CAPA Forum Group Activity

Break out discussions on

1. Full Booking to Partnership
2. Letting Go
3. Team Away Days
4. Choice Appointment

People were asked to rotate across four groups and discuss the challenges and possible solutions to implementing the above.

Full Booking to Partnership

Definition

If the service user is going to return for partnership work a system exists whereby they can leave the Choice appointment with a booked Partnership appointment with the selected clinician/s. Full booking to partnership requires a partnership diary and no internal waiting list.

* Full booking extends your capacity by moving clients into anticipated capacity (planned Core Partnership appointments), rather than waiting for capacity to appear. This improves your flow.
* To implement Full Booking to Partnership you need a clinic diary system of blank Core Partnership appointments available to fully book into. This needs team and individual job planning to be done.

***What are the challenges to implementing Full Booking to Partnership?***

***Discuss possible solutions***

Group responses

History of CAPA – Anne and Steve did a lot of the initial Choice Appointments. In NZ we don’t have that resource of very experienced people to just do Choice.

Some services therefore use a post Choice mini MDT to allocate (or not) into partnership.

Post Choice MDTs involve Choice clinicians that have done their Choice Appointments on their given day to determine whether people are right for the service and who the appropriate partnership clinician is.

* Mini MDT post Choice , **benefits:**
* mitigates risks across disciplines
* Stops same person being allocated the same sorts of cases.
* Supports allocation process
* If post Choice mini MDTs held routinely after Choice clinics, service is able to provide a quick turnaround post Choice, with whanau notified. If mini MDTs are held a week later following a Choice clinic, it leads to **bottlenecks**.

Electronic diary – helps identify early when there are not enough partnerships, which can lead to discussion in larger weekly MDT about who could flex. MDT also opportunity to revisit job plans, also assist with transition planning

Choice clinician meeting useful to recap – monitor allocation also – so that partnership clinicians don’t get the same type of cases.

**Question**: How would a psychometric test fit into this? Book out for 6 weeks or wait until results back before booking partnership appointments.

Services generally have limited capacity for psychologist/ psychiatrist to partnership – but default would be general case worker would do first partnership.

When service at capacity – at post Choice mini MDT there is group decision to allocate available partnership appointments and decide who will go on a short waitlist.

Challenges

Concern though is that sometimes the ‘squeaky wheel’ gets seen first.

= Criteria need to be used and reviewed regularly to determine who’s in or out.

Current challenge is that demand in outweighing capacity. Acuity is higher. Primary level services are also struggling. Online directories like Health Point and Linkages are useful to find out what else is provided in the community (though not always easy to navigate!)

Services used to be able to allocate post Choice – but now they go onto a wait list. Then get allocated months later when partnership space available.

Letting Go

Definition and CAPA pointers

* In every family there is work “to do” and for some mental health problems our work may never be done due to the recurrent or persistent nature of the problem.
* CAMHS interventions may involve a burst of intense contact during times of acute difficulty followed by infrequent ‘booster’ contact.
* For families with multiple, complex health and social care needs – it’s important for CAMHS not to work in isolation. Families may continue to need help and support but not always from CAMHS. The sooner we engage EFFECTIVELY with other systems the better we can let go of families appropriately and safely.
* The amount and duration of work we do with families is so much more significant than the referral rate in determining the size of waiting lists.

**Manage variation in closing cases**

* ask what needs to be done to close the case at supervision
* start discussing with families the time when they will no longer come to the service, right from first contact

**Use Care Plans**

* as a team agree on the headings and format of care plans
* include reviews and outcome measures

**A systemic approach to long-term problems**

* ask families with chronic problems what long terms services they need
* develop agreements with partner agencies about how to support families with long term mental health or neurodevelopmental conditions

**Peer Group Discussion (a Letting Go task)**

The service has systems for weekly small group multi-disciplinary discussion (no more than 4 staff) to consider on-going work. This is a “letting go” task as well as developing a learning culture across many clinical competencies. This is NOT the MDT or individual supervision, but may be in addition to these

CAPA involves lots of clinical case discussion. As a minimum there must be discussion of Choice work and Partnership work in addition to individual clinical supervision. This ensures work is safe and on track, supports clinicians, and increases learning in staff. It reduces variation in practice, allows sharing of new ideas and formulations and staff enjoy it!

What are the challenges to implementing Letting Go?

Discuss possible solutions

Group responses

Things to consider

* Asking “The Hard Questions”
* Goal setting at the beginning
* Keeping to our core business
* More collaboration with NGO’s
* Framing expectations
* Individual/group/supervision
* Continues to be a struggle
* Multiple complex issues
* Going on Parental Leave
* Oh but….!!
* Whose needs are being met?
* Anxious picking up next clients
* No appropriate service to transition to
* Level of competence of NGO’s
* Only point of contact

Team Away Days

Definition and CAPA pointers

The service has regular Team away days (at least once a quarter). The agenda is set by the team and involves content to facilitate clinical learning, team relationships and business planning. Management support this time and content and do not scrutinise the agenda

Team away days are absolutely essential in a CAPA system. CAPA teams need to know and trust each other. CAPA is a transparent system. Teams know what each other’s workloads are, their skills, personalities, style of working and outcomes. This can be quite a change from a more traditional system whereby no-one really knows what goes on when you shut your door.

