South West Yorkshire Partnership NHS
NHS Foundation Trust

With all of us in mind

Caseload activity audit

Wakefield Learning Disability Service

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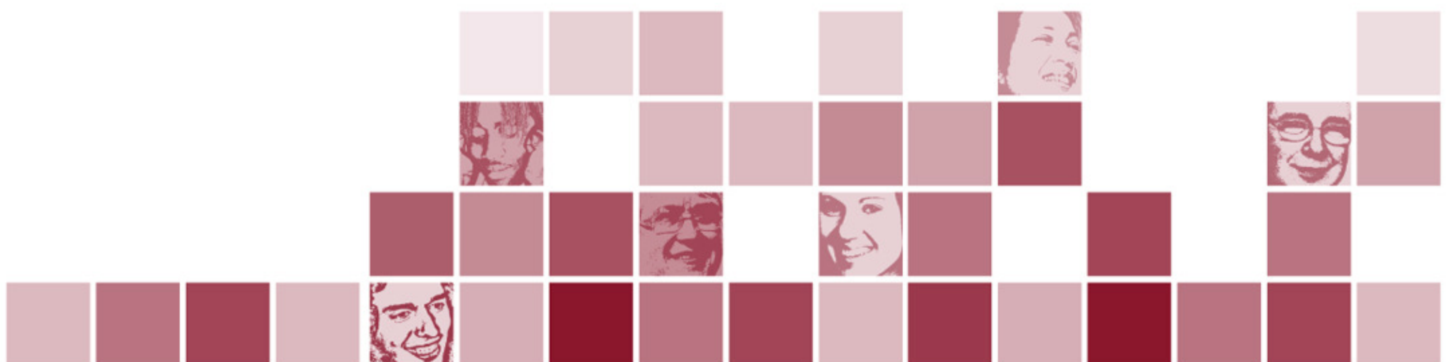

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Please note:
Percentages throughout this report may add up to +/- 100% due to rounding up/down.

EXECUTIVE SUMMARY

The Clinical governance support team (CGST) was commissioned by Ann Rutter, Service Manager in Learning Disability Services in Wakefield to support an audit of caseload activity of community nurses deployed in local authority areas.

Expectations and pressure in services are constantly changing due to: new policy or evidence, specific local needs and consumer demands. In the care of people with a learning disability this can be particularly demanding as demographic changes prevail and both commissioning and clinical need grows exponentially in this vulnerable group. Similarly services are challenged to provide good quality services in climate financial cutbacks along with increasing quality. In addressing some these issues this important audit will inform service development to fulfil the directions of regional health framework and the implementation of the recommendation from Chief Nursing Officer's review of LD nursing.

'Learning disability nurses provide a vital contribution to the well-being of people with learning disabilities. They work through providing direct care and support to those with complex needs and their family carers, and also through helping other health and social care workers respond appropriately. It is important that we consider how the valuable resource of learning disability nursing is best applied to have the greatest impact in contributing to well-being in the future.' (Christine Beasley CNO (2007)

The main conclusions are:

- The total number of clients on the caseload ranged from 5 to 47, with an overall total of 362.The RNLDs had a total of 295 cases (mean number 27, range 5-47) and the HCSW had 67 cases (mean number 17, range 12-20).
- Overall the highest proportion of cases was moderate (41%), followed by severe (35%) and mild (24%) and the highest proportion for risk was mild (42%), followed by medium (33%) and severe (25%). Overall the highest score for challenges and demands was managing clinical risk / crisis (3.4) and demand from private services (3.2).
- The total number of referrals during the audit period was 53: 30 emergency referrals, 10 out of district referrals, 51 continuing healthcare assessment referrals, and 52 actual continuing healthcare assessments undertaken.
- The main diagnoses were challenging behaviours (38%), diagnosed mental health problems (26%) and epilepsy (23%). Additional activities during the audit period that lasted for over an hour totalled 227.

The main recommendations are:

- Longitudinally there is the potential to gather some of the data collected by this audit to provide robust management/ commissioning information either in sample (activity periods such as in this one) or in an ongoing manner.
- The potential for the introduction of a caseload management tool is explored to enable caseloads to be managed in an evidenced manner with an outcomes focus

so that introduced interventions employed have care plan time scales to enable precision monitoring of activities for all cases particularly those on case loads over one year.

- The role of the nurse in level 1 of the pathway is clarified to identify the specific requirements of the roles and interface with level 2.
- All additional activity is commissioned appropriately within agreed guidelines with service manager's and that user of the service understand limitation and option to meet specific need.
- The teams examine lean/news ways of working in the management of workload pressure including the high intensity areas of mental health, challenging behaviour and medicines management in the community.

1. INTRODUCTION

The Clinical governance support team (CGST) was commissioned by Ann Rutter, Service Manager in Learning Disability Services in Wakefield to support an audit of caseload activity of community nurses deployed to local authority areas.

1.1 Background

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has a number of community nurses deployed to local authority areas. Their roles are diverse and become increasingly pressured due to local and national policy demands.

The audit will provide evidence to enable senior managers to support their deployment responsibilities, understand individual and team activities, advise local authorities and support future commissioning.

1.2 Aim

To audit case load activity of community nurses deployed to local authority areas.

1.3 Methodology

The project team developed an audit tool which was disseminated to the community nurses in Wakefield in July 2009.

The completed audit forms were returned to the CGST for data entry.

CGST performed the analysis using the PASW (formerly SPSS) software package and produced a report.

All aspects of confidentiality were maintained throughout the project.

