Clinical Strategy
2016–2021
A vision for the transformation of mental health services
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Our shared values

We are welcoming so you feel valued.
Friendly and polite.
Accessible and open.
Make time for you.

We are professional so you feel safe.
Safe.
Knowledgeable.
Self-aware of my impact on others.

We are respectful so you can feel understood.
Respect you.
Respect dignity.
Respect privacy.

We work as a team so you can feel involved.
Work together.
Listen and clearly communicate.
Offer solutions and choices.

We are kind so you can feel cared for.
Compassionate.
Helpful.
Encouraging.

We are positive so you can feel hopeful.
We aim high.
Improvement based on evidence.
Positive feedback.
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Camden and Islington NHS Foundation Trust (C&I) is the major provider of mental health and substance misuse services in the boroughs of Camden and Islington. C&I also delivers services in Kingston-upon-Thames.

This clinical strategy reflects an holistic approach of promoting health and wellbeing by considering mind, body, family, friends, community and environment. We recognise that health and wellbeing are shaped by individual characteristics, lifestyle choices and environmental influences. Instead of attempting to fix people and their problems, or do things to them rather than with them, our recovery-orientated services look at individual needs and help people reach their potential. We will provide services that are accessible, person-centred and responsive to the often complex needs of individuals.

The main determinants of health are socio-economic. In order to promote good health, prevent ill health and reduce inequalities in health, C&I will work with its partner organisations to act on these social determinants that are likely to impair people’s health.

The NHS is facing multiple challenges including severe financial constraints, increasing demand, higher expectations of quality and increasing regulation. This strategy is a vision for the transformation of mental health and substance misuse services to address these challenges.
The diagram above illustrates key aspects of this strategy. We will promote recovery, resilience and independence. We will deliver services in practice-based services and in our specialist care-pathways. We have chosen 10 overarching themes and principles for our clinical model.

- We will co-produce with our service users and carers their treatment and support
- We will work in a recovery-orientated way
- We will offer evidence-based interventions
- We will choose outcomes that measure things that matter to service users and carers and use these to shape our services
- We will integrate with other services so that service users have their mental, physical and social needs met in a coherent way
- We will prevent mental illness deteriorating or relapsing in all our service users and we will contribute to initiatives that prevent mental health problems in children and young people
- We will equip all our clinical staff to address drug and alcohol problems
- We will improve access to our services for everyone regardless of gender, race, ethnicity, disability, sexual orientation and other protected characteristics
- We will choose a quality improvement methodology and implement it
- We will grow our already strong interest in research
The diagram above illustrates how we will structure our services.

1. We will develop practice-based teams that work locally with GPs and other services in primary care, such as our iCope services. They will offer rapid assessments near to where people live by senior clinicians who can make decisions about treatments, access services in the community, or if needed, refer to our specialist care-pathways. They will link people into the local community resources and services. They will be better placed to see people who won’t engage with secondary care mental health services. They will support GPs in managing people with chronic mental illnesses who are stable. Along with our acute services, the practice-based teams will be the entry point into our specialist care-pathways.

2. We will continue to develop our specialist care-pathways that deliver treatment and support to people with similar needs due to mental illness. The focus of these services will be to help people achieve their recovery goals and link into their local social networks and community resources. Access to these pathways is based on risk, intensity and the need for specialist treatment.

With the help of our commissioners and partner organisations we will develop an Integrated Practice Unit for people with psychosis. We believe this way of bringing together all the providers who deliver care to people with psychosis and co-ordinating their treatment and support will deliver a better quality service and better outcomes, especially physical health outcomes.
In order to deliver this strategy all our strategies will be re-aligned to support it, including the organisational development strategy, workforce strategy, information technology strategy and estates strategy. We will work closely with our Local Authorities to deliver our delegated Local Authority duties.

Other key items in this strategy are:

- Our engagement with and support of carers
- Using service user and carer feedback to improve patient experience and shape our services.
Section 1: Introduction

This strategy builds on our previous clinical strategy and lays out the future direction and priorities for all C&I services. The document has been set out to firstly reflect the views of service users, carers and staff because they are the people who will make this a reality. Although it has been broken down into sections, the strategy must be read and applied as a whole. Everything in this document is important and the position in the document does not reflect its importance.

This strategy was developed with the help of service users, carers and staff. It is intended to bring these groups and the organisation together with the common aim that people who use C&I services will have the best possible prospect of recovery and independence through the best use of our available resources.

This is a live strategy that can develop in response to feedback from service users, carers, staff, and our partner organisations. It can adapt to changing health and social care landscapes. It supports the NHS Five Year Forward View and the strategies of our local partner organisations for the provision of mental health and other related services.

The core outcomes of the strategy are:

- To strengthen and further develop mental health and substance misuse services provided within primary care and community settings
- To maintain specialist care-pathways based on clinical need
- To strengthen the focus on recovery, resilience and independence

The vision and strategic aims of C&I

This strategy supports our vision that people who use C&I services will have the best possible prospect of recovery within the resources we have available. This vision is underpinned by three strategic aims; excellence, innovation and growth.

**C&I Vision**
People who use C&I services will have the best possible prospect of recovery within the resources we have available

**Excellence**
We will continually improve the quality and safety of service delivery, service user experience and improve outcomes
We will deliver the highest levels of quality and financial performance

**Innovation**
We will rapidly adopt best practice and maintain a culture of innovation in service development

**Growth**
We will pursue organic and inorganic growth opportunities through strategic partnerships and research and development
Section 2: What the previous strategy has achieved

The Clinical Quality Strategy 2013-2016 was launched in May 2013 against the backdrop of the recommendations of the Francis report. As a result of this strategy the following key things were achieved:

- A care-pathway approach
- Enhanced focus on evidence based treatments
- Simplified entry points into our services
- Once referrals were received, we took responsibility to get them to the correct team. We called this “no bouncing”
- High quality assessments on entering our service
- Greater specialisation of services, including the introduction of new models

Community Mental Health Division

- We developed new models for the Personality Disorders (PD) service, Complex Depression, Anxiety and Trauma (CDAT) service, and the Neuro-Developmental Disorders (NDD) service
- The Assessment and Advice Teams were established
- The Islington Parental Mental Health Service (Growing Together) started in 2014 to provide mental health interventions to parents with children under five years of age, a multi-agency collaboration between Whittington Health and C&I
- Improving Access to Psychological Therapies (IAPT) services were further developed under an integrated management structure
Acute Services Division
- The assessment ward is fully functional
- The Approved Mental Health Professionals (AMHP) services have been amalgamated into a single, cross-borough service
- An Integrated Liaison and Assessment Service is now in place in the Whittington Hospital, and negotiations are taking with the Royal Free Hospital and University College London Hospital
- The acute pathway has been strengthened with the opening of the Rivers Crisis House in South Camden

Rehabilitation and Recovery Division
- Recovery teams are established
- The Assertive Outreach Teams (AOT) are maintaining caseloads around 90 each as planned
- In Islington the new community rehabilitation service is in place and providing support to the 24 hour supported accommodation units
- The Recovery College is now open and growing

Substance Misuse Services Division
- A service model has been developed that brings together the specialist skills of C&I staff with those of the third sector
- The service has been remodelled to make it more recovery focused and it has achieved key targets in enabling service users to become drug-free and leave treatment services successfully
- C&I ran the substance misuse service at HMP Pentonville successfully for four years. Numbers in treatment rose from 70 to over 250. Nurse prescribing and dual diagnosis services were introduced. When the contract expired we decided not to bid for the new service

Services for Ageing and Mental Health
- The community recovery service for older people is open and delivering a responsive, time-limited service

Other key achievements that we have co-produced with our commissioners
- The number of inpatient beds has been increased
- We have established a 24 hour crisis telephone line
- A transitions service (Mind the Gap) has been established with staff from C&I and CAMHS (Children and Adolescent Mental Health Services) to help smooth the transition for adolescents moving to adult services
- The dementia pathway is strengthened with the Dementia Navigator service in Islington
- The acute pathway for older people has been strengthened with the new home treatment team
- The IAPT service (Improving Access to Psychological Services) in Camden is working with Long Term Conditions (LTC) pathways to offer better access to psychological interventions for people with LTCS and common mental health problems
- Our local crisis concordat plan was drawn up and fully implemented
Section 3: How and whom we have consulted

In May 2015 Dr Vincent Kirchner, Medical Director, was asked to lead on the review of the clinical strategy. A small Project Group was convened which included representatives from professional leads and operational staff. A collaborative approach was taken and we consulted as many stakeholders as possible.

Two service user and carer events took place in July and September 2015 to understand the priorities for service users and carers and also to feedback how their ideas have been translated into the strategy. An event was held with the Council of Governors in September 2015. Comments by e-mail were received from service users and carers.

Staff members were asked for ideas and contributions via e-mail, posters and through meetings in the divisions.

Meetings were also held with professional leads, consultants, service managers, academics, executive directors, the C&I Board, commissioners and Local Authority representatives.
Section 4: What we heard from service users and carers

We worked within the spirit of National Voices and Think Local Act Personal aspirations. National Voices is a coalition of health and social care charities in England. Think Local Act Personal is a national strategic partnership of more than 40 organisations committed to the implementation of personalisation and community-based healthcare. National Voices and Think Local Act Personal worked together to produce No Assumptions, which sets out a number of ‘I’ statements from people with lived experience of mental illness. It aims to help commissioners and service providers organise services that are person-centred and recovery oriented.

We regularly ask service users to complete the Family and Friends test. During the period April–October 2015, 611 service users responded and 81.7% said they would recommend the service they had received. This included service users in the boroughs of Camden and Islington.

In 2015 Islington Clinical Commissioning Group and Islington Borough Council commissioned iBug (Islington Borough User Group) to ask service users in Islington how they felt about the services provided by C&I. Of the 152 respondents, over 74% reported that they thought the services were good or very good, 68% said that services were flexible, empathic and met their specific needs, and 76% confirmed that they had received talking therapies to help their recovery. However, when asked if services had improved over the previous 12 months, only 39% said they had and 44% said they remained about the same.

We used the ‘I’ statements in the No Assumptions document as the basis for the first event with our service users and carers specifically aimed at informing this strategy and to help us better understand their expectations of our services and what matters to them, both now and going forward.
Section 4: (cont)

This is what our service users and carers told us is important to them:

Who I am:
- I want to be defined as an individual
- I want my cultural identity to be recognised and understood
- Don’t label me by my diagnosis or illness; it is detrimental to my identity

What’s important to me:
- I want clear simple pathways into and through my care and support, that I can see and understand
- I want clear information about what I can expect and to know the faces of people I might see
- I want different services to know about each other to ensure they can give me the care I need when I need it
- I want to know what I need to do if I am in a crisis and to receive a quick response
- As a carer I want to be better informed and supported but understand this sometimes needs to be balanced with the views and needs of the person I am caring for
- If I am not seen in my own home, I want the environment to be welcoming and comfortable and automatically take into account any sensory impairments I might have

How I wish to be supported:
- I want to be seen by a skilled person as soon as possible who listens to me and treats me with respect
- I want staff to have more conversations with me to get to know me and understand me better so that my plan is about me not just my illness
- I want my mental and physical health needs to be recognised and addressed
- I value peer support both on the wards and in the community as well as professional and clinical support
- I want services and support to be designed in partnership with people with lived experience of mental health services
- I want to be offered talking therapy, not just medication. Medication might be the quickest way to stop a crisis but not the best way to address the cause
- I want better links to community activities such as the arts, music, theatre, libraries, social groups
- Keep me in touch with my community and my culture

How People behave with me:
- I want services and professionals to listen to me, respect me and not make assumptions about me
- I want the staff I meet to be trained to understand mental health and physical health needs and able to help me as a whole person
- I want staff to talk to me about what and who is important to me in my life
- I want all the professionals working with me to meet together with me and my family or carer regularly
- Any Advance Decisions I made need respecting in a crisis
- Listen before judging me
We also asked people about the use of digital technology and sharing their notes with other professionals or holding them themselves. Most people agreed that smartphones and other digital technologies were useful, for example, for appointment or medication reminders. They also thought that it would be helpful if all relevant professionals had access to their records.

