Old and New Ways of Working

Rebecca West – Senior Occupational Therapist and Team Manager

Rebecca.West@nyypct.nhs.uk

Amber Cooperthwaite – Senior Occupational Therapist

Amber.Cooperthwaite@nyypct.nhs.uk

Assertive Outreach Team York & Selby

North Yorkshire & York Primary Care Trust

Workshop Outline:

- Setting the Scene:
  - Who are we?
  - How did we get here?
  - Key Influences
- Rationale for Change:
  - “Frustration”
  - Time to reflect
- Something new is needed!
- The Recovery Pathway

Community Outreach Team (2000 – 2004)

40 Clients 4 WTE Key workers

9am – 5pm Monday to Friday

Assertive Outreach Team (2004 onwards)

92 Clients 10 WTE Key workers

8am – 8pm Mon to Fri &

9am – 5pm W-ends & Bank Holidays

Selby & York AO Staff Compliment
May 2009 - Clients: 92 (Capacity)

Nursing Staff:
- Band Six – 4
- Band Five – 1

Medical Support:
- Consultant Psychiatrist – 0.7
- SpR – 0.6
- SHO – 1

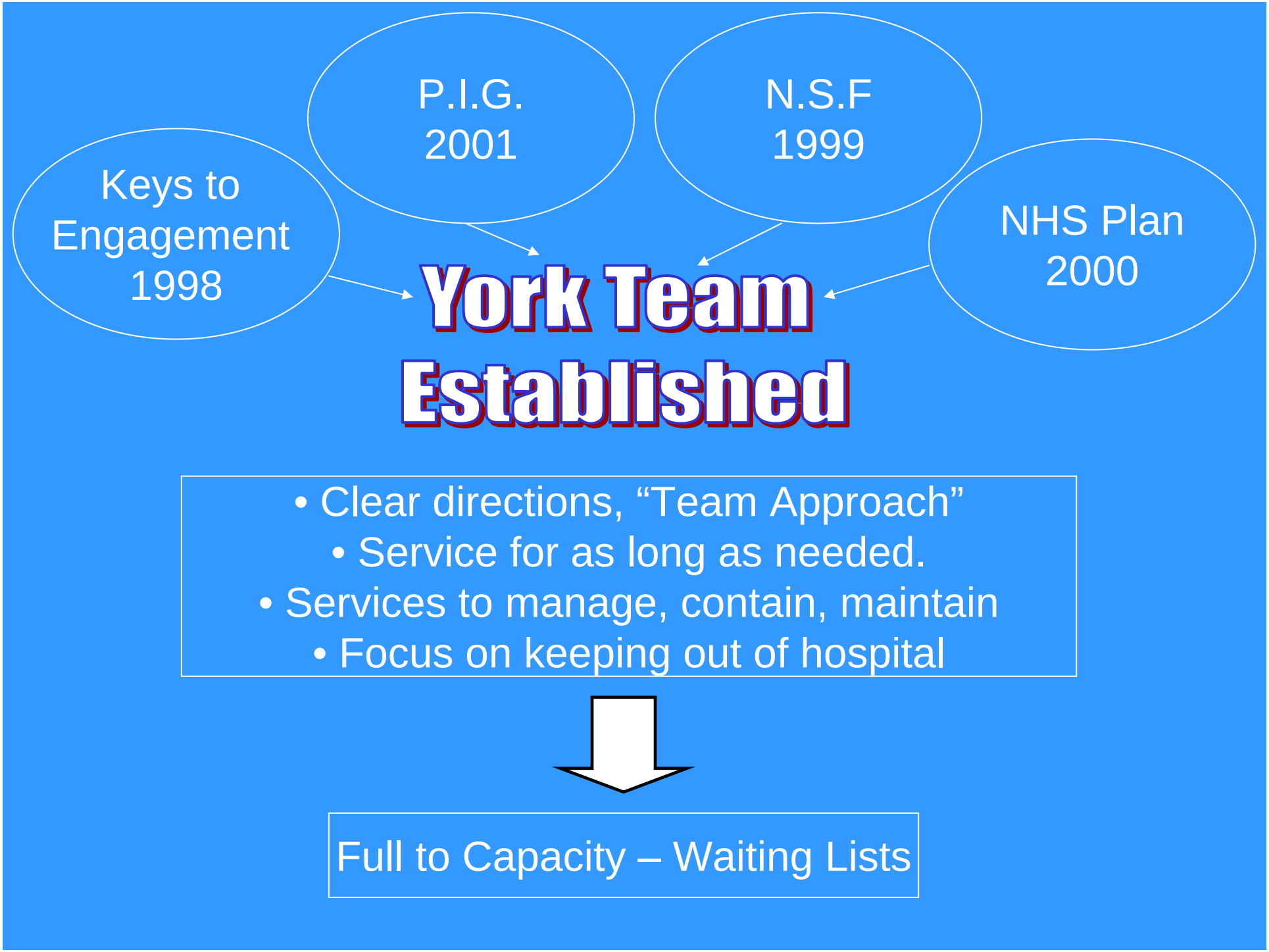
Psychologists:
- Clinical Psychologist - 1

