Monitoring Community Mental Health Team Caseloads:

a systematic audit of practitioner caseloads
using a criterion-based audit tool

AUDIT 2006

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On behalf of: Community Teams Forum

Audit Support:
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Frances Battlebury, Administrator, Luton Community Mental Health Service

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Introduction:

‘Good caseload management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that staff in care coordinator roles are maintaining caseloads of suitable sizes with individuals who have active needs and that support and clinical supervision is provided.’ (DH 1999: 23)

This recommendation is reinforced within the Trust’s county-wide Care Programme Approach Policy (CPA) (BLPT 2005: 15). However, it has long been known that monitoring caseloads is a complex issue, as limiting such to simple numbers of service-users on caseloads is potentially misleading of actual workload and does not recognise the many other important activities that are undertaken by practitioners.

Caseload mix and size are clearly important factors in working effectively within community mental health teams (CMHT) and, as highlighted by Greenwood et al (2000), different team professionals can be expected to have different case-mixes and correspondingly different caseload sizes, which is likely to reflect the difference in roles that are provided. Greenwood et al (2000), in their survey of six CMHTs in South West London, reported that community mental health nurses (CMHN) had a mean caseload of 30.3 service-users (range = 18 – 34.3) with social workers (SW) having a mean caseload of 13.1 service-users (range = 9.5 – 26). They concluded that this difference probably reflected their different roles: CMHN caseloads had by far the highest proportion of service-users with a psychosis, possibly as a consequence of their established role in administering intramuscular depot medication; social workers had smaller caseloads, which probably reflected their other responsibilities, such as Approved Social Work duty. Furthermore, team practitioners who are involved in providing in-depth therapeutic interventions might be expected to work with fewer service-users.

In 2000 & 2001, the local community mental health service piloted the use of a criterion-based caseload monitoring tool based upon a thermometer weighting system, which involves giving service-users a weighted rating for a series of CPA-related criteria (McDermott & Reid 1999, Butler 2001).

A further local audit of CMHT practitioner caseloads was conducted in December 2004, using an adapted version of this caseload audit tool: 47 community mental health practitioners returned audit data on 917 service-users, approximately 40% of whom were receiving enhanced CPA care (Butler 2005). Following this audit activity, a series of key recommendations relating to caseload management, monitoring and supervision were made. Consequently, a number of community mental health practitioners have maintained a concurrent profile of their individual caseload using the caseload monitoring tool, for use within caseload supervision, and some team managers have been addressing caseload management issues within the supervision setting, which has been supported through the concurrent use of the caseload monitoring tool. It is worth noting that some practitioners have found that concurrent use of the tool has helped to clarify and highlight specific caseload pressures. Furthermore, it was recommended that an externally validated caseload audit of the whole service is conducted on a periodic basis, to be scheduled into the service clinical audit forward plan.

Following discussion at the Trust’s recently established Community Teams Forum, it was agreed to conduct another caseload audit of community mental health (CMH) practitioners across the Trust during June 2006. The methodology and findings of this audit are presented within this report and direct comparisons are made with the data obtained during the previous audit, where this is meaningful.
Method:

Each qualified mental health practitioner in each CMH Team was asked to conduct an audit of their current caseload between June 23rd & June 30th, using a caseload monitoring tool (see Appendix 1).

This audit tool requires the practitioner to assess each service-user on their caseload against seven CPA-related criteria (risk, relapse pattern, needs, support, engagement & compliance, contact, and CPA coordination). Each criterion is weighted from 1 – 5, in accordance with specific service-user descriptors, with greater levels of risk / complexity / need being indicated by higher weightings. Completed for each service-user on the practitioner's caseload, this provides an overall caseload profile. As mentioned above, this tool was previously used within a service caseload profiling exercise in 2001 and then again in December 2004 (Butler 2005).

Each practitioner was asked to record and return their caseload data, in the form of weighted ratings for each service-user on their caseload, in electronic format using a specially devised Excel spreadsheet. This spreadsheet had been devised and e-mailed to practitioners in facilitating audit data collection and subsequent analysis. Instructions for using the audit tool and recording caseload weightings were included within the Excel spreadsheet. Average caseload weightings for each caseload criterion were calculated automatically upon caseload data-entry by the practitioner.

