term view/evidence: 65% of this group achieve successful, sustained community living over 5 years and 8% achieve independent living (Trieman and Leff, 2002; Killaspy and Zis, 2012)

Support from rehabilitation services: 8x ↑ achieving /sustaining community living compared to generic CMHTs (Lavelle et al, 2011).

More evaluation data from recent publications – Bunyan, Killaspy, 2016
### Table 1  Admission costs per year pre- and post-rehabilitation

<table>
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<tr>
<th></th>
<th>Pre-rehabilitation</th>
<th>Post-rehabilitation</th>
<th>Statistics</th>
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<tbody>
<tr>
<td>Individual cost, mean (s.e.)</td>
<td>£66 000 (£10 000)</td>
<td>£18 000 (£9 000)</td>
<td>$t_{(20)} = 3.200, P = 0.004$</td>
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<tr>
<td>Total cost ($n = 22$)</td>
<td>£132 4000</td>
<td>£386 000</td>
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</table>
IMPACT OF INSUFFICIENT REHABILITATION SERVICES ON OTHER PARTS OF THE MENTAL HEALTH SYSTEM

Acute Psychiatric Inpatient Delays (16% - Crisp Review)

Out of Area Placements – acute and Rehab; Winterbourne

Revolving door readmissions & Placement breakdowns

Neglect in the community
Community Rehabilitation Team Functions

- Census approach; whole system management; manage budgets
- Advisory function – acute ward/community in-reach
- Ongoing Rehab & Recovery > independence
- Right Rehab complement locally; Service Development; Market stimulation; step down/up
- Maintain placements.
- Rehab OAPS; Manage transitions

[Image]
Recognising housing as a mental health intervention

The provision of supported housing can...

- Reduce hospital admissions
- Reduce the costs related to out-of-area placements
- Reduce the risks associated with tenancy breakdown
- Reduce transfer delays from hospital to home

© Centre for Mental Health, 2016. From More than shelter (2016) available at www.centreformentalhealth.org.uk/more-than-shelter
CQC report: The state of care in mental health services 2014 to 2017

• 3,500 people in ‘locked rehab’ settings. Cost approx 85 million / year across England; total on Rehab approx. 500 million
• Most are OATS and around 2/3 are in the private sector
• OATs are not good value
• Many MDTs are not sufficiently well trained in Rehabilitation, to provide high quality, intensive rehabilitation
IN
SIGHT
AND
IN
MIND

A toolkit to reduce the use of out of area mental health services
March 2011

to contents

https://www.rcpsych.ac.uk/pdf/insightandinmind.pdf
Rehab NICE guidance development currently underway
http://www.rcpsych.ac.uk/workinpsychiatry/faculties/rehabilitationandsocial.aspx
Enabling RECOVERY
The principles and practice of rehabilitation psychiatry

Edited by Frank Holloway
Sridevi Kalidindi
Helen Killaspy
& Glenn Roberts
MORTALITY GAP

In south east London:
- 16 years for women
- 18 years for men

Cause: Most deaths from physical health conditions CVD, Stroke

Partly due to socio-demographic factors – health inequalities

It is ‘lethal discrimination’ at worst, at best, failure to act on evidence
High Dependency Rehabilitation – Length of stay 2016-17

- Average 372 days for patients discharge in year
- London peer group highlighted
High Dependency Rehabilitation – workforce

- Average 19.8 WTE per 10 beds
- Includes clinical and non-clinical ward staff
High Dependency Rehabilitation – Skill mix

- 41% registered nursing
- 43% support workers / HCAs
- 2% Consultant Psychiatry
- 1% Clinical Psychology
- 3% OT
Long Term Complex Care – Length of stay 2016-17

- Average 653 days for patients discharge in year
- London peer group highlighted

Longer Term Complex / Continuing Care - Mean length of stay for patients discharged in year
Getting It Right First Time
Clinically-led programme, reducing variation and improving outcomes
Mental Health Rehabilitation – Dr Sridevi Kalidindi

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement
Introducing GIRFT

Tackling unwarranted variation to improve quality of patient care while also identifying significant savings.

• Review of 35 clinical specialties leading to national reports for each.
• Started in orthopaedics in 2012
• Led by frontline clinicians who are expert in the areas they are reviewing.
• Peer to peer engagement helping clinicians to
  • identify changes that will improve care
  • reduce unwanted variation
  • deliver efficiencies
  • and to design plans to implement those changes – using data.
• Support across all trusts and STPs to drive locally designed improvements and to share best practice across the country.
• Agreed efficiency savings: c.£1.4bn per year by 2020-21, starting with between £240m-£420m in 2017-18
From pilot to national programme

33 programmes underway; 1300+ visits by clinical leads already

Process:

• Engagement - Set data requirements then collect data.
• Trust / CCG / LA – level analysis and tailored reports.
• Visits to every Trust / CCG / LA – develop an action plan.
• Regional implementation support.
• Share good practice.