We recommend away days at least four times a year, preferably off site. The whole team needs to be part of the day, but a sub team may organise it. Ensure that it is not just led by the management group. Include admin staff. The content can be wide ranging and depends on the interests and needs of the team at the time. As an example, content we have used includes: talking about the Choice-Partnership transfer, when is it OK to keep from Choice, developing clinical groups, thinking about a school refusal care bundle, reviewing the trust IT system, considering anti-discriminatory practice, doing Tai-Chi!

What are the challenges to implementing Team Away Days?

Discuss possible solutions

Group responses

Team Away day is about

* Focus on the CAPA process. Keep it focussed
* Team building
* Light and creative – involve community
* Decisions/actions
* Pre-book dates for all to attend
* Link Kupu to next hui
* Kaimahi “interest/passion” – champions – sub groups work on identified areas
* Buy in! – no surprises
* Bottom up
* Back to Basic’s – drifted away from original Kupu – TEAM CARE
* Split day – mane – mahi – afternoon – fun
* Mixing development clinical need and fun
* CAPA not reviewed, discussed – KPI’s co design with MoH
* Staff changes – management “wants/needs” to be CAPA not KPI
* Sub groups work on identified areas
* Support from manager
* Expected to have them – 4 x per year
* Planning – dates/years away days
* Priorities by team – focus
* Staff enjoy them – nice activities, movies/lunch
* Staff present study days, issues of concern – CAPA, in-service training
* Cover by other services to allow all staff to have day together
* Positive day, mix of work and activity
* No work days helps with difficult team dynamics
* 6 monthly
	+ Noho marae
	+ CAMHS day (training
* Moved away from CAPA focus to other demands
* Agenda is important – fun is also important

Barriers

* + Competing demands (eg. Rising to the Challenge, KPIs)
	+ Lack of cover/willingness to cover
	+ Time
	+ Organisation
	+ Anxiety
	+ Cost
	+ Not a priority
	+ Clinical time
	+ Lack of staff buy in
	+ Perception that managers won’t support it
	+ Waiting list
	+ Whaiora are more important
	+ Meeting fatigue
	+ Lack of action
	+ Started with hiss and roar – then fizzled out
	+ PTSD – uncertainty
	+ No fun (management don’t allow) – staff don’t enjoy them
	+ Venue – has to be free or staff contribute own money

Choice Appointments

At the beginning of the Choice appointment, all clinicians ensure that service users are informed about what will happen. All clinicians work in a Choice framework. Clinicians complete appropriate tasks for clinical governance and risk management.

* + Curiosity about the service user’s view
	+ and our reflected opinion;
	+ evolving a Joint Formulation followed by a
	+ Discussion of Alternatives (not all involving mental health services) ending in
	+ The [Choice point](http://www.capa.co.uk/choice/choicepoint.html)
	+ Maximised by their engagement tasks

Engaging

Engaging and motivating service users is key to CAPA. From the initial Choice appointment everything should feel personalised, collaborative, useful and focused. We help the person make sense of their experiences, motivating them to change things and offering them alternatives that may help them reach those goals. It helps to explore things they have already done so that they can build on these. It is also worth being open about the possible consequences of not changing things.

Joint Formulation

Reaching a shared understanding of the problem (i.e. a joint formulation).

For the client to engage in change they need to know what interventions may help and what these involve. How often are we explicit with people about what a particular therapy is like or how long it may take for things to improve? They need warning that things may seem to get worse before they get better (e.g. a ‘compliant’ daughter who now has anorexia nervosa may turn into a ‘stroppy’ teenager as they recover). Only after we have had these explicit conversations can clients truly make an informed choice about what they want to happen.

There is likely to be a range of interventions that may help them. Rarely are the problems we see pure and present in isolation.

Agreeing things they can do to help themselves further engages them in the change process and builds on their self-efficacy.

What are the challenges to implementing Choice Framework?

Discuss possible solutions

Clinicians

Choice clinicians need to be skilled. Skilled role includes:

* Mental health issues/formulation
* Knowledge of partnership clinician skills
* Knowledge of community
* Engage people/ motivate
* Risk management
* Therapeutic rapport

Is CHOICE a good match for that clinician?

New staff

Choice clinicians group to support people doing Choice

More senior people available to consult with.

Clear goals – to help move through system.

Reviewing time spent = comprehensive assessment

 = assessment letter

 = on travel

Assessment default setting for clinicians and take it into Choice.

Choice is not triage and not doing a full initial assessment. Choice template different from full assessment template.

Choice appointment

What’s the problem?

What has the client tried?

Who is best to help?

Strengths?

Listening to the story and what’s helpful.

Screening - short term

* medium term
* Long term needs

Intervention as part of Choice

To achieve consistency consider – template, small group discussion post choice? Dedicated clinicians, targeted Choice appointments e.g. Infants, FDS.

How time is allocated

Brief versus comprehensive – are we the right service? Too brief and information could be missed

Too much time on Choice Appointment – mow screening triage

Not expected to enter anything into CPA

Summary /diagnostic signpost

Update risk assessment => change letter to reflect this

Goal setting – can’t let go without goals

Use MDTS to discuss cases that you’re unsure on. Consider first are they right for the service?