1.4 Staff involved

Ann Rutter	Service Manager Wakefield Learning Disability Service
Nigel McLoughlin	Lead Professional Nurse, Learning Disability Service
Hazel Baxter	CGST Lead for Older Peoples & Learning Disability Service
Suzy Whitehead	CGST Clinical Audit Facilitator

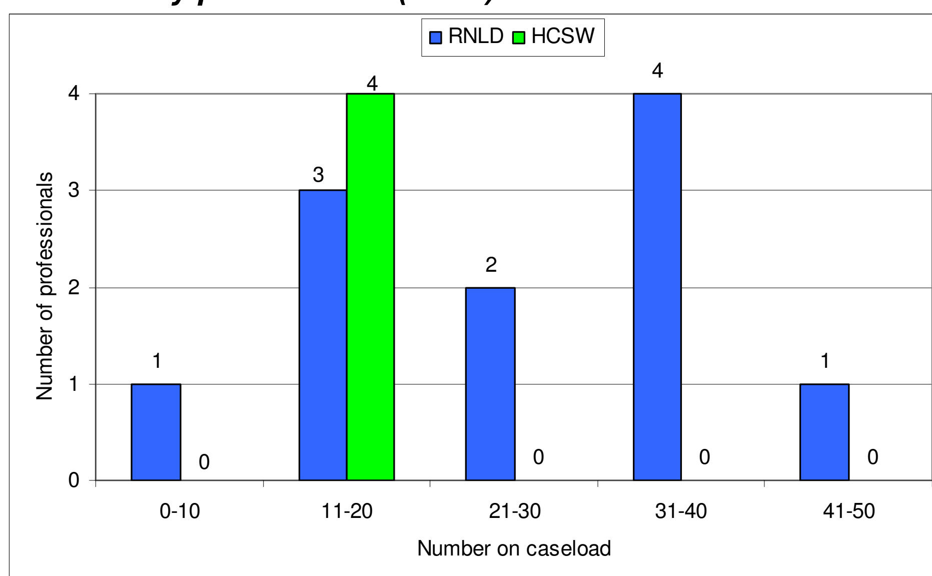
2. RESULTS

A total of 15 completed audit forms were returned to the Clinical governance support Team from the Wakefield community nurses, of which eleven were Registered Nurses in Learning Disability (RNLD) and four were Health Care Support Workers (HCSW).

2.1 Caseload

The total number of clients on the caseload ranged from 5 to 47, with an overall total of 362 service users. Figure 1 shows the spread of the case loads.

Figure 1: Caseload by professional (N=15)



The RNLDs had a total of 295 cases (mean number 27, range 5-47) and the HCSW had 67 cases (mean number 17, range 12-20).

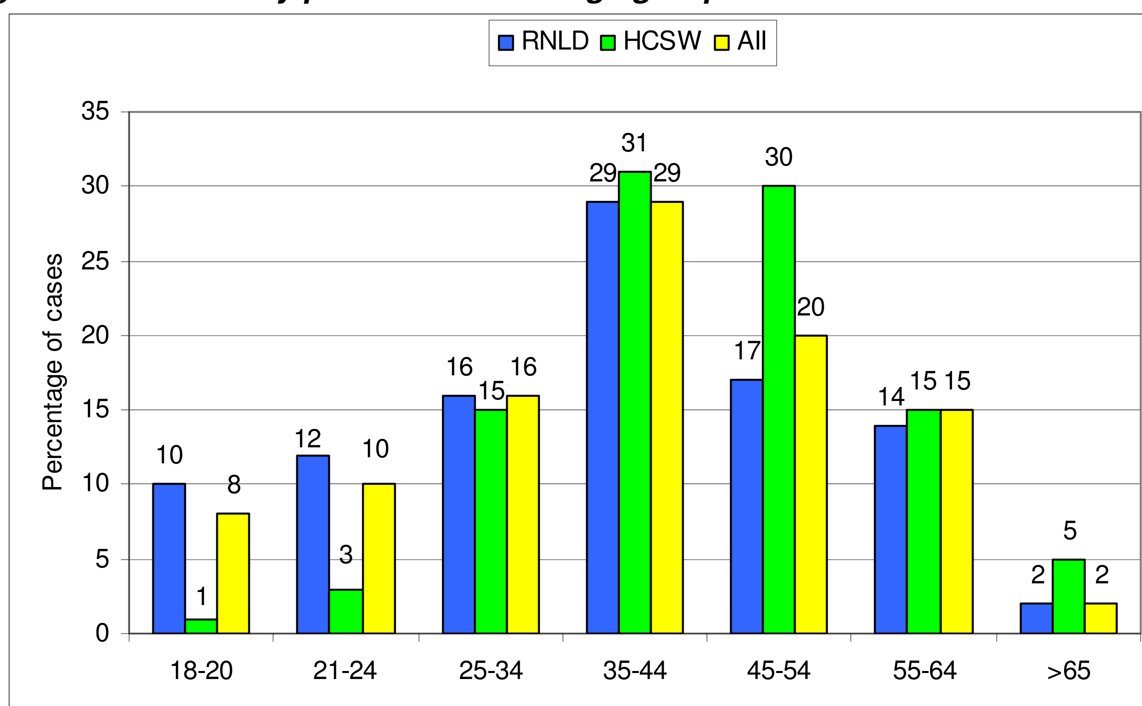
- 260/362 (72%) service users were clinical cases (mean number 22 range 5-47).
- 9/362 (2%) service users were care management cases (mean number 2, range 0-9).
- 10/362 (3%) service users were both clinical and clinical management cases (mean number 2, range 0-9).
- 73/362 (20%) were not specified.
- Of the 67 HCSW cases 48 (72%) were designated as clinical. 19 (28%) did not specify type of management.

2.2 Gender and age groups

There were 197 (54%) male and 159 (44%) female service users. Six (2%) were not specified.

Figure 2 (overleaf) shows the total caseload split by age group and by professional. The chart shows that 49% of the caseload are aged between 35-54 years. The age group was not specified in 31 cases.