Data was received from practitioners working within 13 teams between June 23rd & July 28th 2006, which included caseload data from 11 Community Mental Health Teams, the Luton Forensic Team and Luton Assertive Outreach Team. Data was thus received from:

- 79 professionally qualified community mental health practitioners (45 CMH Nurses, 30 Social Workers, 3 Senior Practitioners, 1 Occupational Therapist)
- 12 Team Managers (although the full time Luton CMHT Managers confirmed that they did not carry a caseload, unlike Team Managers working within the other teams; the Leighton Buzzard CMHT had two Team Managers, with each fulfilling a part manager & part practitioner role)
- 11 Community Support Workers / Support Time & Recovery (STR) Workers, from five of the eleven CMHTs

This therefore represents the largest return of caseload audit data from the Trust’s CMH Services to date.

As for the previous audit (Butler 2005), a series of additional data items were requested: total client contact time, total travel time and total administration time for each service-user, in minutes per month – unfortunately, this data was only returned by 27 CMH practitioners.

Audit data was forwarded in electronic format to the Consultant Nurse (Acute Mental Health) for analysis and reporting.

Note:
A preliminary report of the initial findings was provided during mid July 2006 in time for the July meeting of the Community Teams Forum. The full findings of this audit are provided within this report.
Findings: aggregate caseload data

As shown in Tables 1 - 4, the total active caseload audited represented 102 team-members and 1,734 service-users.

Table 1: Luton CMHT Caseload Data

<table>
<thead>
<tr>
<th>TEAM</th>
<th>No. of Team-members returning caseload data</th>
<th>Average caseload for F/T generic workers (range)</th>
<th>Total active service-user caseload</th>
<th>Total service-users rated as &gt;=4/5 for Care Coordination (% of total cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton NW CMHT (exc. Team Manager)</td>
<td>5</td>
<td>31 (29 – 33) for CMHNs (33 in Dec 2004)</td>
<td>124</td>
<td>25 (20.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15.5 (13 – 18) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luton SW CMHT (exc. Team Manager)</td>
<td>6</td>
<td>25 (13 – 40) for CMHNs (35 in Dec 2004)</td>
<td>138</td>
<td>42 (30.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19.5 (15 – 24) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luton SE CMHT (exc. Team Manager)</td>
<td>5</td>
<td>30 (23 – 38) for CMHNs (36 in Dec 2004)</td>
<td>157</td>
<td>39 (24.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36 for SW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luton NE CMHT (exc. Team Manager)</td>
<td>8</td>
<td>25 (19 – 30) for CMHNs</td>
<td>150</td>
<td>59 (39.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19 (18 – 20) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 for CSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>24 Team-members</td>
<td>28 per F/T CMHN</td>
<td>569</td>
<td>165 (29%) service-users rated as &gt;= 4/5 for Care Coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22.5 per F/T SW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(service-users per F/T worker)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key:
CMHNs = community mental health nurses; SWs = social workers; CSWs = community support workers

Note:
The Luton CMHT Managers did not have a clinical caseload

As shown in Table 1, there is a small variation in total team caseload size for the Luton CMHTs (based on registered practitioners only), some variation of practitioner caseload sizes within and between teams and considerable variation between team caseloads in the proportion of service-users receiving enhanced CPA care (20 – 39%). The Luton SE CMHT social worker has a significantly higher caseload than social workers who are working within the other teams. Considering data from the previous audit, the actual size of CMHN caseload has reduced.

As shown in Table 2, the total team caseload size is similar for three of the Heartlands CMHTs, being smaller for the Ampthill CMHT (based on registered practitioners only). CMHN and SW caseloads have increased within the Dunstable CMHT, whilst CMHN caseloads have reduced in the Leighton Buzzard CMHT since the previous audit. SW caseloads in the Ampthill CMHT are significantly lower than for the other CMHTs. Team managers within the Dunstable and Biggleswade CMHTs have a small caseload, whilst the two job-sharing team
managers within the Leighton Buzzard CMHT have considerable caseloads. It must be noted that the Leighton Buzzard Team Manager / SW was providing cover for a second caseload. As for the Luton CMHTs, there was considerable variation between team caseloads in the proportion of service-users receiving enhanced CPA care (32 – 65%), with the Leighton Buzzard CMHT having a significantly greater proportion of service-users receiving enhanced CPA care.