This is the beginning of an ongoing conversation with service users and carers about how we co-produce and deliver services.
Section 5: What we heard from staff

We heard inspiring ideas from many staff members of how our services could be developed. The overarching principal that our staff told us was that service users, their families and carers must be at the centre of everything we do. They are our priority and should be cared for with respect, dignity, kindness and compassion. Our staff told us that for the clinical strategy to be effective it must have a vision that is meaningful to them, service users, their families and carers and translate into tangible aims. The strategy should help create a culture of caring and commitment to our values.

Key messages from the staff

• Our services must be responsive and professional at all times offering equal access for everyone irrespective of age, gender, and ethnicity. Disabilities, including sensory and cognitive, must be accommodated. Services must be available 24 hours a day and in easily accessible locations

• Our care-pathways must be well designed to facilitate service users accessing the treatment and support they need quickly and easily. Different services within C&I need to work together so that there are no gaps when service users move between services

• There must be clearer links between mental health care and physical health care, with prompt access to the management of long term conditions by clinical experts. Integration of services will improve this access

• Assessments must be comprehensive and holistic and repeat assessments must be avoided. Specialist assessments should be accessible without delay.

• Care plans must be created in partnership with our service users. They must be accessible and clear. They should empower service users, encourage autonomy and independence, and be sensitive to their journey of recovery. Agreeing realistic, achievable goals is core to meaningful care planning. Care plans should be shared with those persons who are important to the care and wellbeing of that person

• The quality of care and meaningful clinical outcomes are very important, but in order to demonstrate quality, the measures we use must be more than just numbers

• A better definition of what a crisis is needs to be developed alongside our service users. People in acute distress due to mental illness must be prioritised for care and treatment in their homes and communities as quickly as possible. Our services must focus on interventions and education that will help people avoid finding themselves in a crisis. Crisis teams should focus on those service users who are most unwell and have a repertoire of interventions beyond a reliance on medication

• We need to gather more information about service user experience and work in collaboration with service users and carers in order to learn from them, so that we can better shape our services around lived experiences of mental illness
Clinical supervision, reflective practice, mindfulness and mentoring are essential tools for staff to deliver effective care. Technology can support staff in accessing seminars and other training on the internet; professional forums through social media; internet library resources; and supervision via video links.

Learning and development: Staff must be equipped with expert knowledge and skills, especially talking therapies. All staff need access to information about the local area and its health and social care resources so that they can link service users, families and carers into available services.

Digital technology can support the delivery of clinical services such as text reminders of appointments and reminders to take medication. Access to care records on secure mobile devices would allow staff to stay up to date and allow for better use of time.

Some people feared that a lack of resources will impact adversely on the quality of care through diminished clinical staff numbers and support services.
Section 6: What we heard from local partner organisations

Mental illness is the largest cause of disability in the UK. The wider social and economic impact of mental illness in London costs an estimated £26 billion with great personal costs. For example, a man who has experienced psychosis has a life expectancy 15 years shorter than the general population.

To establish the local priorities for mental health we met with local stakeholders and reviewed documents of our local partner organisations and those relating to London as a whole.

The common principles include:

• putting service users and carers at the heart of all care
• helping service users take control of their own care
• the importance of prevention of ill health
• giving children a healthy, happy start to life
• access to opportunities to reach your potential
• being safe
• having a home
• having an income/employment

A common goal is reducing the life expectancy gap for people with serious mental illness through better physical health care. Mental health services must help address the underlying causes such as smoking, hypertension, diabetes, cancer and obesity.

Mental health services need to focus on tackling long-term and complex conditions.

There should be better involvement of carers. There needs to be a stronger focus on safeguarding and our staff helped to develop a better understanding of ‘Making Safeguarding Personal’ and the duties and responsibilities relating the Care Act 2014.

Care-pathways need to be clearer with better integration between primary care and mental health services. Services must ensure that service users and carers know how to get help in a crisis. There should be an emphasis on people getting help before a crisis occurs, particularly for some minority groups,

Having a skilled and engaged workforce is crucial to delivering these challenges.
Section 7: What we learnt from national documents

The current national strategy for mental health in England published in 2011 No Health Without Mental Health¹ envisioned improving outcomes for people with mental health problems including better recovery, providing a better experience of care and support and improving the physical health of people with mental health problems. It established a mandate for the parity of esteem between mental and physical health.

Improving mental health provision is a central theme in NHS England’s 2014 Five Year Forward View², which sets out the need for change in how we deliver services in the future. The strategy includes a focus on prevention, allowing people more control over their care, better use of technology and so-called triple integration: between primary and secondary care, between mental health and physical health and between health and social care. The Five Year Forward View suggests that mental health outcomes can improve by better prevention, increasing early access to effective treatments and crisis care, and integrating care to reduce mortality. It challenges us to develop new models of care to better provide for the needs of our population and the increasing demand on our health services.

Together with many of our partners C&I has signed up to the 2014 Crisis Care Concordat to ensure that our residents get the help they need in a mental health crisis. Getting access to the right care when it is needed is the central theme to the Care Quality Commission’s 2015 report Right Here Right Now³ which highlights the need for changing attitudes to improving care for people in a mental health crisis.

A new national strategy up to 2020 for mental health in England is currently being developed and the Mental Health Taskforce⁴ has heard from large numbers of service users, carers and professionals. They have identified four important themes that mental health providers need to focus on in the future: improving prevention of mental ill health, improving access to care, providing more integrated care and changing attitudes towards mental illness. Early findings from the taskforce support a ‘community asset’ approach, particularly in working with community and voluntary sector organisations, to equip people with knowledge and skills to understand and manage their own mental health and that of those close to them. This was considered especially important within black and ethnic minority communities.

There is a call for greater use of social prescribing, which links people with mental health problems into social activities in the community for wide-ranging benefits to overall health, including the opportunity to develop social networks.

Recent reports such as Transforming Care⁵ (2012) and the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities⁶ (2013) have focussed on the importance of making appropriate adjustments to ensure the needs of people with learning disabilities are met and that they have positive experiences of health services.

The Care Act 2014⁷ builds on recent reviews and reforms, simplifying and replacing numerous previous laws, to provide a coherent approach to adult social care in England. Part one of the Act (and its Statutory Guidance) consolidates and modernises the framework of care and support law; it set out new duties for local authorities and partners, and new rights for service users and carers.
The Care Act 2014 aims to achieve:

- Clearer, fairer care and support
- Wellbeing – physical, mental and emotional – of both the person needing care and their carer.
- Prevention: Local Authorities (and their partners in health, housing, welfare and employment services) must now take steps to prevent, reduce or delay the need for care and support for all local people
- People in control of their care
- Integration: Local Authorities have a statutory requirement to collaborate, cooperate and integrate with other public authorities e.g. health and housing. It also requires seamless transitions for young people moving to adult social care services.
Section 8: What we know about our local population

Camden

Camden has the third highest prevalence of psychotic disorder and the seventh highest prevalence of depression in London. It is estimated that about 36,700 people in Camden suffer with depression or anxiety. The suicide rate has been reducing since 2001 and in 2011-2013 it was below the national average and equal to the London average. The relatively younger population explains a lower prevalence of dementia.

Camden (2015:2025) - Short Term

Above is the population pyramid for Camden and the white edges indicate the population growth over the next ten years. In 2015, there were 237,364 people living in Camden. Each year the population is forecast to grow by about 3,655 people (1.54%). This growth is driven by the difference between local births and deaths (0.71%); net migration out to other parts of the UK (-1.1%); and net immigration from overseas (1.93%). Over the ten year period from 2015 to 2025 the population is forecast to grow from 237,000 to 264,000 (11% cumulative growth).

There is a significantly higher percentage of the population between the ages of 20 and 40 years and relatively few children and older people compared with the rest of England. Two thirds of the borough is ethnically mixed with no predominant ethnic community. The remaining one third is inhabited by predominantly white British people. 35% of residents are from Black and Ethnic minority backgrounds. There is a large Lesbian Gay Bisexual and Transgender (LGBT) community.
The population pyramid above demonstrates an interesting fact about Camden. In the age range 18-35, 40% of people arrived in the past 12 months and 70% arrived in the past 5 years. This in part explains why 38% of people admitted to our inpatient services are not known to our community services.

Camden is the 74th most deprived Local Authority in England. The North-West part of the borough is more affluent and it becomes progressively poorer towards the South.

With three main rail terminals (Kings Cross, Euston and St Pancras) Camden has a large number of new arrivals from across the UK and abroad. Some have mental health and substance misuse problems and present to A&E or the police, from where C&I provide treatment and support.
Section 8: (cont)

Islington

Islington has the highest prevalence of psychotic disorders in England, nearly double the national average. The rates of diagnosed psychosis and bipolar disorders are significantly higher in people from some black and ethnic minority communities. Islington has the highest prevalence of depression in London.

It is estimated that about 31,000 people in Islington suffer with depression or anxiety. The suicide rate has been reducing since 2001 and in 2011-2013 it was below the national average and slightly above the London average. The relatively younger population explains a lower prevalence of dementia.

Islington (2015:2025) - Short Term

Above is the population pyramid for Islington and the white edges indicate the population growth over the next ten years. In 2015, there were 224,554 people living in Islington. Each year the population is forecast to grow by about 4,177 people (1.86%). This growth is driven by the difference between local births and deaths (0.83%); net migration out to other parts of the UK (-0.66%); and, net immigration from overseas (0.83%). Over the ten year period from 2015 to 2025 the population is forecast to grow from 225,000 to 254,000 (13% cumulative growth).

There is a significantly higher percentage of the population between the ages of 20 and 40 years and relatively few children and older people compared with the rest of England. Three quarters of the borough is ethnically mixed with no predominant ethnic group. The remaining one quarter is inhabited by predominantly white British people. 26% of residents are from Black and Ethnic minority backgrounds.

Islington is the 14th most deprived Local Authority in England. The borough has a few small pockets of higher financial capability, with the rest of the population having low financial capability.
Section 8: (cont)

**Kingston-Upon-Thames**

Below is the population pyramid for Kingston and the white edges indicate the population growth over the next ten years. The population of Kingston in 2013 was approximately 167,000. It is expected to grow by 6% between 2013 and 2018.

Kingston is becoming more ethnically diverse with the number of people from black and ethnic minority communities having risen by 10% over the ten years to the 2011 census to 26%. The most represented groups are Indian, Sri Lankan and Korean.

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**Kingston-Upon-Thames (2015:2025) - Short Term**

People in Kingston are generally healthier than in London as a whole. However, there are stark differences between areas. It is estimated that 19,500 people in Kingston will suffer from anxiety or depression, of which many will be suitable for treatment with psychological therapies. Relatively fewer people have psychotic disorders; the prevalence is 0.8% compared to the London average of 1%. Kingston’s completion rate for substance misuse treatment programmes was lower in 2012 than the London average.
Section 9: What are our must-dos and constraints

Delivering standards
The Care Quality Commission (CQC) is the statutory regulator for the quality of health and social care in England. It is responsible for registering and monitoring compliance of NHS and social care providers with the essential standards of quality and safety. Registration with the CQC is a national requirement. There is now much greater rigour in and expectations from the CQC. Although this robust approach is welcomed, it does add a much greater burden on services in delivering these standards and preparing for inspections.

Access targets
There are national access and waiting time targets for Improving Access to Psychological Therapies, Early Intervention in Psychosis and Hospital Liaison - we are required to meet these targets.

Population
Over the next 10 years it is expected that 56,000 more people will live in Camden and Islington. This means there will be over 1,300 more people with schizophrenia and bipolar disorder. We also face the adverse social consequences related to a period of financial austerity.

A relatively large number of young professionals, students and immigrants move into the boroughs. Along with tourists they contribute to a large group of new service users who enter our acute pathway directly. Furthermore, the public has higher expectations of the quality and availability of services.

Cumulatively these factors contribute to a higher demand on services.

Finances
Nationally, the NHS is under enormous financial pressure. The NHS is likely to face efficiency savings of 4% (or more) per year at a time when there are significant demand pressures – for C&I this could equate to around £25m of savings (or more) over the course of this parliament.

The adverse financial position of all health services in North Central London (Barnet, Camden, Enfield, Haringey and Islington) may have an impact on local commissioning and therefore the Trust’s financial capacity. We remain committed to our obligation to deliver value for money to the taxpayer and are therefore mindful of the financial context.
Section 10:
What we have chosen to act on and how

Overarching themes:
The 10 key themes we have identified are:
1. Co-production of treatment and support
2. Recovery-orientated treatment and support
3. Evidence-based interventions
4. Outcomes that matter to service users
5. Integration with other services and physical healthcare
6. Prevention
7. Drugs and alcohol
8. Equality and diversity
9. Quality improvement
10. Research
Section 10: (cont)

1. Co-production of treatment and support

What

Service users told us they want staff to talk to them about what and who is important to them. They want to be treated as a whole person, bearing in mind their culture and community. They want their care plan to be about them and not just their illness. Staff told us how important it is for treatment and care plans to be designed with service users and carers so that they are meaningful and more likely to achieve the goals of service users.

