

How I manage my caseload

Caseload management is a skill required of any speech and language therapist, whatever the numbers or client group involved. Balancing available resources with developments in the profession and the wishes of clients brings many pressures. Three contributions demonstrate the reality of good caseload management - not some magic solution waiting to be found but an ongoing, evolving team exercise.

The following article is one of three contributions to this feature on caseload management in the Spring 98 issue of *Speech & Language Therapy in Practice*.

Adult Learning Disability - from quantity to quality

*Teresa Catcheside and Jill Eddlestone explain how,
their team is working towards providing a more flexible service.*

The invitation to write this arrived at an interesting time. Like other departments, we have found ourselves subject to many changes over the past few years. We have been reviewing our service as a whole, looking at our ways of working and identifying how we could improve and make limited resources more effective. Caseload management is a major consideration.

The team

We form part of the speech and language therapy learning disabilities team comprising a full-time manager, three team leaders, a specialist in profound and multiple handicap (PMLD), a specialist and a chief post in working with individuals who challenge services, seven generalist therapists whose caseloads include adults with learning disabilities (based in Day Centres) and three whole time equivalent assistants. We are divided into three teams, North, South and City, based on geographical and social services / health care divisions covering a population of 2785 individuals with identified learning disabilities (Leicestershire Register of individuals with Learning Disabilities). Although not all known to our service, most will be seen for assessment and / or therapy at some time.

Problems facing us include:

1. **Numbers** Although a comparatively large department, the sheer number already on our caseloads makes it very difficult to manage the caseload successfully and maintain a consistently high standard of therapy. In some ways we are victims of our own success as development work with other professionals has raised awareness of our role. From these successes, particularly in working with PMLD clients, those who challenge, and those with eating and drinking difficulties, we are receiving increasing referrals with an expectation we will respond almost immediately and provide input and liaison at an intensive level.
2. **Contract Currency** Perhaps the most significant factor is that the speech and language therapy contract with the purchasing authorities (most importantly with the local Health Authority) is based on the numbers of clients we see on a face to face basis. There is therefore always the pressure to see large numbers, with the ensuing difficulties in terms of quality for the client and stress for the therapist. There are strong arguments against this basis for contracting; see *Communicating Quality* 2 p.134, no. 9, also *Money*, 1997.

3. **Consultative projects** We are increasingly involved with communication based projects, such as making information more accessible to clients with learning disabilities, eg. health leaflets and videos. These are very exciting and our expertise is often essential for success. Problems arise in that, again, time spent on this development work is not available for direct work and, indeed, under the present system is not acknowledged.
4. **Audit, developing policies and procedures, research and development, outcome measures** All are essential duties for our team, but of course require adequate time for meetings and planning. We also feel strongly there should be development of formal systems for support and mentoring of therapists new to or inexperienced in learning disability work. Presently, to cope with the numbers, all therapists need to work alone, carrying their own caseload. We see this as a major negative effect of unmanageable caseloads.
5. **Open ended versus episodes of therapy** Our way of working can be described as 'open ended' in that we see a client for therapy for a particular communicative need, eg. developing more appropriate ways of greeting others, then, when that aim is realised, another communication goal is identified, eg. working with signs/symbols to make simple choices. This encourages the therapist to keep the client's case 'open' thereby continuing very high numbers and causing ever-increasing problems maintaining casenote / caseload standards, managing review procedures etc.

So, there seemed to be nothing for it but to clear three days from our diaries and get together as a team to thrash things out.

Planning renegotiation

We agreed the only way forward is to renegotiate the contract currency allowing us flexibility for consultative and development work.

Over the next year we are going to work as a team to develop a project focusing our input away from direct work towards changing and adapting a client's communicative environment. We will then have 'permission' to take time to work alongside a colleague and be able to pool skills. There will be the opportunity to develop effective and sensitive outcome measures, essential in any negotiations to change the contract currency.

We have agreed a system of prioritisation for new referrals, based on guidelines in Communicating Quality 2.

We will carry out case studies from referral to discharge to distinguish more effective ways of working episodically. Through these, we will identify the time needed for assessment, goal planning, liaison, therapy planning, face to face therapy, recording, report writing, follow up work and review. Differing methods of intervention and management can then be compared and changes in working practices made.

We need this period of information gathering so we have sufficient data to present to managers and purchasers specifically regarding what constitutes an ideal model of intervention in terms of length of input / episode, and the content or focus of our intervention - from the individual to environmental. At the same time, our solutions need to embrace quality measures and continuing professional development.

Active team

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These major service issues cannot be addressed overnight. It would also be impossible to address them as an individual therapist. We feel very fortunate to be part of an active, forward looking team, itself part of a large department (38.1 whole time equivalent). Working cohesively gives us a voice and therefore the opportunity to be proactive in initiating changes to help us move from a quantitative towards qualitative and, we are sure, very effective model of input.

Teresa Catcheside and Jill Eddlestone are speech and language therapy team leaders for Fosse Health NHS Trust in Leicestershire. Both specialise in working with adults with learning disabilities.

References

RCSLT (1996) *Communicating Quality 2*. London: Royal College of Speech and Language Therapists.

Money, D. (1997) A comparison of three approaches to delivering a speech and language therapy service to people with learning disabilities. *European Journal of Disorders of Communication* 32 (4).