Social Workers:
- AMHP – 1
- Band Five – 2

Occupational Therapists:
- Manager, Band Seven – 1
- Band Six – 2

Recovery Support Workers:
- Band Three – 4.2

Admin Support:
- Medical Secretary – 1
- Secretary - 1


P.I.G.
2001
N.S.F
1999
Keys to
Engagement
1998
NHS Plan
2000
York Team
Established
• Clear directions, “Team Approach”
• Service for as long as needed.
• Services to manage, contain, maintain
• Focus on keeping out of hospital
Full to Capacity – Waiting Lists

Policy Implementation Guide (2001)

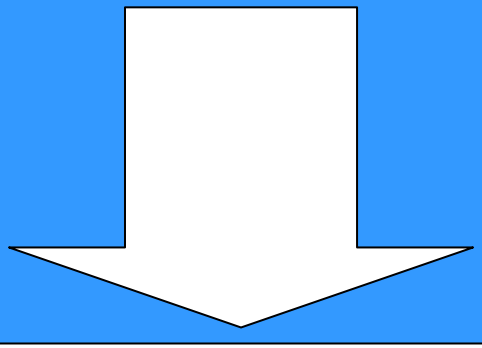
"the service shall support service users and his or her family for sustained periods"

"treatment should be provided on a 'long-term' basis with an emphasis on continuity of care"

"As long as there is evidence of benefit, Assertive Outreach should continue indefinitely"

Team Approach – Key Themes

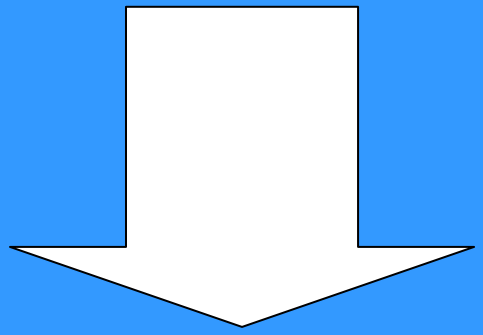
- Staff know and work with all service users.
- Continuity of care is provided by the team as a whole.
- The collective skills and experience of a whole team are made accessible to all clients.
- Workers act together in decision making.
- Shared responsibilities towards all clients.
- Dependence on individual workers is reduced – staff are interchangeable.
- Staff burnout is reduced.



2004 Onwards

Recovery Messages:

- Focus on strengths/ hopes
- Maintenance is not enough
- Moving on from services
- Positive risk taking
- Changing perspectives on the chances of recovery



Working Towards Recovery – A Familiar Phrase

"Recovery is the personal journey of an individual, the process of rebuilding a meaningful, satisfying and valued life" (Rachel Perkins, 2002)

"It involves individuals taking small, concrete steps. Setting goals and breaking down large tasks into manageable steps" (Rethink , 2004)

"If we want to develop recovery orientated services we need to offer systematically, organised and personally tailored collaborative help, treatment and care in an atmosphere of hope and optimism" (Lester & Gask 2006)