We have therefore chosen co-production of care as the first overarching theme for all our services. Instead of services ‘doing for’ they will ‘do with’ service users. Through helping and supporting them, service users can become participants in their community rather than dependent on services.

Service-users have also said it is essential that they all have equal opportunities to become involved in the business of the Trust, to understand the governance arrangements in place to support them, and to know how they will be recognised and rewarded for their contributions.

How

- We will share good practice and provide training for staff on co-production, patient experience, care planning and discharge planning
- We will develop mechanisms to collect feedback about patient experience and present this to staff to inform their practice
- We will work with our partner organisations to give service users access to their care records
- We will provide good information to service users and carers on conditions and treatment options, we will improve the quality and accessibility of information
- Divisions will produce information about the treatment and support they offer both in written form and on the C&I website
- We will download information leaflets on medication from the NHS Choices website and give these to service users along with a verbal explanation about their medication
- We will encourage and support service users to do advanced plans and upload these to the electronic patient record system
- Service users are co-producing a Service User Co-Production Strategy. This will clarify the expectations of the roles service users can take in designing new services, improving service delivery, and taking up work opportunities in C&I
- We will review the Service User Alliance, which is the main forum for representatives of service-user groups to meet staff, and work in collaboration with C&I services
- Trust Women’s Action Group, a group of women who have used services, will continue to help review our policies, provide training and agree themes for the group to develop and take forward into actions
2. Recovery-orientated treatment and support

What

Service users said they want staff to get to know them and understand them better so that their care plan is about them not just their illness. Staff said care plans should empower service users, encourage autonomy and independence, and be sensitive to their journey of recovery. We have chosen recovery as the second overarching theme for all our services.

*Recovery isn’t about getting back to how you were before, it’s about building something new* (www.Rethink.org, 2015)

Recovery means different things to different people. We use ‘recovery’ to mean service users working towards their goals, having opportunities and control to fulfil their goals and having hope for the future. Not everyone will stop having symptoms during their recovery, but a goal can be to stop them from affecting their life as much. Medical treatment is one way towards recovery. It helps a lot of people, but it is not the only way to recover. Recovery is something you achieve for yourself. It is not something that someone else does for you, but others may be able to help if you want them to (www.Rethink.org, 2015).

How

- We will share good practice and provide training for staff on recovery-orientated practice
- We will engage positively with service users to support them in setting and achieving their own goals
- We will help service users to develop greater resilience and independence through supporting them to achieve accommodation, employment/income and social networks
- We will continue to provide opportunities for service users to explore meaningful occupations, to improve their quality of life
- We will support the development of personal health budgets
- We will continue developing services that support recovery, including the recovery college, peer workers and re-ablement services
- We will identifying areas of good practice in the Trust and get those staff to help with disseminating these skills
- We will look to engage external organisations that support organisations with developing recovery-orientated approaches

Outcome

- Our service users will feel connected to their social network
- Our service users will have a sense of hope and optimism
- Our service users will feel their identity has been respected
- Our service users will feel a sense of meaning and purpose in their lives
- Our service users will feel empowered to manage their mental health problems
Section 10: (cont)

3. Evidence based interventions

What
Service users and carers told us they want to be seen by a skilled person and offered a range of therapies. Staff said they want to be equipped with expert knowledge and skills, especially talking therapies. They want services to be professional. These comments led us to the third overarching theme about evidence-based interventions. Research shows that certain interventions are effective for mental illness. These interventions are elaborated in the NICE guidelines (National Institute for Health and Care Excellence). The success of interventions is dependent on the power of strong therapeutic alliances between service users and their clinicians.

How
• Our workforce strategy will address the skills, attributes and capability of our staff so that they are equipped to deliver evidenced-based interventions
• All our teams will identify the skills they require in their workforce to deliver all the NICE approved interventions relevant to them and then ensure staff have the relevant training
• Teams will measure whether they are delivering evidence-based interventions, to whom and how effective they are in delivering them
• Every contact that clinicians have with service users will count by ensuring they are helping service users move forward in achieving their recovery goals
• Our pharmacists will provide medicines information, ensure our formulary is evidence based, ensure new NICE guidance on medication is disseminated and incorporated into our policies. They will implement training on medicines and competency assessments for staff

Outcome
• Our service users will achieve their recovery goals more effectively
• Our staff will feel they have the skills to deliver high quality clinical care
Section 10: (cont)

4. Outcomes that matter to service users and carers

What

Service users and carers told us they wanted to co-produce their care plan. Staff emphasised that clinical outcomes are important but that these must be more than just numbers. The evidence-based interventions we deliver must be effective and relevant.

Our commissioners are moving to Value Based Commissioning and we strongly support this direction. When services are commissioned, it will be on the basis of outcomes rather than the number of people treated (volume) or the way in which services are delivered (process). The goal is to achieve the best possible outcomes for people per pound spent. The outcomes are what matter to people. For example “I want to be able to have satisfying social relationships” or “I want to be in good physical health”. This approach drives different providers to work together to better co-ordinate treatment and support, improving patient experience and outcomes. The Integrated Practice Unit (IPU) is an example of outcome based commissioning.

How

• We will work with our commissioners, service users and carers to choose outcome measures that will measure what service users and carers have told us is important to them
• We will work on ways to collect this information in an efficient manner so that it has a minimal impact on clinicians’ time
• Individual services will identify the outcome measures that are particularly relevant and meaningful to the treatments and support they deliver
• Where possible we will choose outcome measures that will allow comparison with other mental health providers

Outcome

• Our service users will achieve their recovery goals more effectively
• Our staff will feel they have the skills to deliver high quality clinical care

5. Integration with other services and physical health care

What

Service users told us they want to be helped as a whole person. Integrating services helps professionals share relevant information and to see the person and their needs in their entirety. Treatment and support becomes more efficient and improves our ability to help service users achieve their goals.

Our service users, carers and staff told us physical health needs must be considered along with mental health needs. Service users and carers want staff to be trained to understand both their mental and physical health needs. This is in keeping with local and national priorities to reduce the mortality gap between people with severe mental illness and the general population through better prevention and management of physical health problems.

Service users said they want different services to know about each other to ensure they can get the treatment and support they need when they need it. They said they want relevant information to be shared with appropriate professionals having access to their records.
Section 10: (cont)

How

- Our workforce strategy will include skills training in physical health care
- All our clinicians will ask about physical health problems and include these in care plans
- Physical health monitoring will be part of normal practice
- We will provide more care through practice-based teams in GP surgeries and other community venues facilitating integration of services
- We will continue to improve our information technology systems to provide relevant information with consent to professionals involved in providing care, especially GPs
- We will work with Long Term Conditions pathways to ensure that people with physical health and mental health problems have easy access to evidence-based interventions for their mental health needs
- We will support and participate in the integration initiatives of our partner organisations such as the Diabetes IPU and Frailty IPU
- Our pharmacists will support medicines reviews and monitoring requirements for physical healthcare especially targeting high risk medicines (e.g. warfarin, insulin)
- Our pharmacists will develop links with GP practice based pharmacists

Outcome

- Our service users will feel that professionals helping them manage their mental and physical health problems are working in a coordinated way and treating them as a whole person
- Our staff will feel confident in managing and monitoring physical health problems up to a level that is appropriate to their training
- Our service users will have better physical health outcomes
Section 10: (cont) 6. Prevention

What

Service users and carers told us they want to be seen by a skilled person as soon as possible. Efficient referral pathways allow people to be seen early in the course of their illness so evidence-based interventions can prevent symptoms deteriorating and recurring.

Mental health services help shoulder the responsibility of preventing physical illness by having discussions with service users, providing them with information and ensuring they have physical examinations and blood testing. Particular topics to address are diet, exercise, alcohol, smoking and dental care.

We are not commissioned to deliver services to children and adolescents so our contribution to giving children a healthy, happy start to life is by supporting our partner organisations who do offer these services. We contribute directly to the mental health of children through our parental mental health services, our service for children of parents who have mental illness and through the treatment and support we give to the numerous parents who access our services.

How

• We will talk to our service users about diet, exercise, alcohol, smoking and dental care
• We will link people to smoking cessation services
• All our sites and services will operate strict non-smoking policies
• We will help service users’ understand their physical health through discussions with them
• We will help service users monitor and manage their physical health problems such as measuring blood pressure and weight, and facilitating blood testing and other investigations
• We will move the assessment functions of our services into the practice-based teams in primary care and staff them with consultant psychiatrists and senior clinicians, who can offer flexibility in how quickly people are seen and can make decisions about their treatment
• We will improve waiting times to treatment in our teams by making team processes as efficient as possible within the resources available
• We will use social prescribing to connect people with voluntary and community services that support prevention
• We will consider the needs of children in households where a parent has a mental illness and is using our services
• We will look for opportunities to support the mental health needs of young people

Outcome

• Service users will be seen as quickly as possible for an expert initial assessment and have as short a wait as possible to access treatment and support
• Our service users will have better physical health outcomes
• The children of our service users will feel supported and, if needed, referred to specialist services in their own right
Section 10: (cont)

7. Drugs and alcohol

What
We know that many of our service users, including a number of older adults, have problems related to alcohol, illicit drugs and novel psychoactive substances (including ‘legal highs’). These problems are so prevalent that we can no longer consider that people with a ‘dual diagnosis’ are a separate patient group requiring different services and workers, but rather that all our services and staff need to be able to help service users address these problems. We have substance misuse services who deliver specialist services and this theme is about what we expect from all our services.

How
• Our workforce strategy will include training for our staff in skills to have conversations with people about their drug and alcohol use
• Our Substance Misuse Services will take a lead on developing this training

Outcome
• Our staff will feel confident to speak to service users about drug and alcohol problems using evidence-based techniques
• More service users will feel enabled to address their drug and alcohol problems

8. Equality and Diversity

What
A fundamental and unique aspect of this Trust is the diverse community we serve and our diverse workforce. We value and celebrate this diversity which adds to the wealth of the organisation and brings enormous benefits in terms of creativity, innovation and prosperity. A diverse and multicultural workforce delivers better clinical quality outcomes. It will be central to everything that we do. Integral to our values is that our service users, carers and staff experience our services as welcoming, inclusive and fostering a culture of mutual understanding and respect. We want to be seen as the employer of choice because of our welcoming attitude to diversity. We want to excel in our statutory duty to ensure that equality, diversity and human rights are embedded into all our functions and activities as required by the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution.

Our ambition is to be the centre of excellence with regard to equality and diversity that inspires working, thinking and learning together to co-produce services which are all recovery focused. By working together with a philosophy of openness, respect, and celebration of diversity combined with a determination to bring about a positive change, our core values can become the lived experiences of each and every member of our diverse community.

The Equality and Diversity Strategy is endorsed by the Board and sets out our proposals to promote a culture whereby the diversity of our service users, carers and staff is positively valued. It contributes to integrating equality and inclusiveness in everything that we do. Making sure we make better use of the data and systems is a priority for us. This ambitious agenda is driven by what we have learnt, e.g. that people from Black African and Caribbean communities continue to be over-represented in mental health services; that staff from BME communities experience discrimination, bullying and harassment and are not getting the same opportunities to progress to senior leadership roles; that people with physical disabilities struggle to access some of our services; that we have limited services aimed at meeting the needs of men or people from LGBT communities.

We fully appreciate that in celebrating diversity we also have to understand the difficulties that different communities experience and what stops or hinders people accessing mental health services. Stigma and discrimination stops people seeking help and/or engaging with services and gets in the way of recovery.
Section 10: (cont)

C&I adopts a holistic approach to supporting women's needs. Our Women’s Lead provides a resource for staff to consult on specific matters to better support women who access our services. We provide training on women’s mental health, domestic and sexual abuse, working with self-injury, responding to disclosures of childhood abuse. This is provided within a trauma informed model of care, which recognises the distressing events that have occurred in the lives of many people who use mental health services.