### Table 2: Heartlands CMHT Caseload Data

<table>
<thead>
<tr>
<th>TEAM</th>
<th>No. of Team-members returning caseload data</th>
<th>Average caseload for F/T generic workers (range)</th>
<th>Total active service-user caseload</th>
<th>Total service-users rated as &gt;=4/5 for Care Coordination (% of total cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dunstable CMHT</td>
<td>8</td>
<td>31 (25 – 38) for CMHNs (27 in Dec 2004)</td>
<td>179</td>
<td>58 (32.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27 for SW (21 in Dec 2004)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 for Team Mgr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leighton Buzzard CMHT</td>
<td>6</td>
<td>26.5 (12 – 41) for CMHNs (32 in Dec 2004)</td>
<td>173</td>
<td>112 (64.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 for SW (22 in Dec 2004)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>35.5 (27 – 44) for Team Mgr (a shared role)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biggleswade CMHT</td>
<td>9</td>
<td>22 (21 – 34) for CMHNs (20 in Dec 2004)</td>
<td>167</td>
<td>77 (46.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26 (22 – 28) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 for Act. Team Mgr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampthill CMHT</td>
<td>10</td>
<td>25 for CMHNs</td>
<td>134</td>
<td>49 (36.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14 (12 – 16) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17 for CSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>33 Team-members</td>
<td>26 per F/T CMHN</td>
<td>653</td>
<td>296 (45.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23 per F/T SW (service-users per F/T worker)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 service-users</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17 for CSW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- CMHNs = community mental health nurses;
- SWs = social workers;
- CSWs = community support workers

As shown in Table 3, there is considerable variation in total team caseloads for Bedford CMHTs (based upon registered practitioners only), close similarity for SW caseload sizes and some variation in CMHN caseload sizes between the three CMHTs. The Bedford East Team Manager has a significantly higher caseload than for any other full-time team manager. A part-time Bedford West CMHN had a caseload of 25 service-users (= equivalent of 42 service-users for a full-time CMHN). Compared with team caseloads for the Luton CMHTs
and Heartlands CMHTs, there was greater similarity in the proportion of service-users receiving enhanced CPA care (53 – 68%) on Bedford CMHT caseloads.

Table 3: Bedford CMHT Caseload Data

<table>
<thead>
<tr>
<th>TEAM</th>
<th>No. of Team-members returning caseload data</th>
<th>Average caseload for F/T generic workers (range)</th>
<th>Total active service-user caseload</th>
<th>Total service-users rated as &gt;=4/5 for Care Coordination (% of total cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedford East CMHT</td>
<td>11</td>
<td>23 (19 – 27) for CMHNs (20 in Dec 2004)</td>
<td>139</td>
<td>95 (68.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 for SW (21 in Dec 2004)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13.5 (10 – 17) for CSWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 for Team Mgr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedford West CMHT</td>
<td>7</td>
<td>20.5 (20 – 21) for CMHNs</td>
<td>113</td>
<td>68 (60.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16 for SW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 for Acting Team Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kempston CMHT</td>
<td>14</td>
<td>26 (22 – 30) for CMHNs</td>
<td>171</td>
<td>90 (52.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 (14 – 24) for SWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 for CSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 – 8 for STR (based on 4 x P/T STR workers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 for Team Mgr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>32 Team-members</td>
<td>23 per F/T CMHN</td>
<td>423</td>
<td>253 (59.8%) service-users rated as &gt;= 4/5 for Care Coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 per F/T SW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: 0.6 WTE CMHN had a caseload of 25 service-users

Key:
CMHNs = community mental health nurses; SWs = social workers; CSWs = community support workers; STR = Support Time & Recovery Workers

Whilst direct comparisons cannot be made between the Luton Forensic Team, Luton Assertive Outreach and the CMHTs, as these are clearly very different teams, caseload sizes are, as expected, much lower in these teams (see Table 4). As would be expected, almost all service-users are receiving enhanced CPA care within these teams.
Table 4: Caseload Data for Other Teams

