Camden and Islington NHS
NHS Foundation Trust

Islington Community Rehabilitation Team Operational Policy

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Camden ISLINGTON
supporting partnership in mental health

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DOCUMENT HISTORY

Date	Version	Amendments

MEMBERSHIP OF THE POLICY DEVELOPMENT/ REVIEW TEAM	Dave Fearon – Senior manager, Islington rehabilitation services Professor Helen Killaspy – Hon consultant in rehabilitation psychiatry
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DO NOT AMEND THIS DOCUMENT

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DEFINITIONS	
POLICY	An organisational statement of rules and standards which govern performance or actions required to be followed by those in employment. A policy should provide a framework for the organisation to work within and should specify in general terms the kind of action that is required. It may be supported by detailed procedures.
PROCEDURE	This is a clear instruction of how to carry out an agreed action.
GUIDELINE	This reflects best practice by reference to the best available evidence and how to apply this evidence in this organisation. The guidelines can be developed by this organisation, or can be adopted from national guidelines e.g. NICE Guidelines.
PROTOCOL	This suggests the best way to approach an action i.e. a best practice guide. It usually follows through a set sequence of actions needed in a logical order. It can establish the expectations of the Care Trust and other organisations for joint working.

1. INTRODUCTION

This document sets out and summarises the procedures for the management of work of the Islington Community Rehabilitation Team. It provides staff with clear guidance on the remit and key functions of this team and is a point of reference for all staff. This is an evolving document, which will be regularly updated in response to local service developments and national guidance.

The Islington Community Rehabilitation Team is a multidisciplinary mental health team working across the London Borough of Islington with service-users with long term complex needs and functional impairment secondary to psychosis. This group require a high level of community support and all live in facilities that are staffed 24 hours per day. The Community Rehabilitation Team caseload includes patients of the two Islington Community Rehabilitation Units (Highview and Aberdeen Park) and residents of the 24 hour specialist supported accommodation facilities within the borough (see Table 1). The team also provides care management to individuals placed in specialist facilities by the Islington adult mental health placement panel outside the borough. In total, the team provides specialist mental health rehabilitative care co-ordination/care management to around 200 service users.

2. SERVICE OBJECTIVES AND ETHOS

The main aim of mental health rehabilitation is to promote service users' recovery, functioning and autonomy to enable them to live successfully in the community with maximum independence and quality of life.

The Islington Community Rehabilitation Team objectives are to:

- Provide specialist, rehabilitative care co-ordination to people with complex, longer term psychosis (this will generally mean service users whose HoNOS Cluster is 12, 13, 16 or 17).

- Use a Recovery orientated approach in all their work with service users and carers.

    - To respect service users as experts by experience
    - To treat service users with dignity and respect at all times
    - To engage service users collaboratively in their care planning
    - To agree individual, tailored care plans with service users and their carers
    - To provide support to carers so that they can continue to support their relative
    - To provide clinical expertise to staff working with service users in high support facilities to ensure that care plans enable service users to gain/regain the necessary skills and confidence to be able to live as independently as possible and to work towards their personal recovery goals

- Provide evidence based mental health interventions, and meet social care needs so that service users receive the most appropriate and clinically effective treatment and support

- Support and liaise with GPs to ensure that service users' physical health needs are met in primary or secondary care as appropriate

- Manage the interface with primary care and other secondary physical health and mental health services effectively to ensure good communication and efficiency

- Work collaboratively and effectively with other statutory and non-statutory agencies and staff involved in the service users' care

- Support service users to access available resources and services that can assist them in their recovery

- Support service users to work towards moving on to less supported accommodation

- Facilitate move through from specialist mental health high support accommodation in Islington to ensure vacancies are available to new referrals into this care pathway

3. CLIENTS OF THE COMMUNITY REHABILITATION TEAM

A substantial proportion of people with severe mental health problems continue to have significant problems with social and personal functioning many years after diagnosis, despite optimum medical treatment. Most are not so disabled or behaviourally disturbed that they require long-term hospital care, but their problems place them at risk of social isolation, self-neglect, relapse into acute illness, inability to cope and exploitation in community settings. The Islington Community Rehabilitation Team will focus on people with a diagnosis of psychosis (schizophrenia, schizoaffective disorder, bipolar affective disorder) who have complex needs that necessitate their residing in a specialist community based mental health facility with 24 hour staffing in Islington. The team also care manage individuals placed in specialist facilities by the Islington adult mental health placement panel outside the borough.