The model aims to provide environments where people can disclose what has happened to them, where they can expect staff to listen with compassion and respect, and where staff have the skills to validate and ‘bear witness’ to these events. Trauma informed teams behave in ways that do not re-traumatise survivors of abuse, for example, knocking on a bedroom door and giving the person time to answer (embedded in the Trust Safety, Privacy and Dignity Policy), and automatically offering service users the choice of the gender of their worker.

C&I provides two women only services; Drayton Park Women’s Crisis House and Resource Centre and Rosewood ward, a treatment ward for acutely ill women requiring admission. The Drayton Park Women’s Crisis House model was developed 20 years ago in collaboration with women who have used services. It is an example of a trauma informed model providing the choice of a women only staff team, accommodation for children, routine exploration of trauma at all assessments, self-referral as an option when in crisis and very clear boundaries and agreements between staff and residents to ensure psychological and physical safety.

People with learning disabilities experience inequalities in accessing healthcare both in terms of their mental and physical health. Most people with learning disabilities access mainstream mental health services.

How

Better Health Outcomes

- We will ensure that all residents regardless of race, age, gender, disability, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity, marriage and civil partnerships are able to access services fairly and consistently
- We will improve our understanding of service user’s cultural needs and background and apply this to how we develop services in order to make services more accessible and acceptable
- We will ensure that at least 20% of young people with mental health needs are transitioned efficiently and effectively to adult services
- We will reduce the proportion of black service-users who are detained under the Mental Health Act. We will explore issues with service users, carers, community organisations/networks, clinicians and commissioners relating to engagement and clinical practice that result in over- or under-representation of people from African and Caribbean communities in different services
- We will continue our work with the Department of Health on the AR-DSA project (Awareness and Response to Domestic and Sexual Abuse) to embed a cultural change within the organisation in relation to responding appropriately to disclosures of domestic and sexual abuse

Improved Patient Access and Experience

- We will ensure that the dedicated programme of planned works to buildings to improve physical accessibility is implemented
- We will improve our recording and monitoring of equalities data by capturing all protected characteristics* on our patient information system. We will analyse this data across services to identify and address areas of inequality or disproportionality
- We will ensure that when transgender people use our services, staff are aware of and work to our transgender protocol
Section 10: (cont)

Representative and supported workforce
- We will significantly increase the number of staff from black and ethnic minority communities at bands 8a-9 from 3% to 15%. This will include a training and development programme for staff at bands 5-7
- We will encourage a positive culture towards people with disabilities
- We will create opportunities for staff from black and ethnic minority communities and staff with disabilities to meet either through staff forums or other activities

Inclusive Leadership
- We will increase the proportion of people from black and ethnic minority communities on the Board from one to three people
- We will develop a programme that will enable the advancement of skilled and qualified local people to take up future positions on the Board
- We will develop an equalities dashboard of key indicators to monitor progress
- We will embed equality targets in appraisals for managers.

Outcome
- Our service users and carers will receive high quality care that is responsive to their diverse needs and takes into account groups with protected characteristics*
- All our staff members will feel valued and have access to opportunities as well as celebrate diversity themselves
- C&I will have a reputation as an organisation that values and cherishes the diversity of its service users, carers and staff

* Protected characteristics = race, age, gender, disability, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity, marriage and civil partnerships
Section 10: (cont)

9. Quality improvement

What
We want services to continually improve. Trusts that have chosen a specific quality improvement methodology have better staff engagement and service user satisfaction as measured in the NHS staff survey and NHS service user survey.

How
- We will undertake a project to choose and implement a quality improvement methodology
- We will promote After Action Review as a method for staff members to review incidents and good practice themselves

Outcome
- C&I will have a quality improvement methodology that all staff will be able to use

10. Research

What
C&I has a strong commitment to integrating clinical care, teaching and research for the benefit of our service users and carers. Clinical research is an important part of what we do. It enables us to provide our service users and carers with the latest, most innovative clinical interventions and services to aid recovery. C&I is a major research hub and a member of University College London Partners (UCLP), one of the world's leading academic health science partnerships.

How
- We will continue to collaborate with other organisations that are also active in research, expanding our knowledge in psychiatry, psychology, nursing, occupational therapy and social care
- We will continue to pursue the opportunities offered by the National Institute for Health Research (NIHR), which funds Research for Patient Benefit, Programme Grants for Applied Research, Programme Development Grants, Health Service and Delivery Research, and Health Technology Assessments
- All service users will be asked whether they would like to be offered the opportunity to participate in research if there is a project relevant to them
- We will add to staff contracts that all staff are expected to support research through taking consent to contact for research from all service users and to help with recruitment to research projects when there are projects relevant to service users in their care
- We will develop the Institute of Mental Health together with University College London.

Outcome
- C&I will have a quality improvement methodology that all staff will be able to use
Section 11: What we cannot do and why

C&I provides evidence-based interventions for people who have mental illnesses. Like the rest of the NHS we have limited financial resources and rising demand. We have a duty to make the best use of resources to improve the mental health of the populations we serve.

We need to free up our specialist care-pathways so that they can quickly take on people who are acutely ill and help them recover. We need to work with our service users and carers to empower them to manage their own mental health by accessing the huge range of existing services in the community provided by the Local Authority and the voluntary sector.

On any single day we have approximately 10,000 service users. About 2,000 service users enter our services every month. There is increasing demand on our services in an environment of restricted financial resources. The overwhelming majority (97%) of people who access our services do so in the community. In contrast to many other NHS mental health trusts we have a large caseload compared to the number of clinical staff members. The only way we can help greater numbers of people with mental illness is by supporting more people in primary care using local community services and networks. These primary care level interventions would be for service users who are in a stable phase of their illness or those with mild or moderate mental illness.
We believe that all our staff must have good therapeutic alliances with service users and carers because this is a vital part of delivering effective treatment and support. We acknowledge that with the way some services have previously operated, often with long-term open-ended care, many of our staff members developed long standing, caring relationships with service users and carers. Many service users and carers value these relationships. With the previous service reconfiguration in 2011-2012 some of these relationships were lost when service users moved to specialist care-pathways. Some of our service users continue to feel great frustration about this loss. We appreciate that this is something we have not been able to repair for that group of service users.

We are asking our service users, carers and staff to change the focus of these clinical relationships from ‘caring for’ to ‘caring with’, i.e. forming a therapeutic alliance. This is a message that has strongly come out of the Mental Health Taskforce where service users have asked to be equipped with knowledge and skills to understand and manage their own mental health and that of those close to them. We will work with all our service users in a collaborative and recovery-orientated way, finding out about their aspirations and goals and helping them to achieve these so that together we nurture their resilience and independence.

All our services will have an approach that includes clarity around the period of time a service will be offered. Individual services will work to timeframes that are appropriate to the needs of their service users and based on evidence and benchmarking with national guidelines. If at the end of a period of treatment a service user has achieved their recovery goals and they don’t need the intensive input of a specialist care-pathway, then they will be supported in primary care. Their care plan will include a clear and easy pathway back into the specialist care-pathway should they need this. We understand and expect that recovery is very different for individuals and that returning to use our services for periods of time will be necessary for some people from time to time. This does not mean a failure on behalf of the service user or services, but that the journey to recover needs input from a variety of sources from time to time.

Often we are asked to see people with problem behaviours that are not primarily due to a mental illness. There is a particular problem with behaviours related to drug and alcohol use and/or antisocial personality traits or disorders where the person show little insight or willingness to engage in meaningful change. This takes up a considerable amount of our resources and this is a function we are not able to do. We understand that for some people with drug and alcohol problems initially engaging with services can be challenging and part of their recovery journey and we will support people to take this first step. We will continue to work with people who are able and willing to engage and benefit from treatment and support.

With the high prevalence rates of mental illness, we know that many people using all services will have mental health problems. About 30% of people the police see and 50% of people in prison have a mental illness. Many people in receipt of housing support have mental health problems. Our commitment to be more accessible to more people, means we cannot take on every person identified with a mental health problem. We need a different way of sharing tasks and responsibilities with Housing, Police, Prison, Probation and other Local Authority services. We need these organisations to develop the skills in their workforce to manage lower levels of mental illness and problem behaviours not due to mental illness and we can support them in gaining these skills. This is part of addressing stigma through making universal services accessible to people with mental illness. Housing Support Officers and the Antisocial Behaviour Unit are good examples of this type of working.
Section 12: What we think will stop us succeeding and what we can do so it won’t go wrong

Finances
All public services, including the NHS, have more to achieve with fewer resources. We must work with our partners to use our shared resources more creatively and effectively for the people we serve. Mental Health services will be moving to new methods of payment from April 2016, either capitation payment or payment for episodes of care. There is a risk that our income may be compromised if our information systems are not robust enough to report all our clinical activity, performance indicators and outcomes.

Loss of contracts
Many core services are now being opened to tender and any services we lose to other providers will impact on our pathways and staffing resource. It is important to ensure we have the right resources to support tendering processes and that current services continue to function even as staff are drawn into the tendering process.

Lack of support from service users
We are doing all we can to engage our service users and carers in the development of this strategy and will continue to do so. However, as we develop our actions and things that are familiar begin to change, service users and carers may start to have doubts that the changes will improve things for them. It is therefore essential that they are working with us on design, implementation and review of all service changes and developments.

Lack of support from our staff
Many of our staff have worked for us for a long time and will have seen many changes, not always for the better, so we must ensure we take them with us and that they understand and are involved in any changes. Low morale and burnout will prevent our success.

We must minimise the risk of staff feeling de-skilled by ensuring the training to support any new ways of working is in place well in advance. We want every member of staff, whatever their role and contribution, to feel that they are a part of delivering this strategy.

Skills in the workforce
To deliver this strategy our workforce needs skills such as recovery-orientated practice, co-producing care, addressing drug and alcohol problems, reflective practice and clinical supervision.

Another essential skill is the ability to effectively use digital technology because productivity gains are likely to be based upon greater adoption of technology. Staff members need to be able to make best use of the electronic patient record system. They also need to enable service users and carers to access online services, such as health, local authority, government, banking and shopping services. The workforce strategy will contain a robust skills training programme.
Section 12: (cont)

**Inability to recruit staff**
There is a London-wide shortage of nurses. It is increasingly difficult to recruit doctors into psychiatry. Services like iCope have a very high turnover of staff because they tend to attract psychology graduates who are aiming to enter a psychology training programme.

Our reputation for high quality training, as a centre of research and delivering innovative care attracts people to apply to work in the organisation. Our workforce strategy, staff wellbeing strategy, and Equality and Diversity strategy and Organisation Development strategy will all help retain staff because they will help staff feel valued and part of the success of the organisation.

**Increasing demand**
We know that we will see a significant increase in demand for our services, not just from our local population, but also from new people coming into the areas we serve. This may result in us being unable to properly implement our strategy. We will continue to work with our Commissioners to better understand the impact of this and the best way to respond within the resources available.

**Constraints on partner organisations, including third sector**
Reduced public spending impacts on all public service organisations, including the voluntary sector, who rely heavily on public funding. We will continue to work with our Commissioners and all our partner organisations to develop community resilience and support the application for alternative funding streams, especially for more local or specialist organisations and groups.

**Being out of synch with partner organisations**
Integrated working is a key driver for C&I and all our partners. However, other demands and expectations governing each organisation can sometimes get in the way of effective partnership working. We must therefore continue working with our partners to ensure that the needs of our population always come first and that we work together with service users and carers to manage competing demands.

**Anxiety about change of treatment or support**
Many of our service users and carers have been receiving care and support for many years, some constant and some as and when needed. Some of the changes we plan will change the way they access that treatment and support and what happens when they feel better. We want to enable people to return to being full members of their community as much as possible and this means enabling people to get on with their lives without being dependent on the Trust. This starts with assessment and care planning, ensuring recovery and well-being goals are included and that our services are just one small part of an individual’s circle of support.

**Lack of confidence in new and different services**
We aim to minimise this by using evidence-based interventions, NICE guidance, and other best practice methods and guidance wherever possible. We will also ensure a continuing dialogue with our service users and carers, our staff and our other partners, to understand if some things are working and others not, and why, and then we will adapt accordingly.

**Personal Health budgets**
These will allow service users to choose services other than those provided by C&I, but we can mitigate against this by ensuring we offer compassionate, high quality, responsive services with excellent service user and carer experience.

