YOUR 3rd EDITION

INSIDE

ISSUE 3 | June 2020

Case Management

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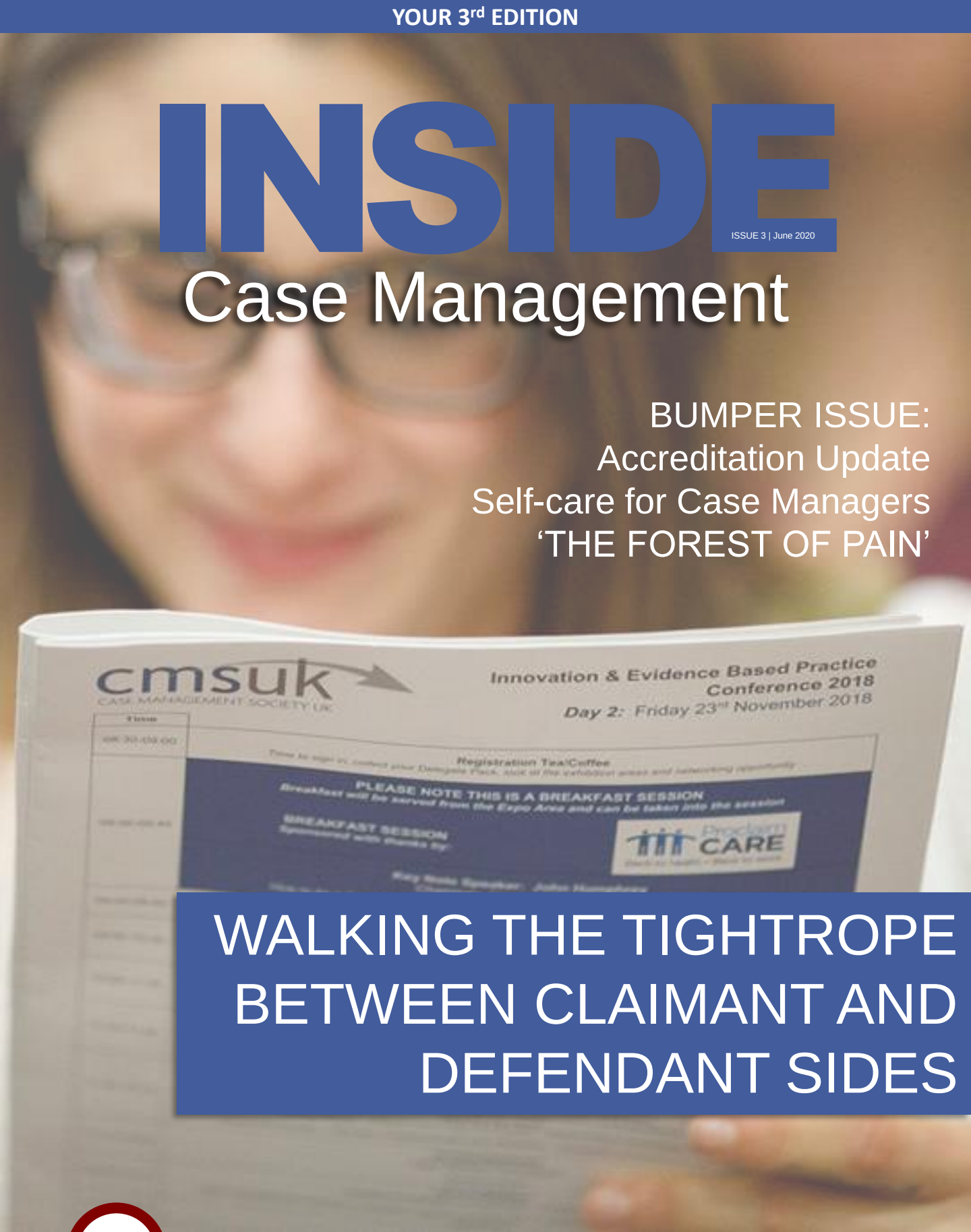

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CASE MANAGEMENT SOCIETY UK

EDITOR'S NOTE

I am delighted to introduce the third issue of INSIDE Case Management.

This is my first update as Editor; the baton having recently been handed to me by Chris Bartlett (ex-Communications Chair), who stepped down from the CMSUK Board last year after five years of service. Chris has certainly left big shoes to fill, but I am fortunate that he remains an active member of the Communications Committee and has played a significant role in the design and publication of this issue – thank you Chris!

At the time of this publication, we remain in the midst of the COVID-19 pandemic; the world as we know it having changed almost beyond recognition within a matter of months.

We recognise the difficulty of "switching off" from the ever-changing nature of the situation and hope that this edition will provide a welcome break from the latest news broadcast.

This issue is jam-packed with content and information, including an update on the newly formed Institute of Registered Case Managers (IRCM); self-care articles relating to diet, mental health and dealing with traumatised individuals; news from our international case manager colleagues and our feature article, "Walking the Tightrope between Claimant and Defendant Sides".

Thank you to everyone who has been involved in making this edition of INSIDE Case Management possible, especially the Communications Committee.

If you have any comments or would like to contribute articles to future editions, please email inside@cmsuk.org.

Stay safe and enjoy the read.

Victoria Collins
CMSUK Communications Chair

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CHAIR'S WELCOME

By Karen Burgin, CMSUK Chair

Welcome to the third edition of our e-magazine INSIDE Case Management; the only dedicated magazine for case managers in the UK. I would like to thank all the contributors to this edition and invite members or interested parties to continue to put forward their ideas and suggestions.