<table>
<thead>
<tr>
<th>TEAM</th>
<th>No. of Team-members returning caseload data</th>
<th>Average caseload for F/T generic workers (range)</th>
<th>Total active service-user caseload</th>
<th>Total service-users rated as &gt;=4/5 for Care Coordination (% of total cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton Forensic Team (Orchard Unit)</td>
<td>4</td>
<td>5 (3 – 7) for CMHNs 17 for SW</td>
<td>32</td>
<td>29 (90.6%)</td>
</tr>
<tr>
<td>Luton Assertive Outreach Team</td>
<td>6</td>
<td>11 (10 – 11) for CMHNs 9 for SW 5 for OT</td>
<td>57</td>
<td>56 (98.2%)</td>
</tr>
<tr>
<td>TOTALS</td>
<td>10 Team-members n/a</td>
<td>n/a (two different teams)</td>
<td>89 service-users n/a</td>
<td>(two different teams)</td>
</tr>
</tbody>
</table>

Key:
CMHNs = community mental health nurses; SWs = social workers; OT = occupational therapists

In summary, considering the caseload sizes for all practitioners, with caseload sizes being adjusted for part-time practitioners, the following average caseload sizes were found (Table 5):

Table 5: Average Caseload Size

<table>
<thead>
<tr>
<th>Community Mental Health Nurse Caseloads</th>
<th>Social Worker Caseloads</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT Locality</td>
<td>Ave. Caseload Size</td>
</tr>
<tr>
<td>Luton</td>
<td>29.7</td>
</tr>
<tr>
<td>Heartlands</td>
<td>26.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>25.7</td>
</tr>
</tbody>
</table>
Summary of Findings

A summary of the comparative findings of this audit are presented, in the form of a series of 17 charts.

Important: when viewing the charts, please refer to the following key

<table>
<thead>
<tr>
<th>KEY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton CMHTs</td>
</tr>
<tr>
<td>LNW = Luton North West CMHT; LSW = Luton South West CMHT; LSE =</td>
</tr>
<tr>
<td>Luton South East CMHT; LNE = Luton North East;</td>
</tr>
<tr>
<td>Heartlands CMHTs</td>
</tr>
<tr>
<td>DN = Dunstable CMHT; LB = Leighton Buzzard CMHT; BG = Biggleswade</td>
</tr>
<tr>
<td>CMHT; AM = Ampthill CMHT</td>
</tr>
<tr>
<td>Bedford CMHTs</td>
</tr>
<tr>
<td>Bed E = Bedford East CMHT; Bed W = Bedford West CMHT; KMP =</td>
</tr>
<tr>
<td>Kempston CMHT</td>
</tr>
<tr>
<td>Luton Other</td>
</tr>
<tr>
<td>L Forens = Luton Forensic Team; L AOT = Luton Assertive Outreach</td>
</tr>
<tr>
<td>Team</td>
</tr>
</tbody>
</table>

Disciplines

Tm Mgr = Team Manager; CMHN = Community Mental Health Nurse; SW = Social Worker; Snr Prac = Senior Practitioner; CSW = Community Support Worker; STR = Support Time & Recovery Worker; OT = Occupational Therapist

Part-Time Practitioners

Where an asterisk (*) is shown, this refers to a ‘PART-TIME’ practitioner

Caseload Size: Charts 1 - 4

These charts highlight the differences in caseload sizes and numbers of service-users being care coordinated (care coordination weighting >= 4/5) by practitioners within the various teams.

Chart 1: Luton CMHT Caseloads
Chart 2: Heartlands CMHT Caseloads

Caseload Sizes for Heartlands CMH Teams & Practitioners (July 2006)
(shows total caseload size & total no. in caseload being care coordinated as enhanced CPA care = eCPA)

Chart 3: Bedford CMHT Caseloads

Caseload Sizes for Bedford CMH Teams & Practitioners (July 2006)
(shows total caseload size & total no. in caseload being care coordinated as enhanced CPA care = eCPA)
Chart 4: Luton Forensic & Luton Assertive Outreach Team Caseloads

As shown in charts 1 – 4:

- actual caseload size varies considerably between practitioners within a team and between different teams
- whilst caseload sizes are generally higher for CMHNs, this is not the case for all teams
- only 6 practitioners have caseloads of 35 service-users or more, four of whom are CMHNs (two Luton SE CMHNs, one Luton SW CMHN and one Dunstable CMHN) and two of whom are Social Workers (a Luton SE SW and the Leighton Buzzard Social Worker / Team Manager, who was covering her own and a colleague’s caseload due to long-term sick leave – a situation that was in the process of being resolved)
- there is a clear difference in the composition of caseloads with some practitioners holding a caseload where the majority of service-users are receiving enhanced CPA care, thus either reflecting differences in needs between team service-user groups or, more likely, a difference in the interpretation and practical application of CPA between teams
- in the Dunstable, Leighton Buzzard, Biggleswade, Bedford East, Bedford West & Kempston CMHTs, the Team Manager works with a small caseload of service-users, which is not a practice expected of Luton CMHT Managers
- as expected, practitioners working within the Luton Forensic and Luton Assertive Outreach Teams have small caseloads of service-users, almost all of whom are receiving enhanced CPA care