Figure 2: Caseload by professional and age group



2.3 Level of learning disability

The estimated or actual level of learning disability was assessed. Table 1 shows the breakdown by severity of learning disability and professional group.

Table 1: Estimated/actual level of learning disability

Estimated /actual level of learning disability	**RNLD**		**HCSW**		**Total**	
	Number	Percentage	Number	Percentage	Number	Percentage
Mild	64	22%	22	33%	86	24%
Moderate	122	42%	27	40%	149	41%
Severe	107	36%	18	27%	125	35%
Total	**293**	**100%**	**67**	**100%**	**360**	**100%**

Note: one RNLD did not specify level (2 cases).

Overall the highest proportion of cases were moderate (41%), followed by severe (35%) and mild (24%). The RNLDs had less mild cases and more severe cases than the HCSWs.

There were no cases with IQ 70 or above.

2.4 Level of risk

The estimated or actual level of risk was also assessed. Table 2 (overleaf) shows the breakdown by level of risk and the professional group. The levels of risk were defined as:

- Low – needs identified but good overall support to manage risk.
- Medium – some risk of breakdown, challenging needs, mental health, physical health but good overall support.
- High – Unpredictable, behaviour, health, support package with potential breakdown / serious safeguarding issues that required sustained interventions.

Table 2: Estimated/actual level of risk

Estimated /actual level of risk	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Mild	119	40%	26	54%	145	42%
Medium	100	34%	14	29%	114	33%
Severe	76	26%	8	17%	84	25%
Total	**295**	**100%**	**48**	**100%**	**343**	**100%**

Note: one HCSW did not specify level of risk (19 cases).

Overall the highest proportion of cases was mild (42%), followed by medium (33%) and severe (25%).

2.5 Accommodation

Caseload holders were asked to identify the type of accommodation inhabited by their caseload. Table 3 shows breakdown by type and professional group.

Table 3: Service users by type of accommodation and professional group

Accommodation	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Independent	28	10%	22	33%	50	14%
Family	87	29%	26	39%	113	31%
Private/residential	89	30%	7	10%	96	26%
Supported living	87	29%	12	18%	99	27%
Foster care / shared lives	2	1%	0	0%	2	1%
Nursing	1	0.5%	0	0%	1	0.5%
Out of area placement	1	0.5%	0	0%	1	0.5%
Total	**295**	**100%**	**67**	**100%**	**362**	**100%**

Most cases lived with family (31%), in supported living (27%) and private / residential care (26%).

Fifteen (4%) cases were fully health funded – six RNLDs.

2.6 Referrals to caseload

The total number of referrals during the audit period 1st April 2009 to 30th June 2009 was 53. The HCSW's did not answer this question.

- 30 emergency referrals
- 10 out of district referrals
- 51 continuing healthcare assessment referrals
- 52 actual continuing healthcare assessment undertaken

2.7 Source of referral

Service users were referred from a variety of sources, from primary care, independent sector, housing, probation/police and other health professionals. Table 4 (overleaf) shows the breakdown by referral source and professional group. For 90 cases the source of referral was not specified.

Table 4: Source of referral and professional group

Source of referral	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
GP	93	38%	16	57%	109	40%
Hospital	8	3%	0	0%	8	3%
Children's services	18	7%	0	0%	18	7%
Other health professional	66	27%	12	43%	78	29%
Housing	1	0.5%	0	0%	1	0.5%
Probation / police	1	0.5%	0	0%	1	0.5%
Other authority	31	13%	0	0%	31	11%
Independent / private provider	20	8%	0	0%	20	7%
Self / carer	6	2%	0	0%	6	2%
Total	**244**	**99%**	**28**	**100%**	**272**	**100%**

The main sources of referrals were from the GP (40%) and other health professionals (29%).

2.8 Reason for referral

A variety of reasons were given for the referrals to the caseload holders. Table 5 shows the reasons by professional group. 77 cases were not specified – 3 RNLD - 38 cases, 2 HCSWs - 39 cases. There were no referrals for parenting, MCA/DOL and HAP.

Table 5: Source of referral and professional group

Reason for referral	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Placement breakdown	12	5%	0	0%	12	4%
Transition	29	11%	0	0%	29	10%
Change in health status	164	64%	16	57%	180	63%
Safeguarding	10	4%	0	0%	10	4%
Screening for LD	3	1%	0	0%	3	1%
Sexuality	10	4%	0	0%	10	4%
Forensic	4	2%	0	0%	4	1%
Health promotion	25	10%	12	43%	37	13%
Total	**257**	**101%**	**28**	**100%**	**285**	**100%**

The highest number of referrals were for a change in health status (63% N=180).

2.9 Waiting times

The total number of allocated referrals waiting for initial assessment was four (2 RNLD).

The total number of assessed referrals waiting for initial intervention was five (2 RNLD, 1 HCSW).

The number waiting for assessment treatment input was 10 (3 RNLD).

Twelve respondents specified the average time between a referral and the first visit.

- 1 (7%) 1-5 days
- 4 (27%) 6-10 days
- 6 (40%) 11-15 days
- 1 (7%) 16 days and over

2.10 Frequency of contact

The respondents were asked to provide the frequency of face to face contacts. Table 6 shows the breakdown by professional group. Half (51%) of the cases were seen monthly.

Table 6: Frequency of contacts

Frequency of contacts	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Daily	3	1%	0	0%	3	1%
Twice weekly	9	3%	1	2%	10	3%
Weekly	46	16%	11	16%	57	16%
Fortnightly	36	12%	16	24%	52	14%
Monthly	163	55%	21	31%	184	51%
3 monthly	28	10%	7	10%	35	9%
6 monthly	3	1%	10	15%	13	4%
Annually	6	2%	0	0%	6	2%
As required	0	0%	1	2%	1	0.5%
Total	**294**	**100%**	**67**	**100%**	**361**	**100.5%**

Note: one case was not specified.