As you work your way through the magazine, you will learn more about the newly established Institute of Registered Case Managers (IRCM). This is the culmination of nearly 10 years' collaborative working between CMSUK, BABICM and VRA towards a regulatory body for case managers. More information can be found on pages 4-5.

This new organisation will impact on CMSUK's role and necessitates change and a clearly defined remit. Our starting point was to agree a revised Mission, Vision and Objectives for CMSUK as follows:

Mission:
To lead best practice for case managers

Vision:
To empower our members by providing support and education

Objectives:
- To build a growing and cohesive community of Case Managers whatever the area of practice.
- To define and develop a professional framework for Case Managers.
- To create and develop working relationships with relevant organisations within the UK and internationally

We have streamlined our sub-committees to reflect the above and are currently working with our Corporate members to better profile their support and contribution.

We continue to work collaboratively with BABICM and VRA and have recently published the first guidelines on behalf of the IRCM. A series of webinars to inform the membership of more detail is being planned for the Autumn, alongside presentations to industry stakeholders such as APIL, FOIL and others.

No introduction this year would be complete without some mention of COVID-19. As for many of you, 2020 has proven to be one of our most challenging, but also our busiest yet. COVID-19 has delivered multiple challenges across all sectors and case management has not been immune. However, alongside this, as I listen to colleagues, what is clear is that it has also provided opportunities to reflect on our practice, identify strengths and limitations, embrace new technology and find new ways of supporting our clients and our businesses.

Via the recently announced 2020 research grants we aim to provide feedback on the positives and possible limitations of the recent forced ways of working, which will allow us to question practice positively and develop further.

With the rescheduling of our annual conference to May 2021, CMSUK is now offering an extensive webinar programme, in addition to considering our first virtual conference. My thanks go to all those individuals who have been so supportive, giving their time freely and willingly to assist with webinar presentations, planning for the 2021 events and far too many other things to mention.

I am immensely proud of the work undertaken by CMSUK over this period and particularly of our office team, Clare Parish and Katie Murray who, although relatively new in post, have stepped up beyond belief. I hope you enjoy reading the magazine and as always any comments would be welcome.

ACCREDITION FOR CASE MANAGERS: BACKGROUND & PROGRESS TO DATE

Background

Since 2010, members of BABICM, CMSUK and VRA have been progressing the development of a professional body for case managers. This was based on the responses to surveys and research - related to the views of case managers and other stakeholders - regarding the need for regulatory mechanisms, underpinned by standardised training and a professional pathway that includes an educational framework.

There has been extensive work via members and leaders of BABICM, CMSUK and the VRA to develop a professional pathway for case managers in the UK. This was based on the "strong evidence in support of the need for a professional pathway that includes an educational framework." In addition, evidence suggested that partnership working between case management organisations would be the most effective way of implementing any change.

Building on the joint work of BABICM and CMSUK which resulted in the development of the Joint Code of Ethics (revised 2017 and amended to reflect the inclusion of the VRA), this tripartite working party has been continuing its' common goal of achieving the highest quality of case management services alongside the protection of service users and the public. Professor Edgar Meyer, Associate Dean at Imperial College Business school and specialist in the Development of Education programmes and Education quality was appointed as a facilitator and has continued to support the direction and development of the goals.

Research related to accreditation models and processes identified that current UK Government policy is only to regulate further groups in exceptional circumstances and where voluntary registers are insufficient to manage the risk involved. The tripartite group undertook an extensive review of a number of alternative mechanisms for accreditation, which included Chartership, the Professional Standards Authority (PSA) and schemes such as the one operated by the Association of Personal Injury Lawyers (APIL). Following this review, it was agreed that the PSA was the most suitable route.

The PSA is an independent body accountable to the UK Parliament and responsible for the oversight of the nine health and social care regulators who maintain professional registers such as NMC and HCPC. They assess the standards and processes that a professional association (such as CMSUK, BABICM and VRA) uses to determine whether a practitioner should be on their register, in order for that register to be accredited (or quality assured) by the PSA. They also review fitness to practice decisions as part of their oversight function. The individual practitioner gains some gravitas from being accepted then onto that PSA accredited register.

In light of this decision the group obtained legal advice related to the legal structure and the business and tax implications for both the new entity and BABICM, CMSUK and VRA. The advice obtained was that any new entity which would be a not for profit organisation and separate from the three main organisations, should be a company limited by guarantee. Such a structure allows rights of membership and would have a board inclusive of representatives of BABICM, CMSUK and VRA.

Following the approval of all three Boards:

- A new company has been established trading as the **Institute of Registered Case Managers (IRCM)**
- An initial Vision and Mission has been agreed
- An application will be submitted to the PSA

ACCREDITION FOR CASE MANAGERS: BACKGROUND & PROGRESS TO DATE

IRCM Mission

To safeguard people who use case management services, by setting and upholding standards for registered case managers.

IRCM Vision

We will be fair, proportionate and effective in administering a nationally recognised register, ensuring protection of service users and the public by promoting and upholding high standards of practice and ethical conduct for the case management profession.