Caseload Weightings: Charts 5 - 8

These charts show the total caseload size and caseload weightings for individual practitioners within each of the teams.
Chart 5: Luton CMHT Caseload Weightings

Total Caseload Size & Total Caseload Weighting for Luton CMH Teams & Practitioners (July 2006)

Teams & Practitioners

Chart 6: Heartlands CMHT Caseload Weightings

Total Caseload Size & Total Caseload Weighting for Heartlands CMH Teams & Practitioners (July 2006)
Chart 7: Heartlands CMHT Caseload Weightings

Chart 8: Luton Forensic & Luton Assertive Outreach Team Caseload Weightings
As shown in Charts 5 – 8:

- Caseload weightings vary considerably between practitioners within a team and between different teams.
- In their original caseload thermometer weighting tool, upon which this caseload tool is based, McDermott & Reid (1999) suggested an upper total caseload weighting limit of 80 points per full-time generic CMHN caseload, which would mean that a full-time qualified mental health practitioner should not work with more than 16 ‘highest priority’ service-users (each weighted as 5/5), emphasising the importance of considering the different levels of needs and risks of service-users on particular caseloads.

(It must be noted that an adjustment to the caseload weighting tool may be necessary in considering and agreeing the maximum caseload weighting level for practitioners working within Forensic or Assertive Outreach Teams, as this tool was originally developed for auditing and promoting equity within CMHT caseloads.)

- If this principle of a maximum of 80 weighting points per caseload is applied, then the caseload of 14 practitioners currently exceeds this maximum threshold, of whom 10 are CMHNs (two Luton NW CMHNs, one Luton SW CMHN, one Luton SE CMHN, one Dunstable CMHN, two Leighton Buzzard CMHNs, two Bedford East CMHNs & one Bedford West CMHN), three are Social Workers (a Luton SE SW, a Leighton Buzzard SW and a Biggleswade SW) and the other is the Leighton Buzzard Social Worker / Team Manager (who, as stated previously, was covering a second caseload at the time of audit).

- The caseload of six practitioners currently exceeded 100 weighting points which is indicative of an excessively demanding caseload (a Luton SW CMHN, a Luton SE CMHN, a Luton SE SW, a Leighton Buzzard CMHN, the Leighton Buzzard Social Worker / Team Manager and a Biggleswade SW).

- Of course, it must be noted that the maximum caseload weighting limit would need to be reduced for those practitioners who are fulfilling other roles, have other significant demands upon their time or are working on a part-time basis.

Caseload Risk Levels: Charts 9 - 13
Charts 9 – 12 show the average risk weightings for individual practitioner caseloads within each of the teams. Chart 13 shows the average risk weighting against caseload size.

As shown in Charts 9 – 13:

- There is considerable variation in the average risk level of individual caseloads, with risk weightings being generally higher for Social Worker caseloads, although this is not the case for all teams.
- Considering the important issue of the level of risk, effective caseload management would suggest that those practitioners who have larger caseloads would be expected to work with service-users presenting a lower degree of risk - an hypothesis that is represented by the diagonal line in Chart 13.
- As shown in Chart 13, the average risk weighting (risk index) falls above the line for 8 practitioners, suggesting one or both of the following: either greater levels of workload for these practitioners; and / or, a comparatively reduced contact time for those service-users presenting the highest level of risk.
Chart 9: Luton CMHT Average Caseload Risk Weightings

Average Caseload Risk Levels for Luton CMH Teams & Practitioners (July 2006)

Chart 10: Heartlands CMHT Average Caseload Risk Weightings

Average Caseload Risk Levels for Heartlands CMH Teams & Practitioners (July 2006)
Chart 11: Bedford CMHT Average Caseload Risk Weightings