2.11 Length of time on caseload

Respondents were asked about the number and length cases were active on their caseloads. Table 7 shows the breakdown by length of time and professional group.

Table 7: Length of time active on caseloads

Length of time active on caseload	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
3-6 months	59	20%	10	21%	69	20%
6-12 months	51	17%	13	27%	64	19%
1-2 years	70	24%	16	33%	86	25%
3-5 years	64	22%	9	19%	73	21%
5-10 years	49	17%	0	0%	49	14%
Total	**293**	**100%**	**48**	**100%**	**341**	**99%**

Note: 21 cases were not specified.

A quarter of cases had been active for 1-2 years (25%). The lowest proportion of active cases was 14% for 5-10 years.

2.12 Discharges

The number of discharges from the caseloads between 1st April and 30th June 2009 was 17 cases. The main reason for discharge was that the clinical outcomes had been achieved (64% N=11). Other reasons were due to death (1), moved out of area (2), client withdrawn (1) and transferred to another professional (2).

2.13 Diagnosis

Respondents were asked to provide the diagnosis for the service users on their caseloads. The main diagnoses were challenging behaviours (38%), diagnosed mental health problems (26%) and epilepsy (23%).

Table 8: Diagnosis

Diagnosis	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Diagnosed mental health problems*	76	26%	13	27%	89	26%
Challenging behaviours*	128	43%	4	8%	132	38%
Suspected mental health problems*	18	6%	4	8%	22	6%
Complex multiple needs*	45	15%	6	13%	51	15%
Epilepsy	71	24%	9	19%	80	23%
Dementia	14	5%	1	2%	15	4%
Autistic spectrum disorder	51	17%	1	2%	52	15%
Training needs of parent / carer	12	4%	0	0%	12	3%
Parent with a learning disability	4	1%	3	6%	7	2%
Other	15	5%	7	15%	22	6%

Note: one HCSW did not specify (19 cases).

* diagnosis definitions

- *Diagnosed mental health problems – a confirmed health reason for the individuals problem.*
- *Challenging behaviour – behaviour that is inappropriate to a situation and challenges those around, may involve aggression, self injury or non communication.*
- *Suspected mental health problems – an unconfirmed health reason for the individual's problem.*
- *Complex multiple needs – individuals with complicated, intricate or a number of co-existing conditions that require sustained interventions by specialist services.*

Other diagnoses were described as:

- Brain injury and acute memory loss
- Temporary loss of muscle function of unknown cause
- ADHD
- DST
- Neurological disease secondary to LD
- Sexual health
- Physical health needs
- Health facilitation

2.14 Professional input

Respondents were asked about the number of service users that only require out patient support, escort to day care, respite and health appointments, continence and medication monitoring of which 34 (9%) only had the following input.

- 14 escort to health appointments – primary / acute
- 4 out-patient support
- 3 review
- 10 continence
- 2 medication monitoring
- 1 depot medication

2.15 Clinical interventions

A total of 395 clinical interventions were used during the audit period across the caseloads. Two HCSW did not complete the question therefore 31 cases are missing. Table 9 shows the breakdown by each clinical intervention and professional group.

Table 9: Clinical interventions used

Clinical interventions	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Assessing MH	74	25%	0	0%	74	20%
Treating MH	53	18%	8	29%	61	17%
Assessing behaviours	54	18%	0	0%	54	15%
Treating behaviour	40	14%	0	0%	40	11%
Managing physical conditions	78	26%	5	18%	83	23%
Managing / assessing / teaching on complex health condition	21	7%	1	6%	22	6%
Health promotion support	38	13%	11	39%	49	14%
Counselling service users / carers emotional situation	4	1%	0	0%	4	1%
Psychological treatment	2	0.5%	0	0%	2	0.5%
Sex education, promotion / guidance / behaviour	9	3%	0	0%	9	2%
Managing physical care needs	42	14%	0	0%	42	12%
Communication skills	12	4%	0	0%	12	3%
Managing medicines	104	35%	0	0%	104	29%
Management of autism	28	9%	0	0%	28	8%

The main clinical interventions were for managing medicines (29%), managing physical conditions (23%) and assessing mental health needs (20%).

2.16 Other activities

Respondents were asked if any additional activity assessments during the audit period. These were sessions that lasted for over an hour.

A total of 227 additional activity sessions were done during the audit period.

Table 10: Additional activity sessions

Activity sessions	RNLD		HCSW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Health promotion group	36	12%	28	42%	64	18%
Strategic working groups	8	3%	0	0%	8	2%
Provider training	27	9%	0	0%	27	7%
Service development	30	10%	0	0%	30	8%
DES	8	3%	0	0%	8	2%
Parenting group	8	3%	4	6%	12	3%
Other	77	26%	1	1%	78	22%
Total	**194**		**33**		**227**	

Other activities were described as:

- Non clinical meetings 16 hours, clinical meeting 2 hours, training 5 hours, review 5 hours, outpatients clinic 6 hours, supervision 8 hours, road show and away day 10.5 hours, health event 5 hours, cook and eat 5 hours
- Reviews x 4 hours
- Away day team plan
- Best interest meetings and strategy meetings 6 hours, supervision (own and others) 7 hours. I had two service users move into a new service during audit period so provider training was high - this is not normal for a three month period.
- DST 2.5 hours, student supervision 8.5 hours, training 36 hours, safeguarding/monitoring 22.5 hours, supervision 5 hours, outpatient clinics 10.5 hours, reviews 9 hours, road show/team away day 10.5 hours, non clinical meetings 31 hours, clinical meetings 10.5 hours.
- Outpatient clinics 3 hours, student support 2.5 hours, DST's 12 hours.
- Clinical meetings 12 hours, strategy meetings 4 hours, safeguarding meetings one hour, parenting group 5 hours, care reviews six hours, out patients 10 hours, team away day 1 hour, non clinical meetings 5 hours, supervision 3 hours.
- DST
- Sexual health training/outpatients/MDT meetings
- Individual and group supervision
- Outpatient clinics

After other activities health promotion groups (18%) were one of the main additional activities.