Over the last 8 months, the group has worked tirelessly to review each organisations' standards of practice alongside those in existence with other professional groups. They have utilised internationally recognised research undertaken by Sue Lukersmith to create first draft technical standards for its' process of accreditation with the PSA. These technical standards will be supported by an education strategy to develop joint training events that underpin the standards and potentially offer a way of raising funds to support the accreditation process. Business standards including finance, governance, PR and marketing are currently being developed.

The group has extended its' membership to include NHS representation as we are actively seeking to include case managers in other sectors as well as those working within the medico-legal/insurance industry.

The Future

Plans for an official launch in early 2021 are being made and a financial model and business plan is in development. Funding of this work to date has been via membership fees paid to the organisations. In order to continue this development the group will be engaging with a range of stakeholders for their support in this exciting development.

BABICM, CMSUK and VRA wish to reinforce their commitment to continue to collaborate in their provision of services to their memberships and work towards accreditation which ultimately provides reassurance to stakeholders and protection of the public.

A comprehensive awareness raising programme, including information campaigns, conference and social media marketing is being planned.

A series of webinars to inform the membership of more detail is being planned for the Autumn, alongside presentations to industry stakeholders such as APIL, FOIL and others.

We are delighted to have been invited to present at the APIL Annual Conference in November 2020 and would welcome other approaches from across case management sectors so that we can access as many stakeholders as possible.

Article by:
Deborah Edwards, Chair VRA
Karen Burgin, Chair CMSUK
Angela Kerr, Chair BABICM

TOGETHER
BABICM, CMSUK & VRA

Self-care for case managers dealing with traumatised individuals

Trauma is arguably unique amongst mental health conditions in that others can 'catch' it vicariously. It is true that all emotions are contagious in some way and that therapists, carers and case managers can pick up the mood of their client if effective boundaries are not in place (and sometimes even if they are), but trauma goes well beyond this. A clients' trauma can leap across the most robust of boundaries and in some cases, even produce PTSD-like symptoms in a person who was never exposed to the trauma themselves. Case managers who hear the stories of trauma from their clients can sometimes feel overwhelmed and may even experience some of the same feelings that their clients do. They can sometimes hear such disturbing tales that this can affect their own functioning, with intrusive thoughts, images, and sleep disturbances plaguing them**.** Anyone who engages empathetically with traumatised individuals can develop 'vicarious' or secondary trauma – so self-care is essential for all case managers involved with such clients.

According to the British Medical Association (https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping) some of the most common signs of vicarious trauma include:

- Becoming overly involved emotionally with the client
- Experiencing bystander guilt, shame, feelings of self-doubt
- Being preoccupied with thoughts of patients outside of the work situation
- Over identification with the client (e.g. having horror and rescue fantasies)
- Difficulty in maintaining professional boundaries with the client, such as overextending self (trying to do more than is in the role to help the client)
- Loss of sense of personal safety and control

The real key to vicarious trauma is that there is some shift in thinking in the carer – some change in their belief in the safety and security of the world or of themselves.

Self care for case managers dealing with traumatised individuals involves intervention and awareness at two points; at the prevention stage and at the management stage.

SPARTA HEALTH

Self-care to reduce the risks of vicarious trauma

Many case managers have to work with traumatised clients, but there are important self-care measures that you can adopt to minimise the risk of 'catching' some of their trauma. Research carried out following 9/11 suggested that those workers most susceptible to vicarious trauma were those with a history of personal trauma, fewer years of professional experience, fewer hours of individual supervision, and larger caseloads[1]. This suggests an interaction between the individual, the organisation and life situation factors. Thus self-care would seem to be especially important for less experienced case managers and those with their own history of trauma.

The first step to self-care is to become better at self-monitoring; case managers might be so busy observing their clients for red flags that they forget to check their own mental health.

Watch out for any of the signs listed above. It is also important to manage your caseload, as the 9/11 research suggests, and if a smaller caseload is not feasible, then trying not to have too many traumatic cases can help.

A strong work-life balance is essential to minimise risk. If possible try to ensure that you have regular breaks away from work and that you have a good mix of other interests and hobbies. These can ground you so that you don't become too absorbed in the problems of your clients; other interests that engage you pull you away from their world of trauma and into your own world of safety.

A trap that case managers can fall into is trying to be the hero by 'saving' the client. Accepting that they can't make things right, but only better (hopefully), is a vital step in self-awareness. It is about being realistic about what can be accomplished; having a mentor, buddy or peer support can help with this balancing act.

Self-care to manage vicarious trauma once it develops

Many case managers who might recognise their vicarious trauma make the mistake of being very dismissive of their own reactions and feel that they have no right to experience them, given the very real trauma that their client went through.

Recognising and validating your own feelings and reactions is thus essential to developing vicarious resilience.

Peer support is very useful in managing reactions to dealing with people's trauma. It can be hard to work through feelings in isolation so having plenty of opportunity to discuss, chat, validate, explore – and even laugh (humour is very important) – can be vital to nurture a case manager working with traumatised individuals. Experienced emotions can be very confusing; the case worker who is experiencing compassion fatigue (see next section) might feel very different from the one having intrusive and disturbing thoughts – but both are normal. Discussing emotional reactions can help normalise them.

Compassion fatigue

A word must also be said about the compassion fatigue that often characterises those who are exposed to so much distress from clients that they are unable to find time to engage in the sort of self-care that protects them from getting burnt out. Compassion fatigue does not typically involve a change in thinking or an experiencing of any PTSD symptoms, but it can lead to physical and mental exhaustion. It is often characterised by a reduction in feelings of caring so it is essential to lookout for signs such as:

- Being increasingly irritated by distressed clients
- Seeing clients as numbers to be processed rather than people
- Increasing feelings of disconnect from clients
- Feeling guilty about the above symptoms

If you notice these signs take action: prioritise your own self-care with exercise, sleep, healthy diet, engaging hobbies, journal writing, social networks etc.