2008

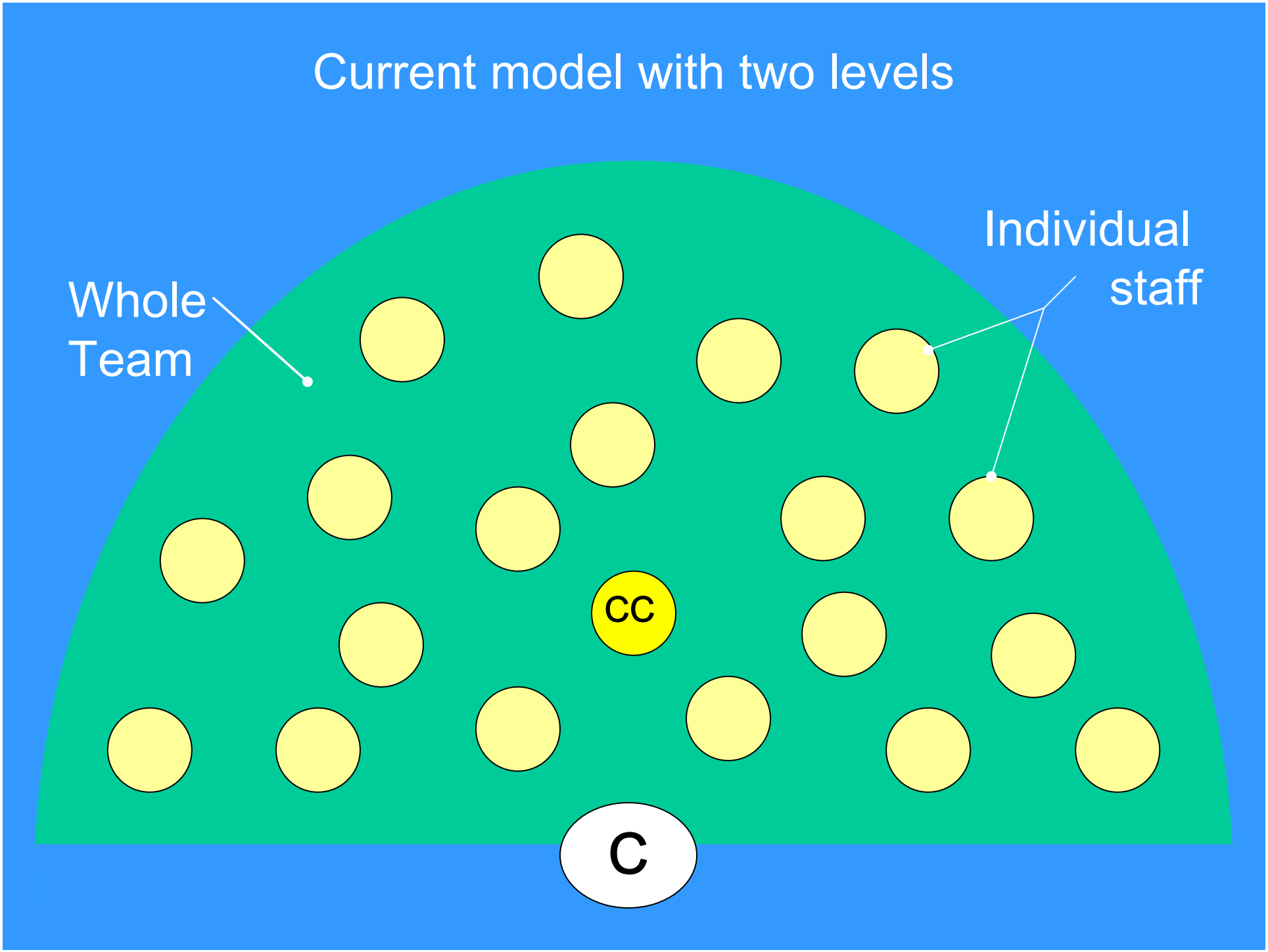
- Services Forever vs Rehabilitation & Moving On – unclear messages

- Full Caseloads – Waiting Lists

Implications for Clients & Families
Challenges for Workers

Frustrations

- Staff having too much work to do – not enough time.
- Staff not applying their own “professional” skills as effectively as they would like.
- Assumptions that “the team takes care of it” – things are missed.
- Clients finding they are telling the same thing to lots of different workers, loss of continuity.
- Staff feeling they are all performing a similar role.


Current model with two levels
Whole Team
Individual staff
CC
C

Whole Team Approach – In Our Team

- Everyone can work with everyone
- Allocate staff resources at a central level.
- Everyone involved in decision making.
- Who does what work is decided in the morning meetings.

The Hub Of it All!