The complex needs that these service users may experience will have complicated their recovery and include:

- non-response to treatment (treatment resistance)
- difficulties with social functioning and everyday living skills
- behaviours that present a risk to others or to themselves, often through self-neglect and vulnerability to exploitation
- challenging behaviours
- co-occurring substance misuse
- co-occurring physical health problems

The team will mainly work with service users who have been assessed as meeting the criteria for **HoNOS Clusters 12, 13, 16 or 17**. However, around 10% of clients of Early Intervention Services (**Cluster 10**) are referred to mental health rehabilitation services due to the severity of their functional impairment and ongoing symptoms of psychosis. Those who require 24 hour supported accommodation can be considered for transfer to the Community Rehabilitation Team. Similarly, some service users have multiple mental health problems and do not easily fit into one HoNOS Cluster or diagnostic category (e.g. people with psychosis co-occurring with Asperger's syndrome, organic brain injury or personality problems). Service users allocated to other clusters residing in 24 hour supported accommodation in Islington can be considered for their appropriateness for the Islington Community Rehabilitation Team on an individual basis and in discussion with their current team/service. However, it is likely that some specialist services within the Trust will be better placed than the Community Rehabilitation Team to deliver appropriate evidence based treatments and support these individuals in their recovery.

4. KEY SKILLS AND FUNCTIONS

Due to the complexity of their needs, a multidisciplinary team is required to deliver specialist, evidence based interventions to stabilise symptoms and promote recovery. This process can take many years and requires staff who enjoy working with service users who progress incrementally over the longer term. As well as holding a long term view, staff need to hold therapeutic optimism for their service users' recovery, even when other services may have lost hope for their recovery.

The following are the **key interventions** provided by the Community Rehabilitation Team.

All interventions will be provided either at the Community Rehabilitation Unit/supported accommodation service or at the Community Rehabilitation Team base:

4.1 Medication

Many people are referred for rehabilitation because they have not responded adequately to medications, often including those prescribed for 'treatment resistant symptoms'. The ability to find the best medication regime to minimise symptoms without producing distressing side-effects is a key skill for the Community Rehabilitation Team psychiatrist. Team nurses will have responsibility for ensuring that service users prescribed depot antipsychotic medication receive this as prescribed. Medication and side effects will be reviewed at every CPA meeting (and at other times as required). Since medication is usually prescribed by the service user's GP, any changes to medication agreed at CPA meetings will be communicated to the GP by the Community Rehabilitation Team in a timely fashion.

The senior members of the team will work with 24 hour supported accommodation providers to review their policies regarding medication management to ensure safe, consistent and appropriate support is given to service users to maximise their adherence with prescribed medication.

The Community Rehabilitation Team will also work closely with the supported accommodation team staff and staff of the Islington clozapine clinic to ensure that relevant policies regarding the prescription, administration and review of this medication are adhered to.

4.2 Psychological interventions

The team will ensure service users have access to evidence based psychological interventions (such as cognitive behavioural therapy adapted for psychosis and family work to promote their understanding of their relative's mental health needs), motivational interviewing for co-morbid substance misuse and "low intensity" psychological interventions (such as relapse prevention, behavioural activation, anxiety management). The team's clinical psychologist will be responsible for delivery of specialist psychological interventions themselves and for training, support and supervision of other team members and the staff of the supported accommodation facilities to deliver low intensity interventions. Where appropriately qualified and supervised, staff other than the clinical psychologist can also deliver specialist psychological interventions.

4.3 Activities of daily living and meaningful occupation

Occupational therapists are key members of any rehabilitation team, providing specialist assessment and interventions to address functional impairments. They will develop care plans with other team staff and staff of the supported accommodation services to address specific problems that the service user may have with everyday living skills (such as self-

care, using laundry facilities, cleaning their living space, budgeting, shopping and cooking). They also ensure that care plans address the service user's access to community resources for leisure, education and employment in order to build routine into their week and to build their confidence and skills in activities and vocational occupations that are meaningful and fit with their personal recovery goals.

4.4 Healthy living and primary care liaison

The team will provide guidance and support to service users to improve unhealthy lifestyles (such as exercise, smoking cessation and dietary advice) and ensure systems are in place to monitor physical health, including annual health checks and blood tests to monitor side effects of medication (including cholesterol, lipids and glucose). The development of strong links with local GPs and liaison regarding clients' physical health problems is a key task for the team and will be enhanced by the inclusion of specialist physical health nurses within the team staff.

The team will work in partnership with GPs and supported accommodation providers to clarify for each service user, the responsibilities of the supported accommodation staff, primary care, secondary physical health care services and the Community Rehabilitation Team staff in monitoring and managing service users' physical health needs.

4.5 Managing in society

The team includes social workers to ensure appropriate attention to service users' social care needs. This will include the specific role of the Approved Mental Health Practitioner in carrying out duties related to the assessment and review of service users subject to the Mental Health Act (1983). Exact figures are not available, but a significant number of the team's service users are likely to be subject to supervised discharge under Community Treatment Orders (CTO). The statutory and legal responsibilities of the AMHP and the team's consultant psychiatrist (the Responsible Clinician for these service users) involved in the management of this group comprises a significant workload in ensuring appropriate legal papers, and social circumstance reports and psychiatric reports for tribunals and managers hearings are completed within the necessary timeframes. Attendance at these hearings by the author of the social circumstances report and the Responsible Clinician is mandatory. It is likely that there will be at least one such hearing per week for service users of the Community Rehabilitation Team. The social workers will also have a lead role in advising and training other staff regarding process related to service users' welfare benefits, management of finances, personal budgets/direct payments, safeguarding and adult protection procedures, advocacy and other legal issues, and Community Care Assessments, which may include Assessment under section 47 of the NHS and Community Care Act, assessment under section 21 National Assistance Act, Fair Access to Care Services (FACS) Assessments, Supported Self-Assessment, and Carers' Assessments.