2.17 Challenges and demands of the role

Respondents were asked to identify the challenges and demands they experienced in undertaking their role. They were asked to place a value on a number of domains using a rating scale of '1 to 5' with '1' being the lowest and '5' being the highest. Table 11 (overleaf) shows the breakdown for each domain by professional group. The average is shown along with the range in the domain.

Table 11: Challenges and demands of the role

Challenges & demands	RNLD		HCSW		Total	
	Average score	Range	Average score	Range	Average score	Range
Managing clinical risk / crisis	3.8	2-5	2.5	1-5	3.4	1-5
Delivering planned clinical interventions	2.5	1-4	3.0	1-5	2.6	1-5
Health needs assessment targets	3.6	1-5	1.0	0-2	2.9	0-5
Administration & clerical	2.4	1-5	2.3	1-4	2.4	1-5
Students	1.1	0-2	1.3	0-3	1.1	0-3
Secondary referrals	3.2	2-5	2.3	1-3	2.9	1-5
Demand from private services	4.0	1-5	1.3	0-3	3.2	0-5
Providing education	2.1	1-5	2.3	0-5	2.7	0-5
Getting secondary specialist input	2.7	2-4	2.8	0-5	2.1	0-5
Care management	1.8	1-5	0.5	0-1	1.5	0-5
HAP	1.6	1-4	2.3	1-5	1.8	1-5
Having the appropriate skills	2.1	1-4	3.0	2-5	2.4	1-5
Clinical supervision / KSF	1.8	1-5	2.0	1-5	1.9	1-5
Clarity of role	3.3	2-5	1.5	1-3	2.8	1-5
Resources	3.0	1-5	2.3	1-4	2.8	1-5
Management support	2.6	1-5	2.0	1-5	2.4	1-5
Stress	2.8	1-5	2.3	1-4	2.6	1-5
CPD	2.2	1-4	2.5	2-3	2.3	1-4
Clinics	2.3	1-5	2.0	1-5	2.2	1-5

Overall the highest score for challenges & demands was managing clinical risk / crisis (3.4) and demand from private services (3.2). The lowest scores were for students (1.1), care management (1.5), HAP (1.8) and clinical supervision (1.9). The other challenges and demands scored between 2 and 3. There were small differences between the RNLDs and the HCSWs.

Two RNLDs made the following comments about this section:

- This is so subjective and subject to change due to personal environmental and professional influences on a daily basis and as such is NOT a reliable guide.
- During the agreed time period CTLD South have been actively involved in reporting, monitoring, supporting and training care providers with regard to a safeguarding investigation.

2.18 General comments

Respondents were asked to add any additional comments of which three RNLD and one HCSW commented:

- This doesn't capture HCSW role adequately as we only take our work direct from the senior nurse. (HCSW)
- Personally I don't think a retrospective audit will prove to be very accurate, a live/current audit would have provided more detailed accurate information. (RNLD)

- This has been difficult to complete since working in community, I have covered all four teams, only spending 2.5 days at CTLD Normanton. (RNLD)
- Difficult to capture whole activities. There are some activities not given headings and no space on audit tool to reflect this. A live audit may have captured activities more effectively. (RNLD)

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

A comprehensive data was gathered from individual nurses case loads which enabled the above formulation to be made and also identify potential areas for action in line with contemporary evidence and policy drivers. What the audit didn't undertake was to analyse individual teams although with the data accrued, this may still be possible? What this means is that the area demographic differences are not taken into account which my be extremely important in understanding pressures in the system and responding accordingly. Nevertheless important data that was gathered is certainly step to realising nursing activity in an evidenced way, and sets the path for further work and the building of efficiencies in the system and across the developing pathway .

3.1.1 Caseload

The total number of clients on a caseload ranged from 5 to 47, with an overall total of 362 service users. 260/362 (72%) service users were clinical cases 9/362 (2%) service users were care management cases 10/362 (3%) service users were both clinical and care management cases (mean number 2, range 0-9). 73/362 (20%) were not specified.

Caseloads above 30 are often considered high and may be worthy of further examination because of the associated risk. The number of care management only cases was low and reflects best practice in maximising the clinical role of the nurse and the ethical dilemma in providing a commissioning / provider role. The 20% not specified is probably worthy of further examination, as this constitutes a considerable knowledge gap in activity.

3.1.2 Gender and age groups

There were 197 (54%) male and 159 (44%) female service users and appears both balanced and reflect cotemporary demographic research data. Figure 2 shows that 49% of the caseload is aged between 35-54 years however the age group was not specified in 31 cases. The number of children in transition appears low (8%) however on year will be higher overhaul.

This group reflects a potential increase in demand based on national projections both for clinical input and commissioning cost. Dedicated transition team are in operation in some parts and clinical staff are part of them.

3.1.3 Level of learning disability

Overall the highest proportions of cases were moderate (41%), followed by severe (35%) and mild (24%). The RNLDs had less mild cases and more severe cases than the HCSWs as one would expect.

3.1.4 Risk

Highest proportion of cases was mild (42%), followed by medium (33%) and severe (25%). *(See criteria page 5)* This data is potentially useful as an aid to managing caseload pressures. Under a third of cases are purported to present as severe risk using the criteria outlined.

In utilizing such data in the future one might wish to agree the criteria with commissioners and the data would be invaluable in plotting trends managing risk and the planning of service delivery.

3.1.5 Accommodation

Most service users lived with their family (31%), (27%) in supported living and private / residential care (26%). A small number of service users lived independently (14%).