➢ Egs – Sheffield and NTW – Rehab OAPs reduction (NB capability & in CMHTs and acute inpatients)
  ➢ C&I – good pathway;
  ➢ Croydon (SLaM) – Community Rehab Team;
  ➢ CWP – Rehab acute inreach – reducing acute OAPs

• CQC outstanding Rehab inpatients
• Outputs: National report with recommendations
  • National, regional implementation support - to drive a culture of continuous improvement in trusts.
Through all our efforts, local or national, we will strive to embody the ‘shoulder to shoulder’ ethos which has become GIRFT’s hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement
Involving service users in their care helps recovery

Service user led CPA in inpatient rehabilitation

Dr Rajesh Mohan

raj_psyc
We all know that people with SMI are often not that involved in their care, (CQC, patient surveys & PEDIC) 

...and many decisions are taken for them

Service user led CPA in inpatient rehabilitation

- More participation and shared decision making
- Which would empower service users &
- Foster collaboration to promote recovery
<table>
<thead>
<tr>
<th>Inpatient rehab sample n=24</th>
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<tbody>
<tr>
<td>All patients had SMI/Psychosis of long duration</td>
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<tr>
<td>Multiple past acute/PICU/forensic admissions (&gt;5)</td>
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<tr>
<td>2/3 had comorbid drug &amp; alcohol problems</td>
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<tr>
<td>75% had at least one long term physical disorder</td>
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<tr>
<td>Significant past risk histories (&gt;80% violence risk)</td>
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<td>High treatment needs &amp; support needs</td>
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Defining the process/steps of patient led CPA

1. Co-produce agenda early
2. Coaching to prepare for CPA
3. Assist during CPA by co-chairing
4. Debrief after CPA meeting
5. Obtain formal feedback

My CPA agenda on 01/11/18
Chair: Me Co-chair____
1. ___________________
2. ___________________
3. ___________________
4. ___________________
5. ___________________
Learning from early feedback

- Having a prompt sheet
- Coaching & practice
- Personal goals & support
- Shared decisions
- "No interrogation"
- Positive feedback
- Help reduce anxiety
- Informal approach

We used all informal feedback to improve CPA meetings
Sample questions from prompt sheets

**Self harm**

- Do I feel safe? What can help me feel safe?
- Can staff support me?

**Risk to others**

- Do other people feel safe around me?
- How can I make others feel safe?

**Housing**

- Where will I live after discharge?
- Who will support me to remain well?

We measured the impact..
It is important for me to lead and chair my own CPA meeting. [9]

I felt well-supported by my team and doctor to prepare for my CPA. [9]

People I wanted to support me and answer my questions were at my CPA. [9]

I had enough time in the CPA meeting to cover things that are important to me. [9]

I felt able to speak openly in the meeting about how I felt about things. [9]
I felt able to ask staff to contribute to my care planning during the meeting.

I felt that I had choice and control over decisions about my care during my CPA.

I feel I understand clearly the decisions and care plans made at my CPA.

Chairing my CPA has helped me to focus on my recovery goals and my independence.

I would like to chair my next CPA.
“It gave me a sense of control and confidence”

“I felt free to speak about things”

“Sharing my views, enlightening in a positive way”

“There should be more time to discuss things”

“I felt that everyone was looking at me”

“I have never chaired a meeting before, it felt good to do it”

“People I wanted to be there, did not come”

“It was good to be able to ask questions”

“It is not really my job to chair meetings”

Using this feedback to improve patient experience
In a nutshell, our QI project taught us...

- Service users can be supported to lead their CPA
- Staff need to have skills to enable Autonomy is essential to recovery
- Achieve & maintain the ‘culture shift’
- Reduce length of stay by promoting recovery
Care Planning – Bio-Psycho-Social-Spiritual

3 levels:
Personal, Environmental, Societal

Co-produced formulation
e.g. 4Ps: Predisposing, Precipitating, Perpetuating Plan

Ensure complexity is factored in

Service User prioritised care plans;
Autonomy & salience are essential to recovery

Improve outcomes by promoting recovery:
Hope
Empowerment
Service User led & centred
Whole system care pathways for rehabilitation

- Early intervention
- CMHT & acute & forensic
- Rehab & recovery

Rehabilitation Services are the exit pathways for those with complex long term needs

- Use national data; learn from good practice
- Innovate locally; QI; DIALOG
- Be service user focussed/led
- Collaborate & integrate
Passionate about collaboration: For more information, etc. please contact us…

Tel 020-76554000

frank.rohricht@nhs.net
paul.binfield@nhs.net
graham.fawcett@nhs.net