4.6 Support to supported accommodation services

Managing continuity of care will be maintained by team members throughout the service user's period of time with the Community Rehabilitation Team. Staff will co-ordinate all aspects of care and support and they will provide regular input and support to the staff of the 24 hour supported accommodation facilities across the borough. They will visit service users at least monthly and a comprehensive review of treatment and support needs will be carried out through the auspices of an annual CPA review meeting (6 monthly at Highview/Aberdeen Park). They will work closely with the supported accommodation staff to ensure that care plans are allied to service users' needs and recovery goals. They will have some flexibility to provide more intensive support if a service user is relapsing or the placement is breaking down. They will facilitate appropriate referrals as necessary to try to prevent admission or

placement breakdown (e.g. to the crisis resolution team/crisis house) and address specific issues with the supported accommodation team that may be contributing to relapse (e.g. medication non-adherence) through review of care plans. A key role will be ensuring that the long term view is held in mind in care planning and service users are supported to take on increasing responsibility for their treatment and care, incrementally and at a pace that they can safely manage. They will support service users and supported accommodation staff to ensure that move-on plans are considered in a timely fashion. They will support service users to consider future accommodation options, support them with visits to potential move-on accommodation and support them through the process of referral, assessment and move-on.

4.7 Management of Risk

- The management of risk is an integral part of the management of care.
- This will include consideration of issues relating to Child Protection and Safeguarding Vulnerable Adults, as per Foundation Trust Policies and multi-agency protocols.
- Risk assessments should identify each person's coping strategies and personal risk management techniques as a basis for helping them manage their own risks.
- All information in relation to risk assessment and management plans will be recorded on RiO.
- Service users have the right to confidentiality. However, there is an assumption of disclosure when necessary, for example when information sharing is critical due to risk, or during safeguarding procedures. In these circumstances information relating to the individual's risk screening, management plan and/or crisis plan will be communicated in a timely, concise and effective manner to all those providing care, including external agencies.
- The principles of the Data Protection Act 1998 and Caldicott guidance will be adhered to as this information will be provided on a "need to know" basis.
- In situations where there is an indication of a significant risk to staff safety, the service user will be seen by two team members. The Personal Safety and Lone Working Policy is in operation.

4.8 Out of area placements

A particular role for the Community Rehabilitation Team is the assessment and review of people placed out of area.

- Out of area placements displace service users from their communities and criticisms of the quality of care and lack of rehabilitative ethos in some have been made.
- Such placements are also expensive, costing, on average around 65% more than similar local services.
- They should be used for people with very complex needs where no local appropriate provision exists.
- Specialists in rehabilitation should be involved in assessing the appropriateness of placing an individual in an out of area placement and reviewing those placed out of area in order to clarify whether local services could provide a better alternative.

The Community Rehabilitation Team care manages people placed out of area where funding has been agreed for this by the Islington mental health placement panel. They carry out regular reviews of all service users placed out of area to:

- Assess whether the placement continues to meet the person's needs
- Identify an appropriately supported, (ideally more independent) placement for the personent to move-on to in the future, ideally in their area of origin where clinically indicated

- To identify with the service user and the staff of the out of area placement clear goals for progression through the pathway being identified (e.g. managing medication more independently, self-catering, budgeting)
- To facilitate assessment by the potential future accommodation provider at an appropriate time
- To liaise with all parties and support the person practically and emotionally through the assessment and move-on process, including visits, transitional leave and final move
- To continue to review the new placement if out of area, or hand over case to local CMHT or community rehabilitation team after an appropriate settling in period

5.THE CARE PATHWAY

5.1 Eligibility Criteria

a) Resident of the London Borough of Islington in one of the Trust's Community Rehabilitation Units (Highview/Aberdeen Park) or specialist 24 hour mental health supported accommodation services (see Table 1).
b) HoNOS cluster 12, 13, 16 or 17 (with some additional discussion required for service users meeting a) who have been assessed as meeting criteria for other Clusters – see previous note).
c) Disputed cases will be escalated for arbitration at the earliest opportunity to the Divisional Manager/Associate Clinical Directors, and then if necessary to the Medical Director if a clinical view is required.