Longitudinal data such as this could be useful in plotting provision of care particularly by identifying where needs and pressures are at there most and may inform service delivery options. For example some community teams in the country have assigned designated professionals to independent providers to prevent overlap and make best use of resources. Some teams also report an overload of activity from the independent sector (see nursing demands).

3.1.6 Referrals to caseload

The total number of referrals during the audit period was 53: 30 emergency referrals, 10 out of district referrals, 51 continuing healthcare assessment referrals, and 52 actual continuing healthcare assessments undertaken. Emergency referral appears high and the criteria set could have been more robust. What constitutes an emergency is difficult to discern for example those related to commissioning and those related clinical crisis and or risk? Both areas have their unique demands and should be separated in the future for commissioning purposes.

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3.1.7 Source of referral and professional group

The main sources of referrals were from the GP (40%) and other health professionals (29%). The latter information is not specific to professional group, which would have been useful in order to accurately assess the impact off level 2 services on the nursing team. Predominantly these referrals are often from a psychiatrist. Internal referrals (other authority) constituted 11% of the referrals.

3.1.8 Reason for referral

A variety of reasons were given for the referrals to the caseload holders: *(See Table 5)* 77 cases were not specified – 3 RNLD - 38 cases, 2 HCSW - 39 cases. The highest numbers of referrals were for a change in health status (63% N=180). There were no referrals for parenting, MCA/DOL and HAP. The HAP result was surprising considering the drive to address health inequalities. On the other hand this initiative is new and demand will probably increase. Proactive preventative can be put on hold due to competing demand or lack of dedicated time. However this can be risky and costly in the long term (crisis and breakdown).

3.1.9 Waiting time, frequency of contact, length of time on case load and discharge

Waiting and response times varied and were at acceptable levels. The highest wait was for assessment and treatment (10 cases). Half (50%) of cases were seen monthly with the rest varying. As one would expect a small number of patients were seen daily (3%) and weekly (16%). Six monthly / yearly contacts were insignificant however they may

feature more strongly in the future due to the review demands of health need assessments.

Length of time on the case load shows some interesting results *(see Table 7)* and may be worthy of further analysis. The percentage number of patients being seen in the 3-10 year period is similar to the 1-2 year period. Some patients may justifiably need such intervention however some studies (Read et al 2001) have detailed concerns of the interdependence of visiting between the care giver and client and that a more rigorous outcomes based approach be more conducive to managing limited resources. (CNO review 2007). However 17 discharges were made over the audit period.

3.1.10 Diagnosis

The main diagnoses *(see table 8)* were challenging behaviours (38%), diagnosed mental health problems (26%) and epilepsy (23%). These results qualify anticipated need however could be broken down further in the future to provide greater demographic data to plot local trends to inform commissioning and training of staff.

3.1.11 Clinical interventions and professional input

A total of 395 clinical interventions were used *(see table 9)* during the audit period across the caseloads and very much mirror the prevailing diagnosis. Two HCSW did not complete the question therefore 31 cases are missing. The main clinical interventions were for managing medicines (29%), managing physical conditions (23%) and assessing mental health needs (20%).These clinical needs demand a high level of skill across the pathway and reflect the Trust drive to build up performance in this area. The development of an outcomes focus could potentially help realise efficiency saving improve quality of care and patient experience. An example of this would be the adoptions of evidenced clinical tools, processes and new ways of working.

34 (9%) service users only required out patient support, escort to day care, respite and health appointments, continence and medication monitoring. This may be an area for examining skill mix and best use of professional time.

3.1.12 Other activities

Additional activity during the audit period that lasted for over an hour totalled 227 *(see table 10)* and ranged from undertaking clinical duties such as health promotion to strategic and professional meetings. The team could examine these areas for duplication and organisation to see if efficiencies could be made.

3.1.13 Challenges and demands of the role

Overall the highest score for challenges and demands was managing clinical risk / crisis (3.4) and demand from private services (3.2). The lowest scores were for students (1.1), care management (1.5), HAP (1.8) and clinical supervision (1.9). The other challenges and demands scored between 2 and 3. There were small differences between the RNLDs and the HCSWs. Clarity of role and having the resources to perform the role was (2.8) and has featured significantly at nurse forums and may add to efficiency and improved moral.

3.2 Recommendations

This case load audit was commissioned specifically to enable service managers and commissioner to understand activity/pressure in the system of the application of the role of learning disability nurse in Wakefield, with a view to supporting efficiencies in the teams in response to local care pathway development, the management of competing demand such as: care management, health facilitation, safeguarding and the increasing need to support capable environment in the independent sector.

The audit tool was development to capture the wide variety of outputs associated with the role and is probably one of the most comprehensive tools to date in this area. This has been endorsed by a request from a national organisation to examine it for potential use in other areas because nationally CTLD are examining how they operate. This is likely also to become more apparent in the future as the present economic climate changes prevail.

Longitudinally there is the potential to gather some of data collected by this audit to provide robust management/commissioning information either in sample (activity periods such as in this one) or in an ongoing manner. This would avoid contamination of the data that potentially occurred in this case due to circumstances out of the team's control i.e. a major safeguarding enquiry and the completion of a high number of continuing health needs assessment. Nurses also reported that a live audit rather than a retrospective one may have provided more accurate information and may also explain why data in some areas is absent.

3.3 Potential areas for action

1. The role of the nurse in level 1 of the pathway is clarified to identify the specific requirements of the role and its interface with level 2 of the service.

2. The team examine lean/news ways of working in the management of workload pressure including the high intensity areas of mental health, challenging behaviour and medicines management in the community.

3. The potential for the introduction of a caseload management tool is explored to enable caseloads to be managed in an evidenced manner.