**Access and other national targets**
Access, waiting time and other national targets can shift the focus of our priorities. We will ensure that we introduce targets as part of a coherent clinical strategy.
Section 13: Our overall clinical model

The diagram above illustrates how services will be organised going forward. The model will need to be adjusted where commissioned services differ between boroughs.

Most people with mental illness will be helped through services provided in the community by GPs, the practice-based teams, iCope, Local Authority services, community physical health services, the voluntary sector (e.g. employment services), peer support, reablement and housing.

The practice-based teams in primary care will be at the heart of our service and will provide locality based services mainly in GP practices. GPs we spoke to told us they want a relationship with a consultant psychiatrist linked to their practice. They want quick and easy access to expert advice. They want patients to be seen in a timely fashion according to their needs. We have piloted these teams and received good feedback from service users and GPs. These pilots demonstrated the effectiveness of these teams in managing mental illnesses within primary care and reducing the need for referral to specialist care-pathways by 60-65%.

The other main entry points into the specialist services will be via the Urgent Care/Acute Pathway, A&E and the police.
We will continue to develop our care-pathways models for clinically defined groups of people with similar mental health needs. These pathways always start with the service user and their GP. Access to specialist care-pathways will depend on level of risk, intensity of interventions required, and the need for a specialist treatment that is only available in these pathways. For some conditions, care-pathways allow high volumes of people to be treated at lower costs. These pathways are there to help service users achieve their recovery goals and return to using services in primary care and the community.

This is what a service user said about a practice-based team

“I have found the treatment from the South Barnet Primary Care Mental Health Pilot scheme to be very helpful during a medication transition phase. I had been on one type of medication for a number of years and was afraid to try any alternative but was given good support during this time to make the change.

My doctor provided clear and excellent guidance, information and instruction about the change in medication. The appointments were thorough and of sufficient quantity to enable me to proceed. I felt that I could contact the service should I have any queries or problems and also that I had some input into my treatment.

I have been discharged but was reassured about who to contact should any problems arise. The location of the appointments was excellent for me.

I have no criticisms or suggestions at this point but wish to thank my doctor and his team for their assistance during this period.”
Section 14: Our practice-based services (primary care)

Practice-Based Teams (Primary Care)

Service-users and carers have told us that they want to receive treatment and support close to home, in the least stigmatising environment possible. We know that there is a lot of unmet mental health need in the community. We also know that early identification and treatment delivers much better outcomes for people. In response to this we are shifting resources away from traditional secondary care mental health services and settings towards delivering mental health expertise and treatment in GP practices and within communities. This will facilitate better integration of primary and secondary care as well as a more integrated approach to physical and mental health conditions in line with the NHS England’s Five Year Forward View and what our service users have told us they want.

- The model of practice-based teams has been co-produced with our service users
- These teams establish close working relationships between GPs and Consultant Psychiatrists, Psychologists and Nurses
- Access is easy and rapid
- These teams can provide the non-urgent assessment and advice function for C&I
- These teams help GPs and other clinicians in primary care support people with serious mental illnesses who are stable on their treatment and who have traditionally been kept on in secondary care outpatient clinics or recovery teams
- Social prescribing is an essential element to support independence and resilience

Camden, Islington, Barnet and Kingston commissioners have funded pilots to build capacity and capability to address mental health needs in primary care. C&I has delivered pilots of practice-based teams in these Boroughs and shown these services are highly effective in providing mental health care within primary care thereby reducing the need for secondary mental health care services by 60-65%.

By pursuing new business opportunities when they arise and ensuring robust and creative relationships with GPs, commissioners and other divisions within the Trust, we plan to expand these services. Future models in some Boroughs will likely be Multi-Speciality Community Provider models and we aim to be an integral part of such services.
A story of someone who has used the practice-based team

Michael, a 24 year old man, was referred by his GP for a diagnostic assessment. He was seen within the Assessment Team by a psychiatry trainee doctor, who discussed the case with the Consultant Psychiatrist in supervision. The impression was in keeping with bipolar affective disorder, but further clarification was needed to confirm the diagnosis and to formulate an initial management plan.

Given the patient was registered at one of the GP practices covered by a practice-based team, the Consultant was able to arrange to see him the following week. This gave the team the opportunity to revisit aspects of his history and clarify the diagnosis in an environment he was more familiar with, and at greater convenience to him. Being co-located in a GP practice, the team was able to share information with the GP face-to-face and together they thought about how to implement a provisional management plan, including further investigations arranged by the GP practice.

Michael returned to see the Consultant a week later and together they decided on how to proceed regarding medication and follow-up. As part of the plan the GP and Consultant will see the patient jointly for a follow-up review. This set up has allowed Michael to feel that the intervention has been more personalised, with a strong network of support that includes his GP and with contact that is local for him.

Michael has since written to say that he is feeling very well supported and understood by the Consultant and the team involved and says;

“Thank you so much!... I think the service is a wonderful asset to the mental health community”.
Section 14: (cont)

How we will do it

- Our Practice-Based Teams in Islington and Kingston will be in place by the end of 2016. We are working with Camden Commissioners to roll out similar teams that will fit in with their current structures.
- Practice-Based teams will use shared records with GPs making treatment and support fully integrated.
- We will amalgamate the Assessment and Advice Teams with the practice-based teams.
- Access will be easy and flexible either directly by service users and carers or via GPs.
- We will maintain a single access point for referrals that do not come from a primary care setting, such as the police.
- Service users will receive their initial assessment from senior clinicians, who are able to make decisions about treatments, access services in the community, or if needed, refer to our specialist care-pathways.
- Staff members with specialist expertise will work across practice-based teams and specialist care-pathway teams.
- We will work with the Recovery Teams to identify people with serious mental illnesses who are stable on their treatment. The practice-based teams will work with GPs and the Integrated Practice Unit to support these service users in primary care.
- Along with the iCope and other services who do social prescribing, the practice-based teams will develop the information network needed to enhance social prescribing throughout C&I services.
- We will organise a ‘co-production hub’ to bring together experts by experience, service users, carers, and staff with the explicit aim of co-producing the development and evaluation of these services.
- We will work with academic colleagues to evaluate the effectiveness of practice-based teams.
A story about someone seen by a practice-based team

Emily is a 21 year old woman, who recently moved to London to pursue a Master’s degree. She presented to her GP feeling suicidal and reporting the experience of a voice inside her head telling her to harm herself.

She was referred to and seen by the crisis team, who in turn referred her to the psychotherapy service and she was offered an initial consultation a few weeks down the line.

In the meantime, although she was a bit better, Emily went back to her GP who discussed her at a practice meeting where several members of the practice-based team were present. The practice-based team were able to access her notes remotely and could share more fully the crisis team intervention with the GP. They noted that the GP was very concerned about Emily. The team’s Consultant Psychiatrist arranged to join the GP at Emily’s next review appointment a week later.

It was an opportunity to observe the GP’s sensitive conversation with Emily and her trust in her GP. The Consultant contributed with some further questions and comments. At the end of the conversation Emily, the GP and the Consultant all felt that they had understood more clearly Emily’s situation, and in particular her resilience and her capacity to make use of the resources available to her, including her GP practice, her peers and resources in the community. The GP felt reassured by having the Consultant present and that there was now a shared risk assessment and care plan.

The GP felt he could continue supporting Emily without referring her to a secondary care mental health service.
Section 14:
(Cont)

**iCope**
(Improving Access to Psychological Treatments)

iCope services provide evidence-based psychological interventions to people with the full range and severity of common mental health problems including depression and anxiety disorders. They provide and promote a stepped care approach, in line with NICE guidelines, offering people the least intensive, effective interventions first. The service is easy to access, encouraging self-referrals.

The team of psychologists, cognitive behavioural therapy (CBT) therapists, counsellors and psychological wellbeing practitioners are mainly based in GP practices. They are a central part of a well-integrated network of services and have good links with substance misuse services, employment support, voluntary sector services and multi-disciplinary support including psychiatrists.

The experience of the current iCope services is a good springboard for helping to further develop these services.

**How we will do it**

- We will offer a choice of the full range of up-to-date evidence-based psychological interventions
- We will routinely measure outcomes with a focus on recovery
- We will be well integrated into GP practices and positively viewed by GPs
- We will ensure there are systems for handling large numbers of referrals efficiently and offering timely access and a choice of appointment times and location
- We will address the current problem of repeated assessments, because this results in increased drop-out rates and costs
- We will improve integration with specialist mental health services
- We will have good links with voluntary sector services
- We will develop the model of working with people with long term physical health conditions and linking to specialist services for these conditions
- We will develop methods of pro-actively engaging harder to reach groups, including black and ethnic minority communities, older adults, young people
- We will actively and creatively engage people who have used iCope in service developments
- We will develop digital-supported therapies, which in the longer run will be more efficient, use less therapist time and improve access, but initially require some investment
- We will maintain good links with research

**Outcome**

- We will meet targets for numbers into treatment and recovery rates
- Services users will have a good experience of the services
- We will have successful recruitment of staff
- We will deliver high quality, cost effective services
Section 15: Our specialist care-pathways

C&I will continue to develop and improve our specialist care-pathways which offer clearly defined, evidence-based treatment and support. These services provide specialist assessments and management beyond what is possible in primary care. Good community orientated services support people at home, provide early assessments of mental health needs in order to prevent crises occurring.

- These teams will provide timely access to their services
- Waiting times will be an important performance measure
- Access to help for people in a crisis due to mental illness requiring urgent care will be prioritised
Section 15: (cont)

The following section describes the different divisions and their care-pathways.

Community Mental Health Division

What we do
The Community Mental Health Division provides a wide spectrum of NICE compliant specialist interventions for people suffering with a variety of mental health problems. Our services based in primary care are the practice-based teams and iCope described above.

Our other services are the Complex Depression Anxiety & Trauma (CDAT) team, Psychodynamic Psychotherapy service, Personality Disorders service, Traumatic Stress Clinic and Neurodevelopmental Disorders (Attention Deficit and Hyperactivity Disorder and Autism Spectrum Disorders) clinic. We also provide innovative services to improve access to specialist mental health support for marginalised, difficult to reach groups via services such as Positive Punch (the gangs project), parental mental health services and Mind the Gap for adolescents moving into adult services.

The Community Division provides the point of entry for all routine referrals for mental health assessments and advice.

Our aims and vision
We provide high quality, safe and innovative care to our service users and their families.

All services within the Community Division deliver explicit care packages with focused, time-limited interventions, clear treatment targets and the monitoring of outcomes to ensure value-based patient care. Services aim to optimise the individual's functioning, promote independence and encourage service users and their carers to participate in shared decision-making.

How we will do it
As well as developing mental health provision in primary care we will retain the specialist care-pathways described above.

• We will reshape our services in order to deliver care and support closer to GP practices and people's homes
• We will develop novel ideas to support self-management
• With our experts by experience we will coproduce a system of local peer support networks to support service users on their journey to recovery
• We know that early identification, support and treatment delivers much better outcomes for people and leads to earlier and sustained recovery. By managing more people within primary care settings we will free up our specialist teams to deliver treatments and reduce waiting times to treatment
• We will make our services flexible according to individual needs. Recovery is an individual journey, which for one person may require specific treatment, but for another it may require a brief period of containment and support at a point in time
• We will retain smaller specialist treatment teams/pathways for those clients who would benefit from specialist psychological treatment

Psychotherapy service
• The consultation function for psychotherapy will move into primary care
• Our psychotherapists will continue to lead panels and forums where the management of the highest risk and most ill patients is reviewed
Section 15: (cont)

Complex Depression Anxiety and Trauma service

- We will implement condition specific clinical pathways
- We will explore novel treatments which are shown to be effective for conditions such as depression, anxiety and traumatic stress disorder, e.g. blended therapy interventions which use digital approaches to enhance face-to-face therapies
- We will work up a business case for transcranial magnetic stimulation
- In the Traumatic Stress Clinic (TSC) we will embed the stepped pathway approach where less complex cases are managed within iCope with supervision from the TSC
- Our TSC team will conduct joint assessments with the practice-based teams to better select service users who can benefit from interventions whilst providing a trauma-informed perspective and advice for people not suitable for the service
- Our TSC team will deliver symptom management groups in community settings and disseminate self-help material in various languages

Neuro-Developmental Disorders Service

- We will work with commissioners to expand these services to meet the greater than expected demand

Personality Disorder Service

We currently provide structured clinical management, care coordination and a range of specialist evidence-based therapies to service users with a diagnosis of personality disorder. The concept of ‘recovery’ within personality disorder services is contentious as our service users often report having ‘emerged’ rather than recovered to a previous state of wellness. By continuing to place service user partnership at the heart of the service we will ensure that we attend to the concept of therapeutic progress and change in a way that is true to the nature of our population and their individual needs.