Table 1. 24 hour specialist mental health supported accommodation services that the Islington Community Rehabilitation Team work with

Service	Number of residents currently care co-ordinated by Islington Recovery teams
Intensive Community Rehabilitation Units (provided by the Trust)	
Aberdeen Park	11
Highview	15
Residential Care Homes (provided by third sector)	
Hornsey Lane	10
Hilldrop	12
St Martin of Tours (New North Road/Wilton Villas)	8 (NNR) 1 (WV)
High Support (24 hour) Accommodation (provided by third sector and the Trust*)	
Ponders Bridge House	12
Davenant Road	12
Canonbury Lane	6
SHP Arundel	22
Barnsbury Rd	20
St George's	10
Southwood Smith	10
Cloudesley Rd	6
Turle Rd	5
Hanley Gardens*	26
Caledonian Rd*	7
TOTAL	**193**

5.2 Referrals and transfers

- Referral will be automatic for patients meeting the eligibility criteria above and discussion between the current care co-ordinating team and the Community Rehabilitation Team will start as soon as a service user is accepted for a place at either a Community Rehabilitation Unit or any of the 24 hour specialist mental health supported accommodation services in Islington.

- The Community Rehabilitation Team will attend the Supported Accommodation Providers' Forum and liaise closely with the supported accommodation referrals administrators to ensure they are aware of all new referrals.

- Care co-ordination will be transferred to the Community Rehabilitation Team from the current team through a transfer CPA meeting held around the time that the person moves to the Community Rehabilitation Unit/24 hour supported accommodation. This meeting should, ideally, be attended by the consultant psychiatrist/higher trainee of the referring team and the Community Rehabilitation Team as well as the care co-ordinator, service user and keyworker at the Community Rehabilitation Unit/supported accommodation.

- It is estimated that 150-200 service users will transfer to the Community Rehabilitation Team from the Islington Recovery teams. This process is likely to take around 9 months to complete.

5.3 Discharge

- When the person is due to move on to less than 24 hour supported accommodation, referral to the appropriate service to support them in their next accommodation will be made. This is likely to be one of the two Islington Recovery teams or the Islington Assertive Outreach Team in most cases. A transfer CPA meeting will be held around the time the service user moves on as described above under "Referrals and transfers".

- Occasionally, the service user may not require ongoing care co-ordination and they will then be potentially discharged from mental health services to the care of their GP. Discussion and detailed handover of appropriate information and advice about ongoing management and the process for re-referral to mental health service will be provided to the GP in such cases.

- A period of co-working between the Community Rehabilitation Team and the new service during the transitional period will be possible (decided on an as needed, case by case basis) for up to 3 months.

- Following discharge from the Community Rehabilitation Team a letter will be sent to the service user's GP with a copy to the service user and other relevant agencies detailing relevant plans and contact details

6. SERVICE STRUCTURE

6.1 Hours of Operation

Monday to Friday 9.00am - 5.00pm, excluding Bank Holidays

6.2 Service Base

Southwood Smith Centre, London N1

6.3 Operational Management

Divisional Manager: Andy Stopher
Associate Clinical Director: Dr Ian Prenelle
Service manager: Dave Fearon

6.4 Planned Team Staffing

Post	WTE	Band	Caseload
Consultant psychiatrist	0.5	Consultant	Whole team
Service manager	0.6	8a	Whole team
Team Manager	1.0	7 or SW equivalent	Whole team
Care co-ordinators / care managers			
OT	0.6	7	5
Psychologist	0.5	7	5 (plus whole-team)
Clinical Specialist Nurse	1.0	6	50 – care manager for out of area clients
Clinical Specialist Nurse	1.0	6	30
Social Worker AMHP	1.0	6	30
Clinical Specialist Nurse	1.0	6	30
Clinical Specialist Nurse	1.0	6	30
Clinical OT	0.4	6	10
Social Worker Basic Grade	1.0	5	30
Clinical Practitioner	1.0	5	30
TOTAL staff	**10.6**		**200 + 50 OATs**

6.5 Documentation

- Within 1 month of transfer to the Community Rehabilitation Team, and in line with annual CPA meetings thereafter and when otherwise relevant, the care co-ordinator will update the Core Assessment, Risk Assessment, and the Mental Health Clustering Tool (including HoNOS) on RiO.

- Team members will document a record of their clinical contacts (or arrange for it to be done by another member of the team) in RiO within 24 hours of the contact.

6.6 Use of Outcome Measures

- The Community Rehabilitation Team will collect and record routine outcome data using measures and metrics recommended by the Royal College of Psychiatrists and CIFT and agreed with the Islington commissioners. As well as Clinician Rated Measures (Health of the National Outcome Scale - symptoms and functioning, Life

Skills Profile – social functioning, Camberwell Assessment of Needs Short Appraisal Scale – total, met and unmet needs), these will include a Patient Reported Outcome Measure (likely to be the Short Warwick Edinburgh Mental Wellbeing Scale).
Metrics will include the proportion of service users moving on successfully per year the proportion of placement breakdowns. Full details of the process and outcome metrics and measures are given in the Service Evaluation Framework.

6.7 Multidisciplinary Clinical Review Meeting

These will be held weekly and will be attended by all members of the multi-disciplinary Community Rehabilitation Team. The meeting will provide an opportunity to feed back on casework, discuss the care of individual service users, formulate management plans and clarify responsibilities for specific tasks.