A final word for those ‘too busy’

In my experience those people most susceptible to compassion fatigue or vicarious trauma tend to be the ones who give so much to others that they have little time or energy left for their own self-care. Self-care should not be seen as a luxury, but as an essential part of being able to deliver good quality care, especially when working with traumatised clients.

Article by Dr Sandi Mann
BSc, MSc, PhD

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[1] Quitangon, Gertie & St. Cyr, Kate & Nelson, Charles & Lascher, Steven. (2016). Vicarious Trauma in Mental Health Professionals Following the 9/11 Terrorist Attacks. Journal of Mental Disorders and Treatment. 2. 10.4172/2471-271X.1000118.

Dr Sandi Mann is a highly experienced Chartered Psychologist with over 15 years’ experience working in the NHS and private sector. Dr Mann is a member of Sparta’s Health Clinical Advisory Team.

Sandi, described by her peers as a one of the most practical experts in her field, has a Doctorate in Psychology, Masters in Organisational Psychology, BSc in Psychology and Diploma in CBT.

Sandi is an Associate Fellow of the British Psychological Society and an Accredited EMDR Practitioner and member of the EMDR Association UK and Ireland. Sandi’s specialisms include panic, phobias, anxiety conditions, OCD, PTSD and depression.

Sandi has published (Hodder & Stoughton) various self-help psychology books; is a columnist for the British Association of Counselling and Psychotherapy (BACP) journal Counselling at Work and is an invited speaker at conferences across the UK. She appears regularly in the media as an expert psychologist and is the Module Leader for MSc Applied Clinical Psychology and BSc Clinical Psychology at the University of Central Lancashire.

THE FOREST OF PAIN.....

I am not a pain expert. I have been working with people who experience chronic pain, neuropathic pain and CRPS for over 20 years, but I repeat I am not a pain expert. I cannot be because I do not experience chronic pain.

The best description of pain I have heard is, pain is 'what the person says it is'. Pain is subjective; what is one person's agony is another's discomfort. As we are all individuals and a product of our very specific environments, our experience and understanding of pain is unique to us. As a therapist, this makes working with people who experience chronic pain both interesting and challenging.

Pain is individual to the person and the person is an individual, so to develop a plan that is suitable for all people runs the risk of becoming so generic that it becomes useless to everyone.

I am an Occupational Therapist (OT) and OTs believe that meaningful or purposeful activity is fundamental to success in life. My practice focusses on enabling an injured person to do things. Whether they 'want' to do activities (meaningful) like hobbies, leisure activities or socialising, or they 'must' do them (purposeful) like getting dressed, going to the toilet or working, I have always felt the best outcomes I have achieved are when these activities are used as my treatment tools.

I feel that OT should be a positive action. Wherever I have worked, I have always found a level of learned helplessness with someone with a life-changing injury. Whether the pyjama paralysis in A&E or the white coat syndrome in community services, this helplessness causes low mood, anxiety and slows progression.

When someone experiences a life changing illness or injury, it is like being dropped into the middle of an unfamiliar forest. Naturally the person will want to get out of the forest as quickly as possible. They will also want to know why they were dropped into the forest, what the immediate dangers are and how they can stop themselves from being dropped into the forest again. A lot of these can be answered by medicine and clinical experts, but that does involve the person standing still, while others around them work hard to determine the answers. How would you feel standing in a forest with people running around you examining the environment to find answers to questions you are not entirely sure of?

Good therapy is when someone walks up to the person in the forest and says, "pick a direction, I have a compass and I will walk along with you and keep you in a straight line". As an OT I know that no matter what direction the person picks, as long as they maintain a straight line and they keep moving forwards, they will eventually get out of the forest. As OT's we ask the injured person to choose an activity (their direction) and we use our expertise of activity and task analysis to ensure that they can establish successful ways to complete the activity (our compass). The goal is to give the injured person the skills to be able to adapt to trekking through their own personal forest so that if or when it happens again they can take positive action to get themselves out.

Just showing them the compass points and talking vaguely about what they thought would be in each general direction, without taking a single step does not help.

Back to my first statement, I am not a pain expert. I am an expert in activity and task analysis, which enables me to help people adapt their activities to the new symptom they are experiencing, in this case pain. I no longer provide pain management programmes; I provide Functional Management programmes with experts in a particular symptom, their symptom. The dynamic then shifts from Therapist and Patient, to two mutually knowledgeable experts setting out on an experiential learning journey, to find their way out of that forest of pain.

Keeping with the forest analogy, it is not as simple as saying let's pick a direction and go. Preparation is key, and generic information about pain management then becomes useful, providing a general 'map' of the area. The knowledge and skill of the OT is also vital; I always like to bring along my metaphorical (in one case literal) hiking kit to ensure that we have the best chance of making it out of the forest.

With OT's utilising a Functional Management programme, the kitting out is just the first part of the intervention. Instead of waving them off, the OT grabs their own hiking gear, most notably their clinical compass and they walk along with them. Our jobs are not to lead the way, but to keep showing the injured person the compass and reviewing the chosen path. The OT is that second pair of eyes, always looking out for a path or clearing, which will make the journey easier or even shorter and they are the voice of encouragement to keep putting one foot in front of the other.