- We will continue to provide specialist interventions to those service users who require intensive, specialist input because they have the highest level of need and/or might have previously not been able to receive an effective intervention in other parts of the mental health system
- As part of the shift towards practice-based teams, we will introduce short-term specialist interventions in GP practices that will provide flexible access to therapeutic approaches that are tailored to the needs of our service users
- We will work flexibly across the whole of the pathway holding dual roles between practice-based teams and the specialist service ensuring that specialist assessments take place early in a service user’s journey within mental health services. This will enable targeted interventions to be delivered at a much earlier stage with better outcomes and ensure continuity of care across the pathway whilst eliminating multiple assessments
- We will reduce waiting times to specialist interventions through our strategy of working closely with practice-based services
- Our service user consultants will continue to be part of all our management structures and continue to co-produce and co-deliver therapeutic interventions. This will ensure that the philosophy of the service that places service users at the heart of practice is sustained and grows to ensure positive, hopeful and optimistic practice.
- We will continue to work on equipping the wider system with knowledge and skills in the effective management of personality disorder through our training and consultation resource, PICT (Psychologically Informed Consultation and Training service) that offers systemic consultation and training to GP practices, the crisis pathway and parental mental health within local authorities. This will ensure that positive, non-stigmatising practice with personality disorder develops through the whole pathway
A story of someone who attends our Personality Disorders Service

Lisa was referred to the service shortly before her 18th birthday having spent 7 months on a psychiatric ward for adolescents. At the time she was detained under the Mental Health Act. She was mostly on close observations because she repeatedly harmed herself and made serious suicide attempts involving ligatures.

Lisa met with the team psychologist and consultant psychiatrist. Her family were seen with her and also on their own. Everyone worked closely together to achieve a discharge plan that avoided her transferring to an adult ward. Lisa and her mother were involved in discussions that concluded that being on a psychiatric ward was increasing her self-harming behaviours because she had relinquished responsibility for her safety and therefore needed to be supported to regain this.

Lisa’s discharge went ahead. Fortnightly reviews with the consultant were arranged for the first 8 weeks, to help both her and her mother manage their fears about her being safe at home again. She was allocated a care coordinator with whom she began to develop a therapeutic relationship. She was seen weekly and more frequently when in a crisis. She has not had any further hospital admissions.

Lisa wanted to go back to school to finish her ‘A’ levels and made this her main goal. She was helped to understand her experience of her emotions and learnt skills that she needed to make changes in her thinking and subsequent behaviours. The team also held six monthly care planning meetings with her school.

During the last 2½ years Lisa has used these therapeutic relationships well, supporting her to feel validated and develop an understanding of herself that is more compassionate and less likely to seriously self-harm. The team have also worked with her mother as a carer.

Lisa has now completed her ‘A’ levels. She achieved high grades and has recently moved to another city to start university. The service has remained in touch with her and her local mental health service in order to offer support and manage her initial anxiety and the potential risks this may cause.
Section 15: (cont)

Rehabilitation & Recovery Division

What we do
Our teams specialise in helping people affected by psychosis and related mental ill health and their family and carers. We provide care in a variety of settings and at different levels of intensity to meet individual needs.

Our aims and vision
Our vision is to deliver an Integrated Practice Unit (IPU) for people with psychosis to improve mental and physical health outcomes. We deliver evidence-based interventions for psychosis such as CBT for psychosis, family therapy and medication. We are recovery-orientated. Our teams include; Assertive Outreach Teams, Early Intervention Services and Recovery Teams, each working with a group of service users with similar needs. We also provide a specialist rehabilitation pathway ranging from high dependency inpatient units to low dependency community rehabilitation units and to community support to people living independently. Kidstime is our service for children of parents who have mental illness.

How we will do it
We will focus our pathways towards recovery-orientated practice:

- We will develop a standardised peer support package (based on Highgate Day Centre work) by December 2015. We will scope the opportunities to further develop the Hillside Clubhouse Peer support role
- We will initiate a new standard of “no change without co-production with service” users by January 2016 on all service developments
- Our pharmacists will co-produce courses on medication in the Recovery College
- We will develop patient-held care plans, and wellbeing and recovery portfolios that are collaboratively produced with service users focussing on strengths, positive goals, social roles, relationships and health promotion. We already have crisis cards that are available to all our service users and portfolios for service users in our rehabilitation pathway
- We will build on our current employment initiatives by employing Individual Placement Support workers as pilots in Camden by December 2016 – these are employment specialists embedded in teams, an approach that is supported by evidence that it improves access to work. We will implement the Islington back-to-work programme initiatives by 2017
- We will lead on 6 monthly trust-wide employment events
- We will build on the educational model of the Recovery College by working towards every staff member having a Recovery College course in their personal development plan by 2017 or evidence that they have been considered in appraisal meetings
Section 15: (cont)

Integrated Practice Unit

An IPU is a conglomeration of services that have come together to provide holistic care to a defined patient population, in this case people with psychotic disorders. It collapses the clinical separation between secondary and primary care into a pathway which is continuous. There is a single point of access and single administrative and appointment scheduling structures. Treatment and support is, as far as possible, co-located in dedicated facilities. Multidisciplinary teams, consisting of both clinical and non-clinical staff, are responsible for all the mental and physical health treatments and support. They meet regularly to discuss cases. A senior clinician oversees each person's treatment and support. Providers see themselves as part of a common organisational unit with joint accountability for outcomes and costs. Outcomes, costs and processes are measured for each person across the full cycle of care, using a common measurement platform.

An IPU for psychosis can thus close the gap between mental and physical health care. Working from a patient register, it can ensure that every service user has the required physical health checks and appropriate interventions offered. It can align with GP practices.

We will develop an IPU for psychosis during 2016. During the first year all service users will receive an introductory leaflet and a letter from their key current provider and/or team outlining local changes. Local champions will be available to discuss the changes and encourage participation. A series of open meetings to discuss changes will be held. Service users will have a coordinated review with all their care providers. Service users will have access to a personal navigator if their needs are complex. The GP and care-coordinator will work closely together. Shared records between providers will be developed. All providers will use the same standard footer in all correspondence. During the second year service users will experience greater coordination of appointment schedules. They will have access to a wide range of treatment and support at a place of their choice or as near as possible. They will have access to urgent and intermediate care teams. They will have access to their electronic records. Discussions will be held with service users about employment, the Recovery College and adult education courses. They will receive a summary report of what was achieved through the IPU during the first year of its existence. Service users will be asked to complete feedback forms every six months to inform service development. All workers will be able to work with a range of presenting issues and use a shared language.
Section 15: (cont)

- By February 2016 we will have consulted with staff and other stakeholders and agreed the optimum structure of the recovery teams and how they will blend with practice-based services.
- We will re-orientate our community Recovery Teams so that they are outward facing and integrated with GP practices.
- A ‘mini’ Recovery Team will collaborate with a group of GP practices.
- Each care coordinator will have a caseload which is optimally linked to one GP practice within the limits of capacity.
- By April 2016 community psychosis staff will be embedded into practice-based teams and supporting the management of people with serious mental illness in these teams.

This will improve how referrals come into our services and will replace the admission-discharge model into something more continuous, i.e. our teams actively managing ill people and supporting GPs in taking over the care of stable patients. This will reduce our caseload in the specialist care-pathways, which will free up clinicians to focus on specialised tasks, e.g. co-produced care plans which are recovery orientated, family therapy, CBT, relapse prevention, wellbeing groups.
This story illustrates how someone will experience the IPU

“I am Andrew. I am 47 and have schizophrenia so I take Clozapine. I am overweight and have diabetes, sleep apnoea and chronic obstructive airways disease. I used to find it hard to wake up in the morning because the medication makes me so drowsy. The sleep apnoea can be exhausting and the machine that’s meant to help me sleep wasn’t really working. I used to stay in alone a lot of the time.

In the past I’ve found it difficult to get to appointments so I was discharged by the specialist sleep disorders team because I missed so many appointments. I didn’t really keep my blood sugar levels in check; when I did they were all over the place.

But today is Tuesday. Jo my support worker is coming to take me to badminton. It’s fun, and good for me, and they all just get me. Jo also reminds me to test my blood sugars and will keep an eye on my blood pressure and weight too. After badminton we are going to see Dr Ian. He will take the meds down if I ask him and will do my MOT, as I call it.

I’m also going back to the sleep clinic. Jo and I had a meeting with them and talked through my problems with the machine. I have a new mask that is so much more comfortable.

If there are other things I need to get sorted, like benefits or other health tests, these appointments will happen right alongside. In the old days staff would encourage me to go to appointments, but the appointments were at different times and it was just too much to keep a track of.

That’s why I like the app on my phone that sends regular reminders. If I ignore that then I’ll have Jo or one of the other staff come by to see that I’m on track. The nice thing is that the different workers seem really clued up on what I’m about. They know I’m keen to lose weight so I can go fishing in Scotland next year. They know visiting my mum each month is really important. I really feel like I have a team behind me”.

Section 15:
(cont)
Rehabilitation pathway

- We will review our mix and number of inpatient and community residential rehabilitation services by November 2015.
- We will explore new models, e.g. a short stay intensive pre-discharge rehabilitation unit to prepare people for discharge to community placements and develop business cases by April 2016 based on the modelling work.
- Our pharmacists will support self-administration programmes on our high and low dependency units.
- We will start rehabilitation work immediately following assessment by the rehabilitation team, wherever the service users is, by offering advice, training and outreach work in collaboration with other teams.
- By April 2016 we will have scoped out the option in relation to joint working with acute day units and acute wards and developed a model for consultation.

Acute Division

What we do

Our acute services consist of a number of teams providing care to those in a crisis due to mental illness requiring intensive levels of treatment and support. These include acute inpatient services, crisis resolution and home treatment teams, recovery centres and crisis houses, most providing alternatives to hospital admission. We have advocacy services in place to support service users on our wards, and in particular those under the Mental Capacity Act and Mental Health Act. We have acute hospital liaison teams in University College Hospital, Royal Free Hospital and the Whittington Hospital, which also form part of this pathway, providing rapid assessment of mental health needs of patients presenting to Emergency Departments or those admitted to acute hospital beds. We have small perinatal services in each of these three hospitals.

The acute services as a whole have been under unprecedented pressure due to increasing demand for services over the past few years. A significant part of this demand is due to a large number of people new to our boroughs presenting in mental health crises, population growth, adverse social circumstances and the use of illicit and novel psychoactive substances (including “legal highs”).

Our aims and vision

We will provide the best possible care for people in a crisis due to mental illness, providing timely support and effective treatment to those requiring a higher level of support than is possible in practice-based services or our other specialist care-pathways. We will work closely with other services to allow for the fastest possible resolution of a crisis and move towards recovery including identifying the most appropriate community services to meet the person’s recovery goals. We will have a robust focus on the prevention of suicide.
Section 15: (cont)

How we will do it

There are a number of areas where we will develop and improve our services to adapt to the challenges ahead.