6.8 Business Meeting

This will take place weekly for all team members, to raise and discuss the pertinent issues regarding non clinical matters.

6.9 Manager's Meetings:

The team manager will attend:

- The monthly Managers' Meeting to support the running of all services.
- The monthly Finance Meeting to monitor expenditure and problem solve.
- The quarterly Performance Meeting to monitor and review performance against the targets set.

7. ADMINISTRATIVE SUPPORT

The role of the **Administrative Team** is to assist with the management and performance data associated with RIO and IAS, to assist with typing for the team, and to ensure a high quality and smooth operation of the resource centre and allied clinics.

Compliance with service standards and with requisite patient's charter standards is monitored.

The Admin lead will together with the Community Rehabilitation Team manager, review and improve the functions and performance of administrative and support systems, and maintain the physical condition and environment of the team base in line with Health & Safety requirements.

The Admin team are also responsible for providing a high quality secretarial and administrative service to the team and will work effectively as a member of both the secretarial and Community Rehabilitation Team and contribute to the effective organisation and running of the service.
Duties include: -

- Audio and copy typing
- Ensuring that an efficient filing system is in operation
- Organising meetings and minute taking
- Completion of patient information data bases
- Monitoring performance of the service against specified standards
- Dealing with telephone enquiries and face -to -face enquiries, recording and passing on messages as appropriate

8. CPA AND CARE MANAGEMENT

The Care Programme Approach (CPA) and Care Management Procedures are well documented in the joint CPA Operational Policy. **All service users accepted for treatment and care by the Community Rehabilitation Team will be subject to CPA**. A small percentage of service users will be residing in out of area placements and will therefore be care co-ordinated by the relevant local mental health service. These service users will require care management by the Community Rehabilitation Team and will require a **full** community care assessment including a statement of need and financial assessment etc.

The four key components of CPA and Care Management are:

- Assessment
- Care Planning
- Care Co-ordination
- Monitoring and Review

All members of the Community Rehabilitation Team should be familiar with the contents and requirements of the CPA Operational Policy. Copies are available in the team base and on the public folder system of the Trust Network.

Meeting the requirements of CPA and Care Management

8.1 Core Assessment

All service users should have a core assessment at the point of transfer, completed /updated on RiO within the first month on the 'core assessment form' on RiO. This standardised form meets the criteria set out in the CPA Operational Policy and is designed to evolve into a 'Community Care Assessment' if indicated. This will lead to a reduction in duplication of assessment time and administration.

8.2 Risk Assessment

An assessment of risk is an integral part of the core assessment for every client. Given their complex needs, all service users of the Community Rehabilitation team should have a full assessment of risk documented on RiO and updated annually and as needed.

8.3 Specialist Assessments

In addition to the core assessment, a further specialist or contributory assessment may be required. Such assessments may require the expertise of any of the professions working within (or linked to) the team. This may lead to the provision of specialist interventions as part of the client's care plan.

8.4 Care Planning

All service users must have a CPA care plan as detailed in the CPA Operational Policy.
The DH guidelines state that the care plan must:

- Identify the interventions and anticipated outcomes
- Record the actions necessary to achieve the agreed goals
- In the event of a disagreement, include the reasons
- Give an estimated time by which the outcomes or goals will be achieved or reviewed
- Detail the contributions of all the agencies involved
- Include appropriate crisis and contingency plans

Care plans should focus on the service user's strengths as well as their needs and seek to promote their recovery. Care plans should recognise clients diverse needs and should reflect their cultural and ethnic background as well as their gender and sexuality.

8.5 Care Co-ordination

Care co-ordinators can come from any discipline including psychiatry, psychology, mental health nursing, social work and occupational therapy. There should **not** be an assumption that the care co-ordinator will always be a mental health nurse or a social worker, although in practice this will often be the case.

The care co-ordinator is responsible for co-ordinating the care plan. Other members of the care team have a responsibility to communicate and liaise with the care co-ordinator regarding the delivery of the agreed care plan. Therefore, any difficulties or changes to the care plan should be communicated directly to the care co-ordinator.

If the care co-ordinator is on leave, a named deputising care co-ordinator must be identified by the Team as per local guidance.

It is important to stress that the care co-ordinator can only be effective in their role if all members of the care team communicate effectively. The role of the care co-ordinator is described in more detail in the CPA Operational Policy.

8.6 Monitoring and Review

Team members will monitor the agreed care plan on an ongoing basis through planned contacts and communication with others involved in the service user's care.

CPA reviews are designed to monitor and evaluate the effectiveness of the care plan and focus on how the needs of the client can continue to be met. The CPA review also incorporates statutory responsibilities to provide and review aftercare for service users subject to section 117. The service user or the carer can also request a review of the care plan at any time.