In my time as an Independent Practitioner I have had the privilege of being able to work with a lot of experts in pain and each time I have refined my processes a little more until now, when I have been able to create a kit that I can offer to OT's to assist pain experts (the clients) to navigate out of their own forests.

I have developed a framework which allows OTs and the pain expert to learn the skills needed to adapt to the chronic pain, allowing the pain expert to continue with their meaningful and purposeful activities. As OT's are the experts in activity and function, I have called it the Functional Management with Pain programme. The framework focusses on how the symptom has affected the injured persons daily function, and provides information regarding how OT's analyse activities and tasks.

The OT then works with the injured person on an 'expert to expert' collaboration, assisting them to utilise those skills to develop a plan to tackle the changes. Finally, the OT works with the injured person to put this plan into practice, helping them review and adapt the programme until it is successful in their life. Here's what one of the OT's said about the programme. "Certainly, working for you has dramatically changed my practice. Loads of the pain OT's also say that the material you produce for them to deliver is changing their approach to the other job. The trick is to get people who have been doing private practice for a while to recognise that their skills haven't really changed much and then not be defensive about it".

The Functional Management with Pain programme, is a positive action - we ask the injured person which direction they would like to go in, we assist them to look for the direction they feel would be the best, we give them the hiking kit and then we go along with them until they are out of the forest. The key thing being that the injured person is not standing still learning to be helpless, they are actively seeking a way out of their situation and taking control with some good company along the way.

Here is what a couple of them had to say about the programme:
"I feel like I've moved forward a lot. There's been a positive impact and I'm more able to understand and express what's going on".

"I feel that this programme has helped me to think about what I do to reduce my pain, for example if a chair is tall enough to sit comfortably in, and to keep active to reduce the pain and keep fit".

To put the journey into perspective, it might be useful to use a case study of one of the pain experts who has put the Functional Management with Pain programme into practice:

Mr M is a 46-year-old man with chronic back pain because of a road traffic collision. Mr M started on his journey out of his personal forest of pain 2 years after the injury. The previous 2 years had been spent seeking medical support for the pain and trying to manage his life.

Mr M had been married for 10 years and had a 5-year-old daughter. He worked as a technical salesman for a large engineering company and was the main wage earner. He was a keen footballer and he played for two local teams and he and his wife regularly socialised with friends and other family members.

When the OT started working with Mr M, he had abandoned his leisure activities and socialisation due to the pain he was experiencing. He was focussing all of his efforts on continuing his work in order to earn enough money to pay his bills. At the time he started his programme, Mr M was reduced to working and resting to reduce pain, so he can work again, eventually he was finding that this was impacting on his ability to be a father.

His first narrative about his pain was, "I am half the person I was, I can't even care for L (daughter) all I do is work and then pray the pain is down enough for me to go back to work the next day".

With the OT, Mr M was able to ascertain that:

- His loss of leisure roles and socialisation was having a detrimental effect on his mood
- His work practices, especially driving, was having a negative impact on his pain
- His pain behaviours made it difficult for him to communicate with his wife
- His attempt to shield his daughter from his difficulties meant that she was unable to compensate for his needs and this strained their relationship.
- His employers had little to no knowledge about his pain and were unsympathetic to his needs.

Mr M made the plan that he:

- Would talk to his employers about his pain and a change in his work role
- Would talk to his wife and daughter about his pain and how they could help
- Return to some level of exercise to help increase his mood.

Following the plan, Mr M was supported by the OT to complete the actions and to help ensure the achievement of his goals. As a result of this, Mr M was:

- Able to change his job role to international sales which meant less time travelling in the car
- Given additional support by his employers to have ergonomic assessments of his work spaces and flexi time contract which allowed him to complete his work at his optimum times
- Able to discuss his pain with his wife and daughter and they were able to establish a routine which enabled him to respond to them when he felt at his best and was able to develop a 'secret code' with his daughter for when daddy would be grumpy
- Able to start swimming on a twice weekly basis and was able to join a swimming exercise group who met informally on a Saturday, two of whom experienced chronic pain.

Mr M's final narrative ended with, "I said in the beginning I was half a man, I can't say I am whole, but I can say I am different, and I can definitely say I can do a lot more even though the pain hasn't changed. There was a lot I could do but I was too unsure to try or even know how to start, but B (the OT) was able to show me and stay with me whilst I got it right. It's a bit weird having someone take you swimming or sit with you at work, but it really helps because she could look at things a different way and get me to really think about how useful the things I did, were. She could put into words what I was thinking and feeling and that really helped, cause once I had it straight in my head I could work out what to do next. I am still in a lot of pain but least I know that this is not going to stop me".

Now, if you have managed to navigate your way through this forest of an article, congratulations! I hope the analogy was useful. Please contact me if you wish to know more about my approach and Functional Management with Pain.

However, if you take nothing else from this article, please consider this: investigations, reports, plans and expert clinical analysis are all very important, but they take time, and, in that time, the injured person could be standing still, learning to rely on others. With early therapy they could start to move forward, take control and learn that they can have a positive impact on their situation.