4. An outcomes focus is introduced for interventions employed coupled with care plan time scales to enable precision monitoring of activities for all cases particularly those on case loads over 1year. (interlinks with 3)

5. The skill mix in roles is explored to examine the distribution of activities between RNLD and HCSW.

6. Consideration is made to how non-clinical work is distributed in the teams to ensure that nurses roles reflect best practice /commissioning guidance including management of risk.

7. Consideration is made to collecting agreeing referral/ activity data across disciplines and teams with commissioners to enable demographics and pressures in the system to be better understood.

8. All additional activity is commissioned appropriately within agreed guidelines with service manager's and that users of the service understand limitation and option to meet specific need.

9. The role/s expectation of the level 1 nurse in HAP and is made explicitly clear due to the regional health targets as quality and performance are scrutinized. No referrals for HAP were received in the audit period and may be indicative of a failure of the service to adequately address this important agenda with the resources that it has.

APPENDIX 1: CLINICAL GOVERNANCE SUPPORT TEAM

The Clinical Governance Support Team (CGST) is a multi-disciplinary consultancy and project management team with a wealth and diversity of expertise, established to promote and facilitate clinical governance and practice effectiveness throughout the Trust.

The aim of the department is to facilitate the provision of high quality services in line with the principles of Clinical Governance and to support the Trust's mission, vision, values and goals.

The Clinical Governance Support Team works through partnerships with clinical and non-clinical staff, service users and carers, health and social care providers, universities and educational providers and voluntary agencies

Service	Description of services/resources
Practice Effectiveness	Promoting practice effectiveness through supporting staff to develop evidence based practice
Advice Surgeries	Providing advice, expertise and encouragement to staff wanting to undertake project work including service development, audit and service evaluation
Project Management	Delivery of localised and trust-wide commissioned projects within the clinical governance agenda, linking services or professions across any number of areas. Monitoring of project activity across the Trust and reporting of audit and evaluation priorities twice yearly to the CASE work stream of the Practice Effectiveness TAG
Links with Trust groups	Linking in and supporting the Trust Care groups and Trust Action Groups
Training and Development	Supporting and developing the skills of staff through clinical governance training, advice surgeries and action learning. Supporting the involvement of service users and carers in audit and evaluation through training, learning and development.
Risk Strategy	Support the organisation's risk strategy
Library	Loan service (books; Journals; CD.ROMS; etc…) access to Intranet, Internet, electronic databases, Inter-library loans; study facilities and electronic database training.
Health Promotion Resource & Information Centre	Loan service (DVDs; videos, resource packs, anatomical charts and models, AV equipment, display boards; etc…); health promotion leaflets and posters.
Clinical Governance	Support the monitoring of clinical governance through the annual report, action plan and the monitoring of the performance against the plan and through the membership of various trust groups.

The team currently covers the full geographical area of the Trust. Location and contact details of all members of the team are as follows:

<table>
<tr><th>Personnel</th><th>Role</th><th>Contact details</th></tr>
<tr><td>Gillian Marley</td><td>CGST Lead for Adult and Forensic Care Groups</td><td rowspan="3">CGST, Castleford & Normanton District Hospital, Lumley Street, Castleford, WF10 5LT
Tel: 01977 628011</td></tr>
<tr><td>Susan Alibone</td><td>Clinical Development Facilitator</td></tr>
<tr><td>Liam Redican</td><td>Project Support Officer</td></tr>
<tr><td>Hazel Baxter</td><td>CGST Lead for Older Peoples' and Learning Disability Care Groups</td><td rowspan="2">CGST, SWYT, 4th Floor, F Mill, Dean Clough, Halifax, HX3 5AX
Tel: 01422 281343
Fax: 01422 281568</td></tr>
<tr><td>Suzy Whitehead</td><td>Clinical Audit Facilitator</td></tr>
<tr><td>Michael Morley</td><td>Library/Resource & Information Centre Co-ordinator</td><td rowspan="2">Library/Resource & Information Centre, Education Centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield,
WF1 3SP.
Tel: 01924 328608</td></tr>
<tr><td>Helen Rotherforth</td><td>Librarian</td></tr>
</table>

APPENDIX 2: TITLE

Learning Disability Services Caseload Activity Audit 2009

NB: See table page 4 for additional criteria & instruction for completion

Initials of caseload holder [ ] Designation - RNLD [ ] HCSW [ ]

Please note: this will not be identified within this audit

Q1 Current caseload numbers:

a) Total on caseload [ ] b) Clinical cases [ ]

c) Care management (CM) cases [ ] d) Clinical & CM [ ]

Q2 a) Number of **male** clients: [ ] b) Number of **female** clients: [ ]

Q3 How many clients do you have in each age group?

18 – 20 [ ] 21 – 24 [ ] 25 – 34 [ ] 35 – 44 [ ]

45 – 54 [ ] 55 – 64 [ ] 65 and over [ ]

Q4 Estimated/actual level of learning disability (Numbers on case load)

Mild [ ] Moderate [ ] Severe [ ] IQ 70 or above [ ]

Please comment on reason for non-learning disabled referrals Q 70 above i.e. Aspergers/MH:

Q5 Estimated/actual level of risk (Numbers on case load)

Low [ ] Medium [ ] High [ ] *NB: See risk table for definition (page 4)*

Q6 How many of your caseload live in the following accommodation?

Independent [ ] Family [ ] Private/Residential [ ]

Supported living [ ] Foster care/shared lives [ ] Nursing [ ]

All those living out of area [ ] Total numbers fully health funded [ ]

Q7 New referrals between 1/4/09 – 30/6/09:

a) Total number of **new** referrals [ ]

b) Number of **emergency** referrals [ ]

c) Number of **out of district** referrals [ ]

d) Number of **continuing healthcare assessment** referrals [ ]

e) Number **of actual continuing healthcare assessment** undertaken [ ]

Q8 How many of your caseload came from the following sources of referral?