A CPA review should include:

- an evaluation of the care plans (i.e. progress, successes and failures)
- sharing relevant information
- review of the needs of the service user and their carers (including risk)
- review of the service user's attitude to the involvement of family and carers
- the identification of unmet need
- agreement of any changes to the care plan

Given the complexity of the service users of the team, CPA reviews will almost always require a multi-disciplinary meeting with all those involved in the service user's care. Staff working in primary care should be invited to the CPA review meeting.

8.7 Time scales for CPA review meetings

The frequency of CPA review meetings should be based on the individual needs of the service user, but there is a statutory obligation to ensure it happens at least annually.

- For service users who have been discharged from hospital the care plan should be reviewed within **4 weeks of discharge**.

8.8. Discharging and Transferring Care

The decision to discharge a service user from the team's caseload must be done as part of the CPA process. Potential discharges should be discussed in supervision and team meetings.

In relation to transfer of care to another team, staff should refer to:

- The CPA operational Policy
- The Protocol on Transfer within C&IFT
- The London Wide Protocol on Transfer of Care

8.9 Out of Area Treatments

Every service user of Mental Health Services on CPA should have a completed CPA Care Plan recorded on the appropriate documentation on RiO. All subsequent reviews should also be recorded on this form.

A small number of Foundation Trust service users are admitted to provider units outside Camden and Islington. It will be necessary for the care co-ordinator to liaise with these units and respective sector teams, to ensure that all mental health service users being discharged, from non-Camden and Islington providers have been assessed, and if appropriate, are included in the CPA.

It should remain a priority to bring such mental health service users back into our services at the earliest opportunity. This will make discharge planning more effective and should make the transition from hospital to community less traumatic for the service user.

Some services within the Trust may also be responsible for care managing services users, such as those placed in residential care or temporary accommodation who are subject to other Trusts CPA procedures.

For such mental health service users admitted back into Foundation Trust inpatient services it is our responsibility to ensure that all mental health service users being discharged to their home address have a completed CPA care plan.

Staff should ensure that care planning and risk assessment are aligned, with a comprehensive risk assessment taking place at every Care Planning review (Reference Care Programme Approach: Operational Policy (July 2011). The assessment of risk should inform the development of a responsive plan of action.

9. LINKS WITH PRIMARY CARE

The team will liaise closely with GPs about service user's treatment and care. It may be efficient to use a link model whereby specific team members act as the contact for specific GP practices. Of note, it is planned that the Community Rehabilitation Team will host one of two Islington physical health matrons in the near future whose role is to facilitate appropriate physical health care for people with long term mental and physical health care conditions. They will also have an important role in GP liaison. Additionally, the consultant psychiatrist may meet regularly with the GPs at their practice. Whilst such meetings provide an opportunity to discuss the management of mutual patients, the exact processes for liaison with GPs require further discussion to clarify local GPs' preferences and the resource implications for the Community Rehabilitation Team, particularly the consultant psychiatrist.

10. LINKS WITH OTHER AGENCIES

The team will also liaise with the following services as needed.

- Inpatient services
- Housing services
- Forensic mental health services
- Children and Families services

These links are formalised through regular meetings (e.g. bed management meeting, rehabilitation referrals meeting, supported housing providers' forum, rehabilitation forensic interface meeting).

11. DOCUMENTATION AND RECORD KEEPING

Case notes are intended to facilitate the care and treatment received by a service user and to demonstrate that such care is offered in an accountable and appropriately sensitive manner.

Case notes are:
- Confidential
- Potential legal documents
- Accessible to service users.

Case notes enable:
- Clear communication. An authorised person will by reading the notes be able to immediately identify a service user's current needs and care plan
- A clear record of care to be kept
- An evaluation of such care to occur

Case notes need to be:
- Accurate
- Accessible
- Non judgmental
- Objective
- Factual
- Comprehensible
- Up to date
- Abbreviations should be kept to a minimum

All records of contact with service users should be completed within one working day of the contact

11.1 Confidentiality and information sharing

Effective information sharing will enable providers to give the best possible service to users. In particular, it should ensure:

- Continuity of care when workers are unavailable
- That users will be fully informed about the range of services available to them

Summary of the main information sharing principles

- All staff have an obligation to safeguard the confidentiality of personal information.
- This is governed by the law, their contracts of employment and in specific cases by codes of conduct laid down by membership of professional bodies.
- Data subjects must be informed in general terms of how their personal information may be used and to whom it may be disclosed as soon as practicable when first accessing services. Data may be shared between team members with the data subject's consent in order to promote their health and well being.

11.2 Disclosure without the data subjects consent may only be made in exceptional circumstances

These include:

- Statutory Disclosure
- Disclosure in the public interest

Disclosure of `**relevant information in the public interest**` can be justified where there are reasonable grounds for believing serious harm would occur to the patient or others in the absence of disclosure. This extends to any misconduct of such a nature that it is in the public interest to disclose to others, including serious crimes, whether committed or at risk of being committed.

Trust staff can disclose personal information without the data subject's consent, to other departments/service areas within Camden & Islington FT, the London Borough of Camden Social Services, the London Borough of Islington Social Services where it is necessary to do so to discharge a statutory duty properly.