Clients regular set appointments

Tasks from team diary

Crises

Tasks already in staff diaries

Morning Meeting 45 minutes

Cancelling client visits

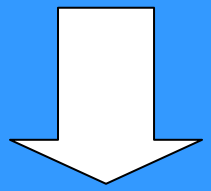
Hoped for admin time lost

Appointments not covered or shorter “pop-in” visits

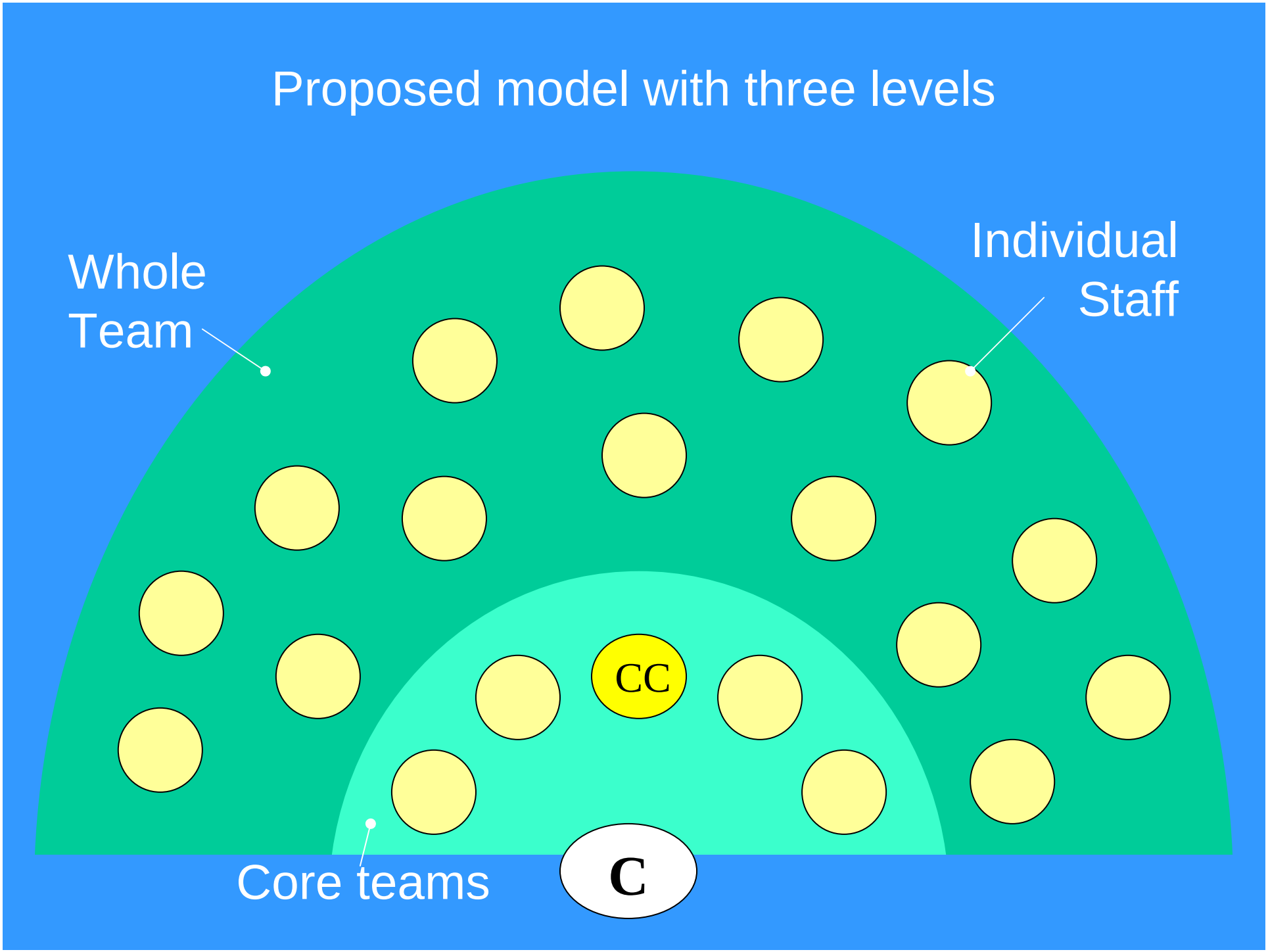
Does it Have To Be Like This?

What Did We Want?

- Allocation of work to more closely match resources
- Ensure the positive aspects of “team approach” were not jeopardised.
- Work more effectively with recovery goals



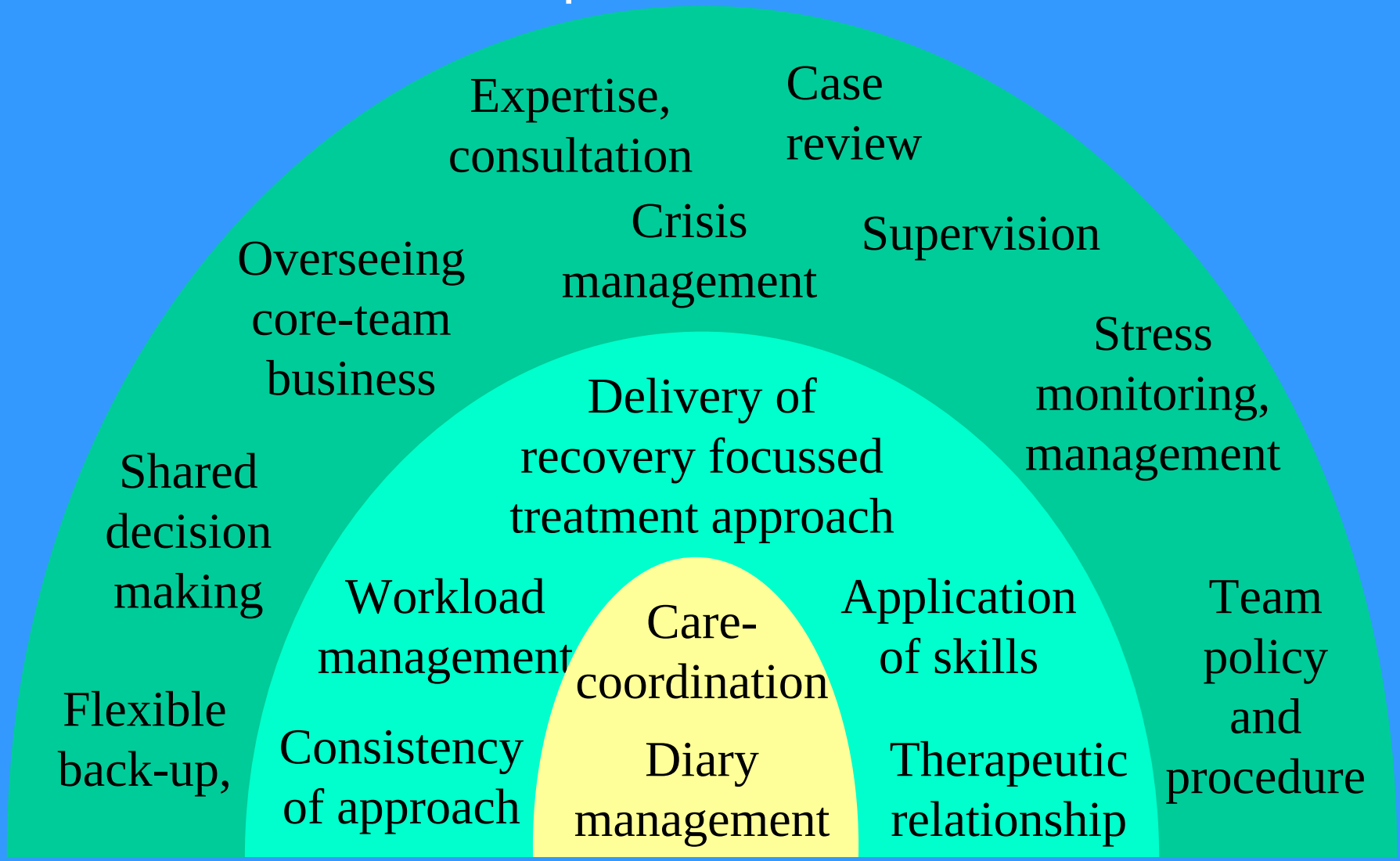
Introduced 3rd aspect to the model
“Core Team Level”