Average Caseload Risk Levels for Bedford CMH Teams & Practitioners (July 2006)

Chart 12: Luton Forensic & Luton AO Team Average Caseload Risk Weightings

Average Caseload Risk Levels for Luton Forensic & AO Teams & Practitioners (July 2006)
Service-User Contact Time

**Time for Service-Users: Charts 14 - 16**

Chart 14 shows the average contact time (for face to face contact, travel and administration) given to each service-user per month (in hours) for each practitioner returning this data (N=27). Chart 15 highlights this contact time for service-users on the practitioner’s caseload as a percentage (%) of their total available working hours. Chart 16 highlights the % of this contact time that is given to fulfilling the administration requirements that are associated with service-user contact.

As shown, an average of 3.24 hours contact time is provided for each service-user per month, representing just over 51% of the practitioner’s total working time. An average of 24% (range = 10% – 45%) of this time is spent on fulfilling administrative requirements. As shown, contact time as a percentage of available working hours was greater for Biggleswade practitioners which may be explained by significantly greater travel time for visiting service-users across a rural area.

Although it is unfortunate that only a few practitioners returned this data, this should be helpful in recognising and agreeing an expected standard for each of these contact parameters.
**Chart 14: Contact Time for Service-Users**

Average Contact Time (per client per month) for Teams & Practitioners (July 2006)
(for all practitioners who provided data on monthly face to face contact time)

**Chart 15: Contact Time as a % of Available Working Time**

% of Total Working Time devoted to direct contact with clients on caseload (July 2006)
(for all practitioners who provided data on monthly face to face contact time)
Setting Meaningful Standards for Caseloads: a proposed method

It is important to account for the additional roles undertaken by practitioners when making a comparative assessment of workload. To highlight this point, it is well-worth considering the additional data provided by practitioners of the Bedford East CMHT; this refers to their various additional roles that were otherwise not fully accounted for within the caseload audit, as the audit tool focused primarily upon their direct clinical work with service-users on their caseload – consider the following two examples, for two full-time CMHNs.

1. Bedford East CMHN 1
   - working with carers = 4.3 hours / month
   - working with service-users who are not on caseload = 6 hours / month
   - fulfilling the role of trainer in providing training on Advance Statements = 6 hours
   - providing duty desk cover = 11 hours / month
   - appropriate adult duty = 6 hours / month
   - fulfilling the role of student mentor = estimated as 12 hours / month
   - acting as a liaison for two GP practices = estimated at 3 hours / month

   this equates to 48.3 hours / month OR 32.2% of this practitioner’s total available time
   (this does not include: providing a depot clinic, attending team meetings, data-entry to the Trust’s clinical information system and liaising with others about care, much of which could be viewed as non face-to-face activity which is related to routine clinical work)

2. Bedford East CMHN 2
   - attending skills training in psychosocial intervention = 15 hours / month
   - fulfilling the role of student mentor = 16 hours / month
   - providing duty desk cover = 8 hours / month
this equates to 39 hours / month OR 26% of this practitioner’s total available time (this
does not include: providing a depot clinic, attending team meetings, attending team / clinical
review meetings, data-entry to the Trust’s clinical information system, liaising with others
about care, attending for supervision and attending for statutory training, much of which could
be viewed as non face-to-face activity which is related to routine clinical work)

Such clearly needs to be considered by the Team Manager when setting an expected
maximum caseload weighting level for each practitioner – for example, a maximum caseload
weighting of 40 – 60 points may be set for a practitioner who has an agreed additional role,
rather than the 80 points for the full-time generic mental health practitioner.

However, any decision to reduce the expected maximum caseload weighting of 80 weighting
points for a full-time generic practitioner would need to exclude the expected routine activities
required of the practitioner in fulfilling their generic role and exclude the expected variation in
availability that occurs as a consequence of annual leave. So for a practitioner who devotes
25% of their available time to ASW (Approved Social Worker role) duty, their expected
maximum caseload weighting could be set at 60 weighting points. Similarly, for a practitioner
who provides 10% of their available time to providing an agreed educational commitment /
role (for example, considering 5% of their available time for teaching + 5% for teaching
preparation), their expected maximum caseload weighting could be set at 72 weighting
points.