This ability effectively allows staff to share information to long as it demonstrably relates to a statutory function and effort is expended to advise service users that this process is likely to happen and that this is documented.

Camden & Islington FT, the London Borough of Camden Social Services and the London Borough of Islington Social Services will ensure that the sharing of information between them is undertaken where the clear aim is to benefit those service users receiving services from more than one agency.

In addition they will ensure the following with regard to information relating to the health and welfare of all service users:

- Information is confidential to that service user and to those providing the individual with care and treatment.

- It is the responsibility of the service user's care co-ordinator to explain at the earliest practicable time what information will be collated, how and for what purpose and with whom it may be shared.

-Information will only be disclosed to those who need to have the information in order to provide, plan and manage effective care and treatment. This may include voluntary or private bodies providing care.

-In these circumstances, care should be paid to the need to ensure that the information disclosed is needed or is likely to be needed for the purposes of the care to be provided.

-Information will not be disclosed to any other persons without the consent of the service user, except in exceptional circumstances (e.g. statutory disclosure, disclosure in the public interest – see above).

-Information about deceased service users will also be treated as confidential and subject to the same principles concerning its use and disclosure.

-All personal information must be treated as confidential.

-Personal information will only be shared if it is needed to deliver a service or undertake an assessment. Information to be shared must be purposeful and justified, and not used for any other purpose than for that which disclosed.

-Information must not be passed to a third party without the agreement of the relevant professional.

-Service users and carers must be told to what extent information will be shared between people providing services and between information systems.

-Service users and carers should be informed about their rights to see the information kept on record about them. The procedure for correcting inaccurate information should be clearly outlined.

-Service users should be informed that a breach of confidentiality is grounds for them to make a formal complaint.

-All staff members from each agency within the service should receive information on confidentiality as part of their induction and training. In addition they should be informed that a breach of confidentiality could result in disciplinary action.

Under the **1998 Data Protection Act**, disclosure of `personal data` must satisfy at least one of the conditions necessary to ensure that the use of this data is fair and lawful as required by the first data protection principle (see below).

PRINCIPLES OF DATA PROTECTION

The eight principles of Data Protection state that personal data must be:

1. Fairly and lawfully processed
2. Processed for limited purposes
3. Adequate, relevant and not excessive
4. Accurate and where necessary kept up to date
5. Not kept longer than necessary
6. Processed in accordance with the data subjects rights
7. Secure
8. Not transferred to other countries without adequate protection

Where information is aggregated or anonymised it will be used only for a justified purpose. Any such disclosure must be on a strict `need to know basis. The minimum information should be disclosed, and it should be anonymised where the recipient does not need to know the data subjects identity.

Trust staff can disclose personal information about a service user to other staff directly involved in the case, their line managers and other who need to know for purposes of planning or quality assurance mechanisms. In such cases it should be clear that personal information is essential for these purposes rather than anonymised aggregated information which might service the purpose sufficiently.

Attention should be paid in all cases to the need to ensure that the person or organisation receiving information will not share that information further and will store written information securely.

Students and other trainees need to have client contact will also need access to personal information about service users.

Finance and administrative staff will need to know some personal information such as details of placement or date of next review.

These staff should hold the minimum information necessary for the discharging of their duties

but should not be routinely provided with personal information over and above this.

11.3 Access to Records

Data subjects have certain rights of access to information held about them. The following policies must be complied with regarding any access requests.

- ***Access To Health Records Policy*** – Camden & Islington FT
- ***Confidentiality Of Health Records Policy*** - Camden & Islington FT
- ***Standards Of Record Keeping Policy*** - Camden & Islington FT
- ***Information sharing within Mental Health Services (leaflet)*** Camden & Islington FT
- ***Access To User Records – Policy & Practice Guidance*** – Document Reference: SS/DEP/1 – Version: 1 – Effective 14/12/98 Camden Social Services

12. QUALITY IMPROVEMENT

12.1 Clinical Governance

Clinical Governance is the framework whereby the Trust ensures the quality of its services. All staff has responsibilities under Clinical Governance, in relation to their own performance and that of their team. Clinical Governance responsibilities are focused on:

- ***Measuring and improving clinical performance -*** entailing the duty to use evidence based practice, maintain consistent records, participate in performance monitoring, and contribute to audit and learn from its results.

- ***Ensuring that we learn from users, carers and others -*** entailing the duty to involve users and carers in all decisions about their care, to act on and pass on their concerns, and to contribute to the development of user and carer involvement in services

- ***Proactively preventing things from going wrong -*** entailing the duty to maintain and update skills, use supervision, follow Trust policies, and report concerns about one's own performance or that of colleagues

- ***Dealing with things which have gone wrong*** - entailing the duty to maintain an open rather than a blaming culture within the team, to report incidents and errors, to support colleagues affected by critical incidents, and to contribute to process of learning from things which do go wrong.

12.2 Audit

The Community Rehabilitation team will need to develop systems for monitoring and measuring outcomes. The Clinical Governance Support Unit will support and advise the Team Manager with this.