Proposed model with three levels
Whole Team
Individual Staff
CC
C
Core teams

Core Team Level

- An intermediate level between whole team and individual level.
- It’s a balance between the other two.
- Has the capacity for all various factors without any of weaknesses of the two extremes.
- The core team level good enough at enough things so it can do recovery work

A breakdown of different several aspects of team working by level at which these may possibly be best performed



Does the Whole Team Approach Best Support Recovery Focussed Work?

Recovery Pathway Development

- Developed by a multi disciplinary group
- August 2008
- Within the first stages of implementation, auditing and evaluation
- Piloting since May 2008
- 6 months of implementation we plan to gather all evaluating material and make changes as necessary

What is the Recovery Pathway?

- Development and extension of other validated needs assessments
- A needs assessment that has been developed specifically with the AO population and service in mind
- Purpose of assessing service user need AND to guide the AOT in providing interventions or support to MEET the service user need
- Links into the CPA process and offers a systematic approach to service delivery

What do we achieve from using it?

- Holistic, comprehensive and user centred assessment
- Empowers service users to become actively engaged in care planning and goal setting
- Strengths approach
- Simple to use, user friendly, uses non jargon language, promotes collaborative practice
- It provides a system to coordinate all the work we do within AO

- Provides consistency, structure and assist in the prioritisation and achievement of recovery focused goals
- Shares with the service user what support can be offered
- Outcome measure - is responsive to changes in need from one point of time to another
- Can be used as a measure of service, based on the interventions offered