Written by

Rob Warren

Neuro & Upper Limb Specialist Occupational Therapist
Clinical Director

THINK Therapy

CORPORATE MEMBER SPOTLIGHT

The OT Practice
EXPERTS IN THERAPY

BY ROYAL APPOINTMENT

The OT Practice, established in 2010, and CMSUK Corporate Member is a leading provider of occupational therapy services with a long-standing history of successfully serving clients from across the case management sector. Their nationwide network of over 250 independent occupational therapists makes them the largest in the UK.

Occupational therapy has proudly enjoyed a long history of Royal support, with Her Royal Highness The Princess Royal having been Patron of The Royal College of Occupational Therapists for over 30 years. Most recently, however, The OT Practice has experienced a first-in-its-kind for this healthcare arena…. a visit from Her Royal Highness, who has never previously attended an independent occupational therapy practice.

"All at The OT Practice are delighted and honoured to have welcomed Her Royal Highness The Princess Royal to our new Head Office and share with her examples of our work and partnerships, as well as our vision for the future of occupational therapy," said Nikki Thompson, Founder and Executive Director of The OT Practice. "We wished to showcase to Her Royal Highness the entrepreneurial spirit, passion and integrity that is so prevalent throughout our work – including, in particular, the diversity of the services we offer to and alongside our partners in case management".

Among other guests and dignitaries, The OT Practice was privileged to welcome to their event Chris Bartlett, Ex-Communications Director at CMSUK, Ben Dawson, Rehabilitation Solutions Commercial Director at HCML, Ian Waters, Director of PI Rehabilitation and Case Management, also at HCML, and Yvonne Spijkerman, Founder, Clinical Director and Expert Witness at Circle Case Management. Each of them were introduced to Her Royal Highness and enjoyed the opportunity to share their organisations' services, the ever-changing landscape of the sector, and the positive impact that working in partnership with The OT Practice has made to the lives of their clients.

"The exposure that Her Royal Highness' Patronage of The Royal College of Occupational Therapists brings, as well as her visit today, is very positive," commented Chris Bartlett. "A big challenge for us at CMSUK is raising the profile of what case managers do and the distinct benefits they offer. We've partnered with The OT Practice for over eight years now and their support of case management is of great importance – this occasion certainly boosts this further".

Although case management has been practiced in the UK since the early 20th century, it wasn't until 2001 that a formal committee was established to set agreed standards and raise the profile of case management. As a corporate member of CMSUK for the last eight years, The OT Practice has both contributed to the ongoing development of the profession and brought to this ever-changing sector a wealth of knowledge, experience and specialist skills. Working collaboratively with statutory occupational therapy services and case management partners, it's clear that great strides have been made in improving rehabilitation, quality of life and – importantly – independence for clients, widening the choice of support available and markedly improving the timescales in which they receive it.

Chris Bartlett supported such growing collaboration: "The future lies in both statutory services and independent Occupational Therapists working together. As our industry changes, along with the needs of our clients, both sectors have differing and important roles to play. Think of it like an orchestra, with statutory and private occupational therapy representing different instruments. The case managers – as conductors – bring in the right specialisms at the right time to ensure an optimised outcome".

Through working with case managers for many years, The OT Practice has gained a thorough knowledge of their specific needs, tailoring their services to provide expert Occupational Therapists covering all clinical specialisms and deliver prompt, reliable and high quality care for clients. Backed by a fully supportive infrastructure, The OT Practice empower their nationwide network of specialist therapists to continue approaching every case proactively and innovatively, enhancing rehabilitation potential and upholding the unparalleled standards of clinical and client care for which this organisation has become so renowned.

"The OT Practice team are consummate professionals and great communicators," commented Ben Dawson, Rehabilitation Solutions Commercial Director at HCML. "They run a very tight ship in terms of processes and operations, and we especially value the breadth of their specialisms in hand therapy, housing, neuro, rehab and paediatrics. Because of this, they are a solid partner for HCML and have been for over three years".

Yvonne Spijkerman, Founder, Clinical Director and Expert Witness at Circle Case Management echoed Ben's comments: "Many of my clients have suffered serious traumatic brain injuries and therefore have a high level of need from the outset. My team and I review this requirement and determine what can be fulfilled by statutory services. For the remainder, we use The OT Practice. The process is very complementary – The OT Practice aren't here to replace statutory services… instead, they have the very specialist expertise we require with a nationwide coverage we find invaluable. That's why we have worked with them now for over six years".

Before unveiling an official plaque to commemorate her visit, HRH The Princess Royal addressed Nikki and all The OT Practice staff and guests. Her speech praised the progress made by the practice, and how the competence and quality of their work is evidential in the levels of independence their clients achieve.

Dr Patricia McClure, Chair of Council for The Royal College of Occupational Therapists also spoke, mirroring HRH The Princess Royal's comments and thanking The OT Practice for their invaluable work, personalised levels of care and unique contribution to the profession.

It goes without saying that The OT Practice and all their guests thoroughly enjoyed this event.

Giles Thompson, Managing Director said: "Today has been a great occasion. I'm particularly proud that the therapists, our office based teams and our partners can come together to share in Her Royal Highness' and The Royal College of Occupational Therapists' recognition of the difference their collective hard work has made – and continues to make – to the lives of so many people."

SUPPORTERS

CMSUK would like to thank our corporate supporters listed below. These organisations enjoy opportunities for increased engagement with the CMSUK audience as well as discounts and exclusive offers. To learn more about becoming a CMSUK corporate sponsor, visit www.cmsuk.org or contact us on 03332 070 755.