Independent/private provider	☐	GP	☐	Other health professional	☐
Children services	☐	Self/carer	☐	Hospital	☐
Other authority	☐	Housing	☐	Probation/police	☐

Q9 Waiting times

a) Number of allocated referrals to you waiting for initial assessment: ☐

b) Number of assessed referrals waiting for initial intervention: ☐

c) Number waiting for assessment treatment service input ☐

Q10 Average time between a referral and first visit (standard referral) ***(Please tick ONE box only):***

1 - 5 days ☐ 6 – 10 days ☐ 11 – 15 days ☐ 16 days and over ☐

Q11 How many of your caseload was referred for each of the following reasons?

Placement breakdown	☐	Transition	☐	Change in health status	☐
Safeguarding	☐	Parenting	☐	MCA/DOL	☐
Screening for LD	☐	Sexuality	☐	Forensic	☐
HAP	☐	Health promotion	☐		

Q12 Discharge - Number of discharges from caseload between 1/4/09 & 30/6/09 ☐

Q13 How many of the above number were discharged for the following reasons?

Death	☐	Moved out of area	☐	Clinical outcomes achieved	☐
Client withdrawn	☐	Transferred to another professional			☐

Other *(please specify):*

Q14 On average how many of your caseload are seen:

a) Daily	☐	b) Twice weekly	☐	c) Weekly	☐
d) Fortnightly	☐	e) Monthly	☐	f) 3 monthly	☐
g) 6 monthly	☐	h) Annually	☐	I) 2 yearly	☐

Q15 Number & length of time active on caseload (months/years)

3/6mths ☐ 6/12mths ☐ 1 to 2 yrs ☐ 3 to 5yrs ☐ 5 to 10yrs ☐

Q16 Out of your caseload, how many service users have? ***(See page 4 for definitions of the above)***

a) diagnosed mental health problems*		b) challenging behaviours*	
c) suspected mental health problems*		d) complex multiple needs*	
e) Epilepsy		f) Dementia	
g) Autistic Spectrum Disorder		h) training needs of parent/carer	
i) Parent with a learning disability		j) other ***(please state below)***	

Other *(please specify):*

Q17 Out of your caseload, how many people **ONLY** require the following input?

Outpatient support		Escort to respite		Review	
Escort to day care		Depot medication		Continence	
Escort to health appointments primary/acute				Medication monitoring	

Other *(please specify):*

Q18 Clinical interventions employed during audit period – ***(number of service users)***

a)	Assessing MH. Interviewing users and carers, gathering information, reporting on	
b)	Treating MH. Providing ongoing support to: manage, monitor, care for MI	
c)	Assessing Behaviour i.e. functional analysis, direct observations.	
d)	Treating Behaviour: Production/implementation of support plans	
e)	Managing physical conditions i.e. epilepsy/diabetes /sleep/diet.	
f)	Managing/assessing/teaching on complex health condition i.e. dementia /SLD	
g)	Health promotion support (specific health need, e.g. weight/ nutrition	
h)	Counselling service user or carers on complex emotional situation i.e. bereavement	
i)	Psychological treatment i.e. CBT anger management /desensitisation	
j)	Sex education, promotion/ guidance/behaviour	
k)	Managing physical care needs - guidance monitoring	
l)	Communication skills, develop, support promote techniques.	
m)	Managing medicines - monitoring / reporting/advising / administering.	
n)	Management of autism i.e.: guiding/ teaching/ producing support plans	

Q19 Additional activity sessions during audit period (Number of sessions lasting over 1 hour)

Health promotion group	☐	Strategic working groups	☐	Provider training	☐
Commissioning Panel	☐	Audit	☐	Service development	☐
DES	☐	Parenting group	☐	Other	☐

Other *(please specify)*:

Q20 **Challenges/demands** to undertaking role. On a scale of 1 to 5 with 5 being the highest, place value on each of the following domains :

a) Managing clinical Risk/crisis	☐	b) Delivering planned clinical interventions	☐
c) Health needs assessment targets	☐	d) Admin and clerical	☐
e) Students	☐	f) Secondary referrals	☐
g) Demand from private services	☐	h) Providing education	☐
i) Getting secondary specialist input	☐	j) Care Management	☐
k) HAP	☐	l) Having the appropriate skills	☐
m) Clinical supervision /KSF	☐	n) Clarity of Role	☐
o) Resources	☐	p) Management support	☐
q) Stress	☐	r) CPD	☐
s) Clinics	☐		

Comments on above:

Any additional comments:

Thank you for completing this audit tool, please return to Suzy Whitehead, 4th Floor, F Mill, Dean Clough, Halifax, HX3 5AX by 1 September 2009

Definitions & instructions

Please complete the audit as accurately as possible in all fields unless they are not applicable. Some data may be held centrally and therefore need to be obtained from your manager or central information system i.e. SIS/RAISE

a) Diagnosed mental health problems:
A confirmed health reason for the individuals problem

b) Challenging behaviour:
Behaviour that is inappropriate to a situation and challenges those around, may involve aggression, self injury or non-communication

c) Suspected mental health problems:
An unconfirmed health reason for the individuals' problem

d) Complex multiple needs:
Individuals with complicated, intricate or a number of co-existing conditions that require sustained interventions by specialist services.

e) DES facilitation:
Service development work including liaison with primary/ secondary care and the development and auditing of initiatives designed to improve healthcare for PLD.

f) Health facilitation:
Person to person work with PLD including Health Action/promotion Plans, supporting access to services and training carers and families in identifying health needs.

g) Level of risk:
Low-Needs identified but good overall support to manage risk.
Medium- Some risk of breakdown, challenging needs, mental health, physical health but good over-all support.

Levels of risk continued
High- Unpredictable, behaviour, health, support package with potential breakdown/ /serious safeguarding issues that require sustained interventions