13. VALUING DIVERSITY

A significant proportion of service users in Camden and Islington are from diverse ethnic and social backgrounds.

The Community Rehabilitation team is committed to the following principles:

- No user of the service receives less favourable treatment as a result of their race, religion, age, disability, sexual orientation, gender or diagnosis.

- Services offered are sensitive to service users' cultural and linguistic needs

- Taking positive action to promote diversity in the workforce

- To fully investigate all reports of alleged discrimination of any kind. Any employee who is believed to have discriminated against others, intentionally or otherwise will face disciplinary action in accordance with the relevant disciplinary procedures

- To enhance staff knowledge on issues related to diversity through training

- To seek feedback through audit or service user surveys to help improve the quality of service and monitor access to services

Racial discrimination and other forms of discrimination have no place in the provision of mental health services within Camden & Islington FT

14. KEY TEAM MANAGEMENT RESPONSIBILITIES

14.1 Caseload Management

The team manager has a responsibility to monitor the caseloads of the team's staff. This should be done via supervision, weekly team meetings, CPA meetings and good information management.

To assist with this and encourage caseload transparency a 'team spreadsheet' should be developed. This spreadsheet will be a standing item at the Team Management Meeting and should be available at the weekly team meetings for discussion.

14.2 Supervision & Appraisal

The document 'Supervision Framework for Mental Health Services' sets out guidelines for supervision within the Trust's teams.

Team managers must ensure that all staff have an annual appraisal using the agreed documentation.

14.3 Training & Development

The framework for Life Long Learning and Continuing Professional Development is integral to the local implementation of Clinical Governance and the local Mental Health Strategy. The local Mental Health Framework for education, training and professional development aims to:

- Promote multidisciplinary and interagency working through joint training
- Enable staff to develop the skills and competencies required to carry out their role effectively
- Facilitate and monitor Continuing Professional Development Plans for all disciplines

Managers must ensure that all staff working in the team have a Professional Development Plan, which incorporates the training and development required to carry out the core responsibilities of their role. This should be monitored and reviewed as part of the supervision and appraisal process.

14.4 Complaints & Local Investigations

Detailed guidance from the Trust and SSD on dealing with complaints is available to all Teams. Managers are expected to lead investigations into complaints about their area of service. The relevant Associate Director should be made aware of all complaints relating to their area of service.

In relation to Local Investigations under the Trust's Serious Incident Procedure, The Associate Director will meet with the relevant Operational service manager to decide who is best placed to carry out the investigation. A copy of the Trust 'Serious Incident Procedure' is available to all managers.

14.5 Finance

As budget holders, all operational service managers will have regular contact with Finance staff in both departments. Budget holders play an important role in maintaining the financial stability of our organisation. The overriding financial duty of a budget holder is to keep costs down and keep within budget.

All operational service managers should adhere to the following principles:

- You must engage in the budget review/setting cycle. This will entail holding regular meetings with your finance representatives to review financial performance against service pressures.

- You must understand that once a budget is collectively set through the budget setting process, no officer has a right to exceed their budget. Any service pressure that cannot be contained within financial targets should be the subject of an agreed action plan to rectify the problem.

- Where necessary you must devise action plans with your finance representative either by:
  * Improving efficiency/retention of staff
  * Agreed service cuts
  * Agreed virement of funds from another service area

- You must ensure that all new service developments are fully costed and funded, either internally or through new monies, through close liaison with finance colleagues.

- You must ensure that your line manager and finance are notified in a timely fashion if any change in service delivery or unit cost will impact on the performance of the team against its financial targets.

15. HEALTH AND SAFETY

All staff have a duty to promote health and safety at work and ensure safe working practices and safety of colleagues, clients and visitors. A commitment to the management of safety will contribute to the quality of the service provided by C&I and LBI, by reducing injuries and ill health, protecting the environment and reducing unnecessary losses and liabilities.

Each site has

- Health & Safety at work manual, which details policy, procedure and guidance which all staff, should be aware of.
- A site co-ordinator who will facilitate and co-ordinate regular health & safety meetings with site staff, and to whom concern should be reported as soon as they are identified. The name of the site co-ordinator is displayed in reception.
- Regular health & safety inspections to ensure all aspects of health and safety are met.
- A First Aid 'lead' – each site must have a trained 'first-aider' available to provide first aid and regularly check that the first–aid box is stocked up.
- A local violence awareness policy which details local guidelines. This is reviewed annually, and updated as necessary.
- A number of mobile phones for staff to use on visits.

15.1 Induction and Training

All new staff must be properly inducted and orientated to their workplace and made aware of health & safety policies and procedures (i.e. emergency responses, panic and fire alarms etc.). All staff will receive mandatory training in violence awareness, fire, lifting and handling and CPR. Refresher training must be attended every year.

15.2 Accident & Incident Reporting

Each site has an accident/incident book that should be completed by staff, clients or visitors as necessary.