We will improve patient experience in a number of ways including:

- Considering service users’ needs in the whole and addressing early on their physical health and social needs that they identify as important to them
- Increasing the focus on carers and carer assessments to support them
- Reducing multiple assessments
- Developing a new model of working on the wards that is more patient-centred and fostering a genuine therapeutic alliance between our staff and service users
- Our pharmacists will be part of co-produced care planning to help service users better manage their medication and side effects
- Once our goal of 95% inpatient bed capacity is maintained, we will look at linking wards to localities and teams to foster closer working relationships and to offer more continuity of care for our patients
- Developing a clear workforce development plan to equip staff with necessary skills
- Freeing up staff to spend more time with patients and less time on administrative tasks
- Improving the safety on our wards
- Providing more talking therapies
- Integrating research developments into everyday practice

There are a number of areas where we will develop and improve our services:

- We will develop models for engaging those groups under-represented in our services, e.g. young black men in the crisis houses and recovery centres
- To help promote a healthy workforce we will implement a Staff Trauma Support Pathway
- We will pursue the creation of a clinical decisions unit based in one of the acute hospitals to help divert more people away from secondary care and allow for an improved patient experience during the assessment process. Such a unit may also reduce pressure on busy emergency departments where mental health patients can wait for long periods
- We will extend the hours that there is consultant presence in our services, particularly over the weekend on our hospital wards and hospital liaison services
- We will participate in the review of perinatal services across North Central London conducted by our commissioners

A revised Crisis Concordat Action Plan will be developed:

- We will develop clear criteria for a crisis team response with our service users, carers, staff and commissioners and clearly describe what services are available for those who do not meet the criteria
- We will review the resourcing of liaison teams with commissioners and agree how resources can be improved to provide 24 hour cover
- We will ensure there is a single assessment process between crisis and liaison teams
- Together with commissioners we will agree a set of performance indicators for the crisis telephone line including qualitative and quantitative information
- We will continue to reduce prone restraints
- We will work to better understand why section 136s are being used and the profile of service users
- We will continue our work on reducing readmissions
Section 15: 
(cont)

Substance Misuse Service Division

What we do
We provide integrated drug and alcohol treatment services across Camden, Islington and Kingston. We use NICE-approved pharmacological and psychological treatments, which are delivered by specialist staff. We work in partnership with service users, recovery peers and third sector providers to deliver recovery-focused treatment and support. We deliver our services from our clinical hubs at the Margarete Centre, Holloway Road, Grays Inn Road and Surbiton Health Centre as well as from satellites in GP surgeries, hostels and, for some of our ageing and frail service users, at home.

Our aims and vision
Our aim is retain specialist NHS input to the substance misuse field by working to our strengths and in partnership with the third sector and recovery peers. We will use our specialist skills to address complex addiction problems along with comorbid physical and psychiatric conditions that are prevalent in this group. We will respond to the changing patterns of drug and alcohol misuse, including the challenges of working with new psychoactive substances. We will continue to work with service users so that they can achieve their goals and aspirations of reducing and stopping their drug and alcohol use and leading more fulfilling and connected lives.

We take a leading role in how C&I as a whole addresses drug and alcohol use and we support other divisions treating co-morbid substance misuse.

How we will do it

Our service users
- We will continue to use the feedback from service user surveys, focus groups and the friends and family test to inform service development
- We will continue to support our active service user group
- We will continue to provide alternative therapies, physical activities and creative activities to improve wellbeing, including acupuncture, massage, sports and painting

Our staff
- We will use supervision and work-based assessments to ensure that our workforce has the requisite clinical skills to deliver evidence-based treatments
Section 15: (cont)

Our partners

• We will strengthen our relationships with the third sector providers and integrate their services with ours to improve and widen our service offer and build on their skills in delivering recovery-focused treatment systems, peer mentoring, volunteering, outreach services, parenting schemes, education, training and employment

• We will invite third sector and mutual aid organisations to deliver services from our clinical hubs

• We will work with partner agencies to ensure maximum coverage of the hepatitis C testing and vaccination programme

• We will continue to work with the mobile tuberculosis unit and the Find & Treat team to ensure that people with tuberculosis are diagnosed early and have access to effective treatment

• We will develop closer links with the specialist liver services to increase access to new and effective treatments for hepatitis C, which bring with them the long-term possibility of eradicating this disease

• We will work with primary care services to address emerging problems of prescription drug dependence, for example, with tramadol, oxycodone and pregabalin.

• In Camden our newly commissioned specialist substance misuse service will work in partnership with the third sector organisations Crime Reduction Initiative (drugs and alcohol service) and Single Homeless Project (an education, training and employment service for Camden and Islington). Commissioners plan to introduce a new way of evaluating performance across the care pathway through an alliance contract. This will mean that the performance of individual services will not be monitored directly but the combined performance of the partnership. Alliance contracts are relatively new to the NHS and we will lead the way in implementing one of the first in the substance misuse field

Our services

• Our services will be community-based with strong links to primary and secondary care

• We will work closely with practice-based teams, teams around the practice (TAP) and iCope to ensure that the needs of clients in primary care are addressed

• We will continue to have satellite clinics in GP surgeries

• We will ensure that our treatment services are accessible to all parts of the community including the hard-to-reach, homeless, vulnerable adults, housebound, women and ethnic minorities. We will continue to work with the Safe Streets Team, provide hostel outreach clinics and undertake domiciliary visits when service users are frail or housebound

• We will develop new services to meet the changing profile of drug use, e.g. our club drug clinic GRIP

• We will develop an assertive outreach team for frequent attenders at emergency and secondary care services who have problems with alcohol misuse and dependence and a community case management team to target street drinkers in Kingston

• We will improve the quality of physical health care checks that clients receive and work closely with primary and secondary care services to ensure that physical health conditions are being managed effectively
Section 15: (cont)

- We have developed a double-step programme to help people with both Post Traumatic Stress Disorder and substance misuse problems and anticipate that with the current refugee crisis that this service will become more in demand.

- We will continue work with local and national research networks, so that our service users have access to new treatments and innovative methods of service delivery. We have recently completed a trial into the use of contingency management to facilitate attendance at appointments and reduce illicit drug use. When the research has been analysed we will implement the findings.

- We will continue to use performance data to monitor quality and measure change. This will include:
  - Data collected at the individual service user level, e.g. outcome monitoring using the Treatment Outcomes Profile and the Alcohol Outcomes Record, and analyse these to measure meaningful change.
  - Service level data, e.g. standardised measures of engagement in effective treatment, numbers in treatment, unplanned discharges and successful completions of treatment.
  - Staff measures using data obtained from the Clinical Dashboards, including care planning, crisis planning, risk assessment and frequency of attendance.

- Each year we will develop a clinical audit plan with service user and commissioner input that will measure compliance with NICE guidance and technology appraisals.

Other C&I services

- Dual diagnosis is becoming an increasingly important issue to staff working on inpatient wards where service users are being admitted in mental health crises after using novel psychoactive substances (including ‘legal highs’) and/or illicit drugs. We will ensure that there is appropriate training and supervision for clinical staff throughout C&I in order for them to have the skills and confidence to have conversations with people about their drug and alcohol use, offer basic interventions and signpost where service users and carers can get more specialist help.
Section 15: (cont)

Services for Ageing and Mental Health (SAMH)

What we do

Our acute care pathway is formed by the inpatient service, a Home Treatment Team (SAMH-HTT), a Community Recovery Service for Older People (CRSOP) and Community Mental Health Teams (CMHTs). The Home Treatment Team works to prevent or reduce the length of hospital admission through working intensively with older adults, in their own home, and supporting their carers. The CRSOP is a day service which provides intensive support to those at risk of admission or facilitates early discharge from hospital. The CMHTs treat and support people who are ill but can be managed with less intensive input at home.

Acute Care pathway

Patients may enter this pathway at any point

According to the Alzheimer’s society, 80% of residents living in care homes will have dementia. We provide residential liaison services to these homes, which work closely with the physical health care services to provide integrated care.

We have developed a dementia pathway in line with the national dementia strategy. We provide two highly regarded memory services with high referral rates and high levels of patient satisfaction. In Islington we provide the Dementia Navigator Service, a post diagnostic service, which includes regular review, signposting and support to every person living with dementia in Islington.

The very first “baby boomers” are now reaching retirement age. Lifestyle choices from early life are influencing the range of presentations within this cohort and both alcohol and substance misuse is more prevalent. Older adults who are harmful drinkers tend to have more hospital admissions, a greater physical health burden and less access to appropriate housing and care.

Patient experience feedback and patient engagement are embedded in our services. We have an active service users’ forum (Advisory Group for Older People, AGOP) and have service user representation on both our management group and clinical governance groups. Our service users are also involved in our recruitment processes at senior levels.
Section 15: (cont)

Our aims and vision
We will deliver well developed care-pathways for people with mental illness related to ageing, including pathways for dementia and acute care. We will provide evidence-based interventions for a range of mental illnesses to people who have needs related to ageing. Although the majority of our service users will have dementia, those we work with most intensively will have moderate to severe mood, anxiety, psychotic as well as organic illnesses.

How we will do it
Our acute pathway
- Our staff will receive training in recovery-orientated practice
- Older people with dementia and acute mental illness will only come into hospital when absolutely necessary, and when they do, we will proactively plan their discharge from day one
- Our Community Mental Health Teams will provide time limited, evidenced-based clinical interventions
- We will evaluate the impact of our interventions through value based outcomes
- We will enhance the support we provide to local care homes and sheltered units so that they can care for people with dementia to the end of their lives. This will be through training and targeted nursing and psychological interventions
- Our wards will be exemplars in the field of in-patient care, particularly for people living with dementia
- We will continue to achieve low levels of anti-psychotic prescription in people with dementia
- We will achieve high patient and carer satisfaction rates
- Our continuing care unit will provide a highly specialist service, for people with dementia who display severe behaviour that challenges, for a time limited period until they are able to be moved to a more residential style setting
- We will be an integrated part of the cross-organisation frailty pathways being developed for older people
- We will work with physical health services to ensure parity of esteem for older people with mental illness and/or dementia

Our dementia pathway
- We will know 90% of people in Camden and Islington who have a diagnosis of dementia, and be offering to them, their carers and their GPs a service that supports them from diagnosis to death
- We will adapt our memory service provision to a more integrated and tiered service that will follow people throughout the course of their diagnosis. The service will provide regular low level contact at a frequency determined by need, and more intensive work delivered by more skilled practitioners at times of crisis
- We will deliver a range of interventions that maximise their cognitive function, enable community participation and reduce the cost to the NHS, Social Care and their carers
- We will evaluate the Dementia Navigator Service
- We will enhance our support to carers by offering to all an evidence-based, manualised intervention given in a one-to-one setting over an eight week period
- We will develop information and interventions for people whose dementia is impacted by their harmful drinking or drugs use
- We will work in partnership with other agencies and third sector organisations to improve the local dementia pathways
A story of someone who uses our memory service

Alice is an 86 year old professor of law who had been caring for her husband until his death the previous year from severe dementia. She presented with a year long history of memory problems and was assessed in her own home by a doctor from the memory service. After having a brain scan, and more detailed neuropsychological testing with the psychologist in the team, she was given a diagnosis of Alzheimer’s disease.

At this appointment a range of issues were discussed with her including her care arrangements, occupation and activities, and Lasting Power of Attorney. Her medication was reviewed and advice given to the GP. Her daughter was signposted to Camden Carers for support. Alice was started on donepezil (dementia medication) and this was monitored by a nurse from the memory service, who also arranged for her medications to be put in a blister pack.

Later on Alice attended a course of cognitive stimulation therapy at the memory service. This involved attendance at an hour long weekly group over a ten week period. After the final group Alice was seen to discuss alternative activities that she might benefit from.

She was given information on U3A (the University of the Third Age) and referred to Adult Social Care for assessment with a view to attending a day centre as she would also require transport. She will be reviewed every 6 months by her allocated nurse, who can link her into other services if required. The service has supported Alice so she can live as independently as possible and do the activities she enjoys.
Section 15: Learning Disabilities

What we do
We provide psychiatry, psychology, nursing, pharmacy and occupational therapy input to Camden Learning Disability Service (CLDS) and Islington Learning Disability Partnership (ILDP). These are Local Authority led, multi-disciplinary teams providing fully integrated health and social care services to people with intellectual disabilities in a variety of community settings.

We also have four designated beds for Camden & Islington patients with learning disabilities within a 16 bed acute psychiatric unit at St Pancras Hospital.

All C&I services can potentially be accessed by people with intellectual disability as only a minority are known to or need specialist services for people with learning disabilities. Therefore we have an overarching theme for all C&I staff to have the skills and knowledge to meet the needs of people with learning disabilities and how to access specialist advice when required.

There is a new further education college for people with learning disabilities and/or Autism in Camden and it will focus on supporting people locally and is also likely to attract students from other areas who may need our support. Clinicians provide input to the college.

Our aims and vision
We will provide evidence-based interventions and outcomes for people with learning disabilities in all our services and support our Local Authority partners in delivering this.