Considering the two examples above, the agreed maximum caseload weighting limits for
these two CMHNs would be: CMHN 1 = 54 weighting points (max. 80 points – 32.2%);
CMHN 2 = 59 weighting points (max. 80 points – 26%). It is worth noting that both of these
CMHNs have average caseload weightings far in excess of this, of 90 & 91 weighting points
respectively.

Using such a method, team managers could agree explicit caseload expectations for
individual practitioners within the team as a component of caseload supervision, with the
objective of ensuring that caseloads are set at a safe and therapeutic level and that the
workload of the team is allocated in an equitable way.

Furthermore, ongoing and concurrent use of the caseload tool would support meaningful
caseload supervision, where discussion could be focused upon the appropriateness and
effectiveness of providing care to service-users who currently merit high or low caseload
weightings. Considering service-users who are currently receiving care from a CMHT, those
with high weightings may be better placed with an alternative ‘more intensive’ service, whilst
those with low weightings could be considered for discharge from the practitioner’s caseload.

Team Caseload Profiles

Team caseload profiles have been formed from the audit data-set, which highlight the level of
complexity and need of each team’s caseload. Highlighting the average criterion weightings
for each team, these profiles are shown as a series of charts within appendix 2.

Considering the eleven CMHTs, team caseload profiles highlight that:

- risk weightings are highest for the Bedford East, Leighton Buzzard and Luton North
  West CMHTs
- relapse weightings are highest for the Leighton Buzzard, Bedford East and Ampthill
  CMHTs
- needs weightings are highest for the Leighton Buzzard, Bedford East and Ampthill
  CMHTs
support weightings are highest for the Leighton Buzzard, Bedford East and Ampthill CMHTs

engagement / compliance weightings are highest for the Leighton Buzzard, Bedford East and Biggleswade CMHTs

contact weightings are highest for the Leighton Buzzard, Ampthill and Bedford East CMHTs

care coordination weightings are highest for the Bedford East, Leighton Buzzard and Bedford West CMHTs

These profiles are best considered as only providing a comparative indication for different teams, as the actual practice of different teams may vary slightly and such may have an impact upon how caseloads are weighted using the caseload weighting tool – for example, this audit sample suggests that different teams are not applying criteria for enhanced CPA care in a consistent way.

Conclusion

As highlighted previously (Butler 2005), this clinical caseload audit tool represents an attempt to achieve a compromise between practical simplicity of use and the known complexity of workload issues. Nevertheless, as with any such tool, it has to be accepted that there is always a degree of subjectivity on the part of the auditor (practitioner) and validator in agreeing weighted ratings.

As shown by the summary findings, there is considerable variation between individual, discipline and team caseloads, which can be summarised as follows:

a. CMHN caseloads are higher than those for SWs, which may well reflect the difference in role (Greenwood et al 2000)
b. CMHN caseloads are highest in Luton and lowest in Bedford
c. SW caseloads are highest in Heartlands and lowest in Bedford
d. caseload sizes exceeded 35 service-users for only six practitioners, four of whom were CMHNs, with three of these CMHNs working within the Luton CMHTs
e. 46% of service-users were weighted as receiving enhanced CPA care (excluding the Luton Forensic and Luton Assertive Outreach Teams), although this was significantly more likely within the Bedford CMHTs and least likely within the Luton CMHTs, suggesting that there is a difference in interpreting and applying criteria for enhanced CPA care across the CMHTs
f. caseload profiles for the Leighton Buzzard, Bedford East, Bedford West and Kempston CMHTs show that at least 50% of service-users are receiving enhanced CPA care, whereas the majority of service-users receive standard CPA care in the other CMHTs
g. the number of service-users receiving enhanced CPA care on individual caseloads varies from 0 – 25 service-users per practitioner (excluding the Leighton Buzzard Team Manager / SW, who was providing cover for two caseloads), which suggests that this workload should be more equitably shared
h. SW caseloads generally have a higher average risk weighting, although there are some exceptions
i. some practitioners have large caseloads that show a high overall risk index, with 8/102 practitioners having a caseload that falls outside of the suggested threshold for risk, which suggests the need for reviewing and routinely monitoring caseloads, to ensure equity and safe practice
j. overall, the Leighton Buzzard CMHT and Bedford East CMHT caseloads were profiled as including greater numbers of service-users with a higher level of need
k. considering McDermott & Reid’s (1999) recommended maximum caseload weighting, the caseloads for 14/102 practitioners exceeded the maximum threshold of 80 weighting points, 10 of whom were CMHNs and three of whom were SWs, with a fairly even distribution across the three localities (Luton, Heartlands and Bedford), thus suggesting the need for enhanced caseload management and supervision (for challenging caseloads) and/or for further resources within some CMHTs