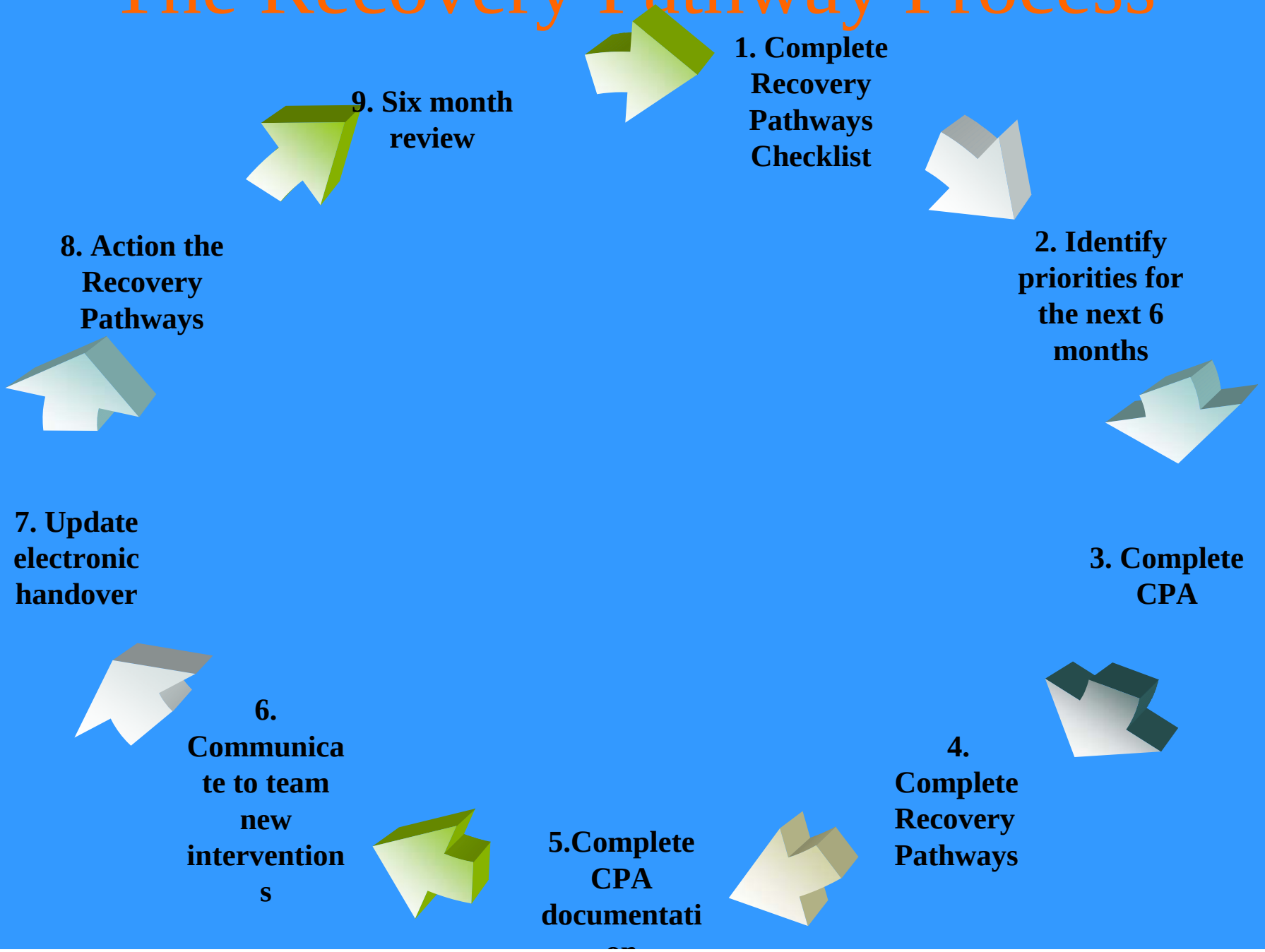
But most importantly…where other assessments stop….the recovery pathway keeps going…….

- Not just an assessment of need
- Goes further to ensure that need is directly linked to the provision of clear interventions and services that AOT can offer to support client recovery goals
- Guidance within AO interventions and shares these interventions with service users in order to MEET THE NEED

How it all actually works

- The Recovery Checklist
- The Recovery Pathways – collaborative goal/care planning
- Links into the Care Programme Approach
- Links within communication

The Recovery Pathway Process



York AOT Recovery Pathways Checklist ***Name:***

Date: ***Assessor:***

Area			*Mark strengths with 'S'* ↓	Need/problem to person YES/ NO MAYBE	Need/problem to others? YES NO who?	Wants help? YES/ NO	Priority? Now/Med/Long	Care Plan New/continue/completed	Notes
1. Self-care	1.1	Physical health or disability							
	1.2	Diet – healthy eating							
	1.3	Cooking							
	1.4	Personal care (hygiene, dental, appearance, etc)							
	1.5	Keeping fit							
2. Living skills	2.1	Accommodation - access							
	2.2	Accommodation - managing							
	2.3	Shopping							
	2.4	Managing money							
	2.5	Transport							
3. Occupation	3.1	Daily routine							
	3.2	Leisure							
	3.3	Work and education							

Area			*Mark strengths with 'S'* ┐▼	Need/problem to person? YES/NO MAYBE	Need/problem to others? YES/NO who?	Wants help? YES/NO	Priority? Now/Med/Long	Care Plan New/continue/completed	Notes
4. Social and relationships	4.1	Engaging and getting help							
	4.2	Social and communication skills							
	4.3	Relationships							
	4.4	Community involvement - cultural, spiritual, political							
	4.5/6	Child care and / or Child protection							
5. Mental health recovery	5.1	Anxiety							
	5.2	Depression							
	5.3	Mood swings and high mood							
	5.4	Unusual thoughts & experiences							
	5.5	Obsessive thinking / compulsive activities							
	5.6	Problems with forgetting & understanding							
	5.7	Trauma and life experiences							