How we will do it
• We will take a lead on training and dissemination of information that is accessible to people with learning disabilities about services, conditions, medication, self-help, etc
• We will prevent unnecessary admissions to acute settings through further development and redirection of community resources, e.g. ensuring appropriate responses to people in crisis or imminent placement breakdown
• We will ensure equal access to mainstream mental health services across the lifespan, but with learning disability specialist support as required e.g. through liaison, training and consultation to mainstream services
• We will ensure adoption of relevant and cross-cutting trust policies within community and inpatient services, e.g. physical health monitoring and inpatient bed management
• We will develop timely and responsive care to prevent out of borough placements and to prevent placement breakdown in line with Transforming Care (NHSE)
• We will delivery on the principles of care set out in relevant NICE guidelines, e.g. NG11 (Prevention and interventions for people with learning disabilities whose behaviour challenges), Autism NICE guidelines, and other forthcoming NICE guidelines
• We will use evidence-based interventions including optimised psychotropic prescribing, and psychological and nursing interventions
• We will ensure efficient pathways with the Neuro-Developmental Disorders service, iCope, Childhood services, transition team, inpatient/acute services and other services
• We will develop systems for consistent outcome and risk monitoring
• We will develop systems for collecting patient and carer feedback and use this to shape services
Section 16: How we will work with Carers

Carers told us they want to be better informed and supported and they understand this sometimes needs to be balanced with the views and needs of the person who is cared for. Carers are a valuable resource to service users and the whole health economy. They are not always given the support they need. They are also not always involved and informed by professionals about the person that they are caring for.

- We will review the ‘Triangle of Care’, which is the relationship between the carer, service user and professional, to better support carers in their caring role
- The Carers Partnership, a group for carers and service managers, will review how much support is offered to carers and devise a work plan to raise awareness about carers, offer them the right kind of support, offer information at the right time, and listen to their concerns
- We will provide carers assessments and implement safeguarding procedures when they are at risk. This is part of our responsibilities under the Care Act 2014

Section 17: How we will deliver our delegated Local Authority duties

The Trust Social Work Strategy launched in 2014 sought to reposition social work and reinforce the values and core skills of social work, i.e. working with the whole person, their family and their community, and protecting those who are vulnerable while recognising that service-users have rights and entitlements, and also a responsibility to become active citizens within their community.

Working in partnership with both London Borough of Camden and London Borough of Islington through the Section 75 partnership agreements is core. Social workers are identified as key leaders in delivering the social care agenda enshrined in the Care Act 2014 and ensuring that all teams understand their responsibilities to integrate health and social care, use resources wisely and to adopt an assets-based approach to their work with service-users to support them in their recovery journey.

We have a responsibility of safeguarding under the Care Act 2014:

- to prevent abuse and exploitation of known vulnerable groups, as well as assist new groups of people, who may be at risk and require safeguarding
- to strengthen partnerships and cooperate with other organisations to protect vulnerable individuals and communities.
Section 18: How we will assure clinical quality

We continually work to improve quality across all services provided by Camden and Islington NHS Foundation Trust. Our quality goals are co-developed with key stakeholders including feedback from service users and carers, staff, and commissioners.

The Quality Assurance Framework (QAF) defines the approach the Trust takes to ensuring our services are delivered to a high quality standard through every step of the patient journey, and for each of the three quality dimensions: patient safety, clinical effectiveness and patient experience.

The QAF is closely aligned with the standards set for us the Care Quality Commission, our regulator. The approach the Trust takes to the QAF was established in 2013, and has been continually evaluated and developed since then, overseen by the Trust's Quality Committee. The QAF provides a system whereby quality assurance processes are determined, maintained, measured, monitored, reported and continually improved.

The QAF explains the elements of Quality Assurance, including the approach to assessing and monitoring quality, and the approach taken to ensure slippage against any standard is identified and addressed effectively.

Annually, the Trust produces Quality Accounts, which set out the year’s quality priorities and report on quality performance from the previous year. The work under the QAF allows continuous internal monitoring to identify risks and to take appropriate action at an early stage before these risks cause major harm or quality concern.

There are three key elements of the QAF:

- Integrated quality assurance dashboard
- Internal quality assurance reviews
- Improvement plans for services with quality concerns
Section 19:
How we will ask for and use feedback from service users and carers about their experience of services

Patient experience sits alongside patient safety and clinical effectiveness as key components of quality in all of our services. We will produce a strategy for patient experience, which sets out our approach to understanding and continually improving patient experience. The key elements of the strategy are:

Continually listening
We will continue to develop the use of patient experience tools for each division. Already many services have tools to capture information about patient experience, and are using these to learn about the experiences of hundreds of service users and carers each month.

Analysis and integration
Patient experience information is routinely included in internal quality assurance reviews. This means that when we review the quality of our services, under the Quality Assurance Framework, the voice of service users and carers is vital to understand the treatment and support people are receiving.

Sharing and collaboration
Patient experience feedback is shared with our teams to inform changes. We work with a number of people with lived experience of using services to develop our tools for understanding patient experience and to develop effective ways of sharing feedback, and our responses, more widely to maximise its impact.

Monitoring and taking action
Feedback themes and associated actions will be continually and robustly monitored. Each clinical division will have a patient experience plan, sitting alongside the clinical audit plans. These plans will be monitored under the Quality Assurance Frameworks to ensure feedback is routinely captured, shared and acted on in line with the patient engagement strategy.
Section 20:
What we will need from our workforce strategy

We aspire to be an employer of choice in health services and to be an exemplary employer within our local community and further afield. We support local jobs for local people, growing our own skill base through training and development, and employing experts with experience.

- Our workforce strategy will outline how C&I will support people with mental health problems, long term conditions and physical and sensory disabilities to be active members of our workforce

Staff members must always demonstrate the values of C&I in their work with service users and carers. Staff members must know about and support the vision and aims of the organisation. Our Organisational Development Strategy aims to create a culture of professionalism and responsiveness amongst our staff, and an environment where staff members feel supported by their clinical and managerial leaders to raise concerns.

Our workforce will adapt its profile of skills, attributes and capability to produce the outcomes we want to achieve for our service users and carers.

It is not enough for our staff members to only have a professional qualification. All staff members must be able to demonstrate:

- Skills in reflective practice and use of clinical supervision in day to day work
- Skills to deliver evidence-based interventions required within their service area
- Core skills to manage physical health, drug and alcohol use, and the needs of people with learning disabilities and other protected characteristics
- Confidence in their knowledge and ability to co-produce care with service users and to work in a recover-orientated way
- Skills and knowledge to link service-users with resources in their community and find ways for them to become active citizens, including through using social prescribing
- Ability to use outcome measures
- Skills and flexibility to adapt to new technology such as the electronic patient record, mobile working, use of apps, remote working with service users and carers
- Ability to work in multidisciplinary teams and with multiple organisations
- Ability to use the techniques of After Action Review
- Knowledge and skills to engage in the quality improvement methodology once this is decided
- Skills to take consent for contact for research and to recruit service users to research projects

We have a good track record of developing new roles such as graduate mental health workers, psychological therapists and psychological wellbeing practitioners in iCope.

- We will look for other opportunities to develop new roles, including physician’s assistants

Better information on outcomes of interventions at clinician level will allow alignment of individual clinicians to roles and tasks where they have demonstrated their ability to deliver good outcomes.
Section 21: What we will need from our estates strategy

Service users and carers told us it is important to them to be seen in environments that are welcoming and comfortable. They also prefer to be seen in or near their own home. There is good evidence that inspirational spaces promote wellbeing, productivity and high quality work. Our clinical services are enhanced by our workforce being able to interact, share ideas and make connections. The way we design our estates can enhance this networking.

**Practice-based teams**
- Our estates will support integrated care through shared spaces with GPs and other partner organisations

**Specialist care-pathways**
- We will have community bases for multi-disciplinary teams to provide treatment and support near to where people live
- We will provide ample, high quality consulting rooms so that the availability of rooms does not limit the efficiency of services
- We will have space from which to deliver non-direct clinical care via telephone, video calling and social media

**Acute pathway**
- We will pursue opportunities to open more crisis houses to cater for hard to reach groups or groups who have not had equal access to them
- We will develop a design for inpatient services that will meet modern demands in promoting recovery, respecting privacy, dignity, comfort, safety and spaces for meaningful activities, including exercise
- There will be better security measures on our inpatient sites to protect our service users from illicit drugs and novel psychoactive substances (including ‘legal highs’)
- Our estates strategy will prioritise repairs on our wards and carry these out on the same day they are reported

**Specialist centres**
- We will have consulting rooms for highly specialised and/or technical assessments
- We will have consulting rooms to provide specialist, time limited, high volume treatments
- We will have specialist neuroimaging
- Our workforce will have access to high quality training facilities and academic meetings to develop their knowledge and skills
- We will co-locate some of these services with the Institute of Mental Health to support our research and development strategy
Section 21:  (cont)

Deciding on the size of the estate

- We will analyse our local population data, including expected growth and prevalence of mental illnesses, and model what the demand on our services will be going forward. This will inform the amount of clinical space we will plan for.

- With the growing demand on services we will plan flexible spaces that could be used as wards, during periods of high demand. This will be balanced with developing community services to the point that they reduce the need for hospital admissions services.
Section 22: What we will need from our information technology strategy

The electronic patient record system is central to the work of clinicians. Administrative tasks are an important part of clinical care, but they take clinicians away from face-to-face contact with service users. A good electronic patient record system is efficient and supports clinical decision making.

- We will ensure there are good IT connections to all our sites and all our sites have Wi-Fi installed
- There will be an ongoing process of streamlining and improving functionality of the electronic patient record system based on feedback from the workforce
- All clinical information will be recorded on the electronic patient record system and no paper records retained

About 97% of our service users are treated and supported in the community. With mobile working devices clinicians can access and enter information on the care records together with the service user and have access to information to inform care planning. This is more productive because it reduces the need to travel back to an office to do administrative tasks.

- We will develop mobile working through the use of handheld electronic devices

The National Information Board has instructed that Trusts must work to granting service users access to their records. Services users need this access to make informed decisions about their treatment and support.

- We will implement service user access to their care records by working with our partner organisations

Sharing relevant information will deliver more effective integration across organisations.

- Service users and carers will be asked about consent to information sharing when they enter our services
- We will continue our work with our partner organisations on sharing relevant information with GPs and other selected professionals involved in service users’ care provided they have consented. These projects include Camden Integrated Digital Record, and Islington Integrated Digital Care Record and Person Held Record

Providing high quality, easily accessible information is essential for people accessing our services and promoting recovery. Digital technology provides a vehicle for this including signposting, information, service user and carer feedback, online booking of appointments and video-calling. Digital technology also provides opportunities for treatments, support self-help and facilitate self-monitoring.

- We will continue to support and update our website to provide high quality information and links to reliable clinical information, e.g. NHS Choices
- We will develop a digital strategy
- We will provide information about and develop online and digital tools to support recovery
- We will develop our systems of collecting service user and carer feedback and feeding this back to teams via live dashboards
Section 23: Documents referenced in the strategy


6. CIPOLD (2013) “Confidential Inquiry into premature deaths of people with learning disabilities final report”, University of Bristol, available at:
   http://www.bristol.ac.uk/cipold/fullfinalreport.pdf

Section 24: Documents we have reviewed


Section 24:
(cont)


## Section 25:
### Acronyms and Abbreviations

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<thead>
<tr>
<th>Acronym</th>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency Department</td>
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<tr>
<td>AMHP</td>
<td>Approved Mental Health Professional</td>
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<tr>
<td>AOT</td>
<td>Assertive Outreach Team</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – our commissioners</td>
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<tr>
<td>CDAT</td>
<td>Complex Depression Anxiety and Trauma - the specialist care pathway for these specific disorders</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission - The statutory regulator for the quality of health and social care in England</td>
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<tr>
<td>C&amp;I</td>
<td>Camden and Islington NHS Foundation Trust</td>
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<tr>
<td>CMHS</td>
<td>Community Mental Health Services</td>
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<tr>
<td>CRHTT</td>
<td>Crisis Resolution Home Treatment Team</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies - locally accessible talking therapy services</td>
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<tr>
<td>iCope</td>
<td>this is the name we have given to our IAPT services</td>
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<tr>
<td>IPU</td>
<td>Integrated Practice Unit</td>
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<tr>
<td>NDD</td>
<td>Neuro-Developmental Disorders</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence - provides national guidance on standards in health and social care</td>
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<tr>
<td>Primary care</td>
<td>Local first line health services usually organised around the General Practitioner (GP)</td>
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<tr>
<td>R&amp;R</td>
<td>Rehabilitation and Recovery Division</td>
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<tr>
<td>SAMH</td>
<td>Services for Ageing and Mental Health</td>
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<tr>
<td>SMS</td>
<td>Substance Misuse Services</td>
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<tr>
<td>UCLP</td>
<td>University College London Partners. Academic health science partnerships.</td>
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