l. a method for agreeing an upper caseload weighting limit for individual practitioners has been presented in ensuring that caseloads are set a safe and therapeutic level, thus promoting a high quality of care and equity of workload

m. from the more limited data provided by 27 practitioners, each service-user receives an average of 3.24 hours of contact with their practitioner per month, of which about a quarter (range = 10% – 45%) is spent on fulfilling administrative requirements

n. from the more limited data provided by 27 practitioners, about half of a practitioner’s available working time is spent on direct contact with service-users

Together with the previous caseload audit (Butler 2005), this audit continues to highlight the potential value of systematically using a practical caseload weighting tool in monitoring and comparing caseloads between practitioners, disciplines and teams, in highlighting relevant issues for caseload supervision and effective caseload management. As a tool that is closely based upon CPA-related criteria, this offers an indicator and guide for the implementation of the Care Programme Approach and a meaningful method for identifying caseload pressures and resource needs.

Service / Practice Recommendations

1. All registered community mental health practitioners are recommended to maintain an up-to-date (concurrent) profile of their individual caseload using a practical caseload monitoring tool, as a method to support caseload supervision, caseload management and the fair and equitable allocation of workload and resources.

2. Team Managers are recommended to ensure the implementation of both clinical supervision and caseload supervision as distinct processes for facilitating effective caseload management. This would allow caseloads and workload to be challenged in a supportive atmosphere, promoting effectiveness, the use of alternative approaches, appropriate transfer and discharge.

3. Team Managers are recommended to agree and periodically review upper caseload weighting limits for individual practitioners, which need to take account of the additional roles and responsibilities fulfilled by some practitioners, using the method described within this paper. Given the actual and likely availability of resources, the priorities for fulfilling particular roles may need to be reviewed.

4. Team and Service Managers are recommended to review the specific team caseload data, which is available as a complementary Excel spreadsheet, in forming more specific action-plans that may include establishing clear priorities for the team and developing proposals for further resources.

5. The Community Teams Forum is recommended to plan for an externally validated caseload audit of all CMHTs on an annual basis.

6. The recently established CPA Working Group for the working age mental health directorate is recommended to review the application of criteria for providing enhanced CPA care, in ensuring clarity of criteria and a consistent application.
References

Department of Health (1999) Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach: a policy booklet. London: DoH
Instructions for making caseload weightings

<table>
<thead>
<tr>
<th>for each service-user on your caseload:</th>
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<tr>
<td>1. consider each of the seven audit criteria in turn</td>
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<td>2. beginning with the lowest weighting descriptor for each criterion in turn, consider the person's needs / problems and the treatment and care that is currently provided (over the last four weeks) in accordance with the descriptions that are given</td>
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<td>3. stop at the description that best describes the present situation for the service-user – record this as the criterion weighting</td>
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<td>4. complete and record weightings for each of the seven criteria (please note: for the ‘support’ criterion, make a distinction between input provided by team disciplines &amp; input provided by other teams / services)</td>
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<td>5. use the automated data record form (an Excel spreadsheet) to record all of your weightings for each service-user on your caseload</td>
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APPENDIX 2:

Team Caseload Profiles

- Luton CMHTs Caseload Profiles
- Heartlands CMHTs Caseload Profiles
- Bedford CMHTs Caseload Profiles
- Luton Forensic & Luton Assertive Outreach Team Caseload Profiles
- All Teams compared on Average Caseload Weightings
Team Caseload Profiles: Heartlands CMHTs (July 2006)
(each criterion is weighted from 1 (= low) to 5 (high))
Caseload Analysis: Aug 2006 / John Butler

Team Caseload Profiles: Luton Forensic & Luton AO Teams (July 2006)
(each criterion is weighted from 1 (= low) to 5 (high))
Teams compared on Average Caseload Weightings (July 2006):
(for each team, this shows the mean of all practitioner average caseload weightings)

Leighton Buzzard: weighting is skewed due to one practitioner temporarily overseeing two caseloads & thus having an unusually high average caseload weighting

more intensive intervention