CMSUK COMMITTEE UPDATES

Membership

A key priority for the Membership Committee has been to ensure our members feel that CMSUK is accessible and providing appropriate support during these difficult days of COVID-19. We have tried to respond quickly to any specific enquiries from members to discuss how we can help, and we are proud to say that as far as we know, we haven't lost any members as a result of the financial difficulties posed by the pandemic. In fact, the membership has continued to grow, which probably reflects the sense of community that has become more important to us all over the days since lockdown.

Following the revision of the CMSUK Mission and Vision statements this year, the Membership Committee is reviewing the benefits of our Company and Corporate memberships. We are trying to speak to representatives from all our member organisations over the next few months, so please do get in touch if you would like to be part of the debate. In addition we are also now exploring how CMSUK can provide more information and advice to our "Supporter" members; those people working alongside case managers, whether they be case manager assistants, administrators or support workers. Do get in touch if you have any suggestions, queries or comments on what CMSUK could do to support these groups of staff.

Sue Ford, Membership Chair

Communications

One of the fundamental purposes of the Committee is to oversee all CMSUK-related communications. The COVID-19 pandemic has resulted in an increased need for communication with, and provision of support and advice to, our members. We have responded to this need by overseeing the provision of regular Board updates to members; the sharing of information via the FAQ section on our website and social media accounts, and the publication of Guidance regarding the delivery of face-to face case management and vocational rehabilitation via the Institute of Registered Case Managers (IRCM).

Another key area we have been focussing on is our social media strategy. Our aim is to provide good content, responsive feedback and two-way communication to increase our presence on social platforms and make social media a key means of communication with our members.

Membership secretary, Katie has taken responsibility for monitoring and communicating with members via our social media channels. We are also working hard to establish and maintain a rolling calendar of high-quality social media content and are delighted to report a 6% increase in followers across all CMSUK's social media sites since April 2020.

Other objectives we are working on include:

- Refreshing the "look & feel" of CMSUK's email and social media communications, to ensure a consistent design language across all platforms
- Updating the CMSUK website content to ensure this is up-to-date and user-friendly
- Launching a new "Events Digest" to keep members informed about all our exciting events.

Victoria Collins, Communications Chair

CMSUK COMMITTEE UPDATES

Events

It has been a busy few months for the Events Committee. The COVID-19 pandemic meant that the pre-planned schedule of events for 2020 needed to be completely revised and this resulted in some difficult decisions having to be made. Sadly, we had to make the decision to cancel the Awards Lunch and November Conference for 2020.

However, with adversity comes opportunity and we have strived to use the current circumstances and technology available to us to expand our event repertoire and continue to meet the needs of our members.

We have significantly increased provision of our popular lunchtime webinar series, for which we have received a lot of positive feedback. In addition, we have successfully converted our planned in-person study days to online events and we are now planning our first-ever virtual conference for 11-12 November 2020.

We are also looking forward to bringing you a showcase Conference in May 2021 in celebration of our 20th year. This two-day conference will be taking place at St John's Hotel in Solihull on 12-13 May 2021, so please save the date.

Teresa Shaw, Events Chair

Research

Due to COVID-19, the 2020 CMSUK Research Grant is being used to support members to undertake a brief literature review on aspects of remote working pertinent to case management. Three of eight project submissions were selected by the Research Committee:

1. Christa Wright from Christa Wright Limited for "A rapid literature review of case management via video conferencing: exploring the barriers and facilitators.
2. Claire Lowther and Dr Devdeep Ahuja* from RTW Plus Ltd. for "Selection criteria for safe and effective remote delivery of case management services: a brief literature review".
3. Dr Peter Tucker and Dr Sophie Gosling from RECOLO for "Telerehabilitation: Remote assessment and treatment - review of the evidence and its relationship with Case Management competencies.

Each project will be awarded £2000 on submission of a completed article, which will be published on the CMSUK website.

The 2019 Research Grant was utilised to fund Master's student, Heidi Stevens to undertake dissertation work to explore the effectiveness of case management in the UK. Heidi has achieved distinction in all the modules she has completed and she is now in the final stages of developing her proposal for the dissertation. Read more about Heidi on pages 29-30.

Research Committee members have also been exploring the option for CMSUK to provide members with access to peer reviewed journals. This work is ongoing.

Devdeep Ahuja, Research Chair

*As one of the applicants, Dr Devdeep Ahuja was not involved in the review process.

NEW! INTERNATIONAL SPOTLIGHT

Case management is an internationally recognised profession. It originated in the USA, but is now widely practiced in various countries throughout the world, including the UK, Australia, Canada, New Zealand and South Africa. Owing to differences in each country's geo-political, social and economic circumstances, implementation of case management can vary considerably; however, the fundamental principle of meeting individuals' health, social care, educational and employment needs through a coordinated and collaborative process remains constant.

CMSUK recognises the importance of collaborating with, and learning from, our international colleagues. As a result, part of CMSUK's strategy over the past few years has been to build and maintain connections with our international colleagues and we are delighted to have established some really strong relationships, particularly in the USA, South Africa and Kenya.

In 2018, Chris Bartlett, then Director and Communications Chair, attended the Case Management Society of America's (CMSA) Annual Conference, where he met Kathy Fraser, CMSA Chair and Carol Garner, Chair of the Case Manager Association of South Africa (CMASA).