Area				Need/problem to person?	Need/problem to others?	Wants help?	Priority?	Care Plan	Notes
Mark strengths with 'S' ▼				YES/NO MAYBE	YES/NO who?	YES/NO	Now/Med/Long	New/continue/completed	
MH Recovery	5.8	Identity, self esteem and confidence							
	5.9	Staying well, coping with setbacks and crisis plans							
6. Substance misuse	5.10	Self-medication	*oral*						
			depot						
	6.1	Smoking							
	6.2	Alcohol use							
	6.3	Drug use							
7. Safety	7.1	Survival skills							
	7.2	Self-harm							
	7.3	Suicide							
	7.4	Harm to others							
	7.5	Legal and offending							

Any other areas of concern/problems/need?	**What does person want to discuss at the CPA Review?**
Person's progress towards goals or aspirations since last assessment/ review?	**CPA Review preparation:** Date of review: Got letter? YES / NO Agreement on time, location, and people invited? YES / NO If NO, changes needed:
Person's priorities and how Outreach Team can help:	Anyone else you want to invite? Have you made appointment with GP for physical health check? YES / NO If NO, reasons/actions:

The Recovery Checklist

- Consists of 37 aspects of life, based on the examples of need that AOT clients have had, in 8 broad areas
- Explores strengths as well as potential needs
- Highlights if other concerned parties think there maybe a need
- Assists in prioritising needs, services and care plans
- Prioritise 3 or 4 recovery goals
- Back page highlights any other area of concern, progress, priorities and how AOT can help, and CPA preparation

Linking into CPA

- Checklist is completed a couple of weeks prior to a CPA
- Completed checklist is used within the pre CPA clinical discussion
- Acts as a point of referral to relevant team members
  - Focussed recovery interventions
- Within the CPA the checklist is utilised as a structure and guide to ensure all service user views and goals are discussed
- After CPA discuss prioritised goals using the Recovery Pathways

Examples from The Recovery Pathway

1.4 Personal care (hygiene, dental care, chiropody, hair care, and appearance)							
You	I need help to manage my self-care	I am aware of my personal care needs	I understand what tasks to do and the changes I need to make	I need regular assistance to manage self care	I sometimes tend to my self care needs but need to do it regularly	I usually have a good self care routine	I am happy with my personal care and appearance
The Team	Assessment of causes, skills and motivation	Information/ education	Goal setting and activity planning to organise a routine. Skills training.	Practical support, help to make/attend appointments, carer/paid carer input	Help to maintain self care routines, prompts, positive reinforcements	Monitoring	No AOT help needed

2.2 Accommodation - managing							
You	My tenancy/ ownership is currently at risk	There are lots of problems with my accommodation: bills, keeping it clean, neighbours, etc	I need help to get organised paying bills and looking after my home	I need someone to do things for me at home	I need more support as I am unable to live on my own		I can manage my accommodation on my own or with help
The Team	Assessment, advice/ information e.g. advocacy/ legal support	Support and liaison with CYC tenancy enforcement, estate management, etc	Practical support: skills training/ development, payment plans set up, referral to supported living scheme, etc	Support with direct Payments, Sect 117 aftercare e.g. cleaning service	Referral to MH Accommodation Officer, Supported Living Schemes,etc	Monitoring /liaison with supports	No AOT help needed

5.4 Unusual thoughts and experiences

You	I need help to manage unusual thoughts/ experiences	I understand thoughts/ experiences	I know my own causes, triggers and patterns	I have coping skills to manage thoughts/ experiences	I can self manage with some assistance from others	Independent self-management	Confident to manage on my own
The Team	Assessment and formulation	Information/ education	Medication/ management	Practical support	Basic coping strategy enhancement	Groups or group work	Structured CBT/ individual therapy	Monitoring	No AOT help needed

7.4 Harm to others

You	I need help to understand or manage violence	I understand my violence – causes and effects	I have alternatives to violence and can act to keep others safe in a crisis	I am using coping strategies/action plans/ support to manage risks	I am working on issues linked to violence	I am managing/reducing my violence (with non-mental health support)	Confident to manage on my own
The Team	Assessment and formulation inc. legal issues	Information / developing a shared understanding	Harm minimisation: public/others protection, safe environment, coping strategies, accessing support	Practical/supportive work e.g. communication skills, anger management	Structured individual or group therapy	Regular assessment and monitoring	No AOT help needed

CPA Documentation

- CPA plan uses the Recovery Pathway headings and language
- Service user priorities and focused interventions are first within the care plans
- Continuous/ monitoring needs are also included with CPA plan although may not need intensive work
- Coordination of assessment, planning, interventions and services
- Ensuring service user input within care plans

3.3 Work and education (including literacy and numeracy)

You	I need help to develop work/education activities	I understand my options and support available	I have short and long term goals	I am developing the knowledge and skills to meet my short term goals	I am working towards long term goals with occasional support	I am meeting my occupation needs myself
The Team	Assessment of strengths and interests checklist	Information and goal setting	Skills and interests development/practice	Short term, interest led courses, voluntary work	Education or work with AOT/external support	Monitoring	No AOT help needed

NEED

Work and education 3.3

Mr X has expressed an interest in completing voluntary work. He understands his options and the support available and is working towards long term goals with occasional support.

INTERVENTION

AOT to provide Mr X with relevant information and assist in goal planning.

AOT to support Mr X in accessing voluntary options.

SERVICE

AOT: 01904 553170

CVS: 01904 621133

5.4 Unusual thoughts and experiences

You	I need help to manage unusual thoughts/ experiences	I understand thoughts/ experienc	I know my own causes, triggers and patterns	I have coping skills to manage thoughts/ experiences	I can self manage with some assistance from others	Independent self-management	Confident to manage on my own

The Team	Assessment and formulation	Information/ education	Medication/ management	Practical support	Basic coping strategy enhancement	Groups or group work	Structured CBT/ individual therapy	Monitoring	No AOT help needed

NEED

Unusual thoughts and experiences 5.4

Mr X has experienced difficulties as a result of his unusual thoughts and experiences. When unwell he is at risk of self neglect and disengagement from mental health services.

INTERVENTION

Mr X to have weekly visits from AOT (Saturday) to discuss any concerns and to offer support as necessary.

AOT to discuss early warning signs and coping strategies and with Mr X .

AOT to provide Mr X with weekly medication and monitor compliance and side effects.

AOT to increase supportive visits and provide Mr X with his medication more regularly should there be concern.

- CPA Care plans need to consider all areas of needs
- Service user priorities/goals go first on care plans
- All other areas go below priorities – needed for monitoring and risk management – communicating within the AOT and with other services involved
- Headings and language from the Recovery Pathway are used throughout to ensure consistency and structure.

Links into Communication

- AOT clinical reviews
- Electronic handover to identify current focus using areas identified
- Acts as quick guide to all staff members
- Guidance to staff for allocated visits
- Structure to visits
- Clearly identifies a plan of action
- Enhances coordination and consistency

Client Name	Recovery Pathway / CPA Interventions:	Risk Information relating to visits	Current Mental State / Information
Mr X **CPA:** 19/9 **Care Co:** AC **Meds:** Depot **Visits:** Thur & Sun **Medical Input:** Liz **CORE GROUP:** Staff Next Appt AC 15/9 JH 22/9 DE 25/9 RB 29/9	**1.3 Cooking:** Plan to increase cooking skills Recovery pathway heading Sun: Complete cooking plan **2.4 Managing money:** Practical support to assist paying bills Thu: accompany to pay point and pay £6 water & £34 rent **3.2 Leisure:** Plan to increase activities at home / outside **- Relevant section of Care Pathway** Invite to teatime group, encourage social activities **- Actual plan** **5.9 Staying Well:** Assessment and formulation: Monitor and assess mental health Medication Plan: Depot fortnightly at clinic	**EWS:** Non attendance of appts, Isolation, Stopping medication. Use of alcohol to excess at times. Hopelessness. Disengagement.	12/08 Paid bills. Did not initiate interaction. Discussed psychotic delusions. PLAN: Agreed to cook Sunday, see at flat – PLAN clearly documented 12/08 Attended tea time group 15/08: Completed cooking, less prompting required, enjoyed session. PLAN: Agreed to see Rachel on Thursday for bills

What's next……

- The most important thing!
- Action the care plans
- Promote engagement, hope and optimism
- 6 month review
- Complete Recovery checklist – review/evaluate strengths, needs and goals
- Repeat the CPA and Recovery Pathway processes
- The Recovery Pathway can be used to demonstrate achievements and movement towards desired goals

Service user comments so far…….

"It helps you think of good things as well as needs"

"It's thorough and comprehensive"

"Helps you to focus on what you want to do"

"I like seeing what AOT can do to help me"

"Good to get own views across"

"Survival skills….what's this?"

"Similar to any other assessment"

"At first she asked why she couldn't use the more simple 'old assessment', but after the tool was explained and the first need completed she got on fine"

AOT comments so far…..

"Helps us to be more systematic within interventions"

"Its sometimes hard to follow up from the CPA with the Recovery Pathway document, can we take out checklist and Recovery Pathways together?" (Yes)

"Helps us focus on specific work, as well as the bigger picture of rehabilitation and recovery within AO"

"Revisiting strengths and needs is good, helps clients see that they are achieving something"

"It helps highlight further pathways, for example drug work, areas of focus and priorities"

"It's good, it just ties everything up together within AO"

"It's giving recovery to clients rather than AOT just being like a safety net, increasing independence and self resilience, not just us monitoring"

Summary

- Explained why, what and how
- Still in early stages
- Plan to evaluate and make changes as necessary in November 2009
- So far it appears to be achieving what it was set out to do:
- An assessment tool developed with the AO service in mind and the group of people we are serving.For the purpose of assessing client strengths, needs and goals as well as providing structure and a systematic approach to coordinating and organising recovery focussed interventions and goals.

Any Questions or Comments???