Since then, CMSUK has maintained contact with Kathy and Carol and continued to build upon these relationships:

Carol attended CMSUK's Conference in Bristol in 2018 and in return, CMSUK Directors, Devdeep Ahuja and Victoria Collins were invited to CMASA's Conference in Cape Town in 2019.

In Cape Town, Devdeep and Victoria met Effie Kagendo, a case manager from Kenya who has been instrumental in establishing the newly formed Case Management Association of Kenya (CMAKE).

Carol and Effie subsequently attended CMSUK's 2019 Conference in Leeds, during which Carol delivered an excellent presentation on case management with limited resources.

This year, CMSUK were planning to sponsor two CMSUK members to attend CMASA's 2020 Conference and although this did not go ahead owing to COVID-19 restrictions, we hope to offer such opportunities again in the future.

International collaboration remains a high priority for CMSUK, so we are delighted to introduce this new International Spotlight section to our INSIDE Case Management magazine. The aim of this section is to provide case management news from around the world and keep you updated regarding CMSUK's international relationships.

In this edition, we have guest articles by Carol Garner about the impact of COVID-19 on case management in South Africa and Effie Kagendo about Kenya's first Case Manager Summit. We also have a feature article about CMSUK's attendance at the CMASA Conference in 2019.

We hope you enjoy this new section and would value your feedback and suggestions for future editions and international introductions. Please email us at inside@cmsuk.org.

Victoria Collins
Communications Chair

CMASA CONFERENCE 2019

Devdeep Ahuja and I were fortunate enough to be invited to represent CMSUK at the Case Manager Association of South Africa's (CMASA) Conference in Cape Town, from 15-17 May 2019.

From the moment we touched down at Cape Town International, we were treated to exceptional hospitality from both our CMASA hosts and fellow delegates from across South Africa and beyond. We were made to feel like true VIPs throughout the conference and were even honoured at the "Rock & Roll" themed dinner-dance event on the Thursday night.

The healthcare system in South Africa is distinctly polarised. Tax-funded statutory (NHS-type) healthcare provision services 84% of the population, but only accounts for 43% of overall healthcare funds, whilst private medical insurance services 16% of the population and accounts for 44% of funds. It is widely acknowledged that the current system is not working. Statutory provision is extremely limited and incurs extensive waiting lists (one of the delegates shared an experience of a client waiting over six years for a hip replacement) and yet private medical insurance is beyond the means of most citizens and often doesn't cover all expenses, leaving scheme members with large out-of-pocket expenses. It was, however, encouraging to hear that by 2025 the government plans to introduce a mandatory National Health Insurance (NHI) aimed at bridging the gap between the two funding streams. This, of course, presents many challenges, but overall the feeling is that this system is long overdue.

Case managers in South Africa operate mostly from within private medical insurance schemes; administrating and authorising healthcare interventions for members, ensuring that services are coordinated effectively and fall within member benefits. ICD/ICF coding is therefore integral to the role and, whilst the system is not without fault, increasing the awareness, understanding and usage of similar practices could be useful to help facilitate standardisation of care within the UK. A smaller but growing number of case managers are engaged in coordinating patient care and rehabilitation pathways in the private sector and personal injury arena.

A common theme when talking to CMASA members was the desire to bring a more rehabilitation-focused approach to case management within South Africa and there was a feeling that they could learn a lot from our practices in the UK. At the same time, I believe there is a lot we could learn from the South African system in terms of resource and cost efficiency and there is an ongoing commitment from the Boards of CMASA and CMSUK to continue our friendship and collaboration.

I am a born and bred South African, but have spent my entire professional case management career in the UK. For me, the conference was therefore enlightening from both a professional and personal perspective; giving me an insight into the healthcare developments of the country of my birth, celebrating the successes of our international colleagues and highlighting the universal challenges of delivering efficient and effective healthcare to all.

Victoria Collins
Communications Chair

CMASA
CASE MANAGER ASSOCIATION OF SOUTH AFRICA

Behind every Hero on the Front Line is another Hero - the Case Manager: A South African Perspective

Unlike the UK, the South African Case Manager focusses on hospital patient management, which includes managing the funding for the insurer, discharge planning and facilitating admission to rehab centres. The COVID-19 lockdown had a significant effect on all of this.

South Africans were not allowed out of their homes (except for groceries and medicine purchases), unless they were an essential worker and although managing the cost of care is essential for insurers, it is not seen as a true essential service.

All visits to hospitals were blocked, including for family members. All elective surgery had been stopped and the focus shifted to being prepared to care for COVID-19 patients.

Case Managers are normally very visible in the hospital and are able to see the clinical picture themselves and not rely on information being passed from the ward staff. With lockdown, all access to patients was blocked for the funder Case Managers and even the hospital based Case Managers were not allowed to roam the hospitals to see patients; there was a veil of silence, yet we were expected to manage the risk and cost.

This required creative thinking and Case Managers are as effective as ever in the front line of the fight for patients affected by the COVID-19 pandemic.

If we take our gold standard of the Standards of Practice, never has there been a more pertinent opportunity to apply them: from assessing, to planning, to measuring and all of this through collaboration and communication. We are faced daily with patients who have been newly diagnosed and are in various processes of the disease, to families who are confused, frightened and don't know where to turn.

Being isolated in your home with family around you is one thing, but being hospitalised and alone with no visitors or interaction with anyone other than a gowned, masked and gloved 'being' is very frightening.

Most patients will recover and then what? They go home to isolate further: they still don't feel 100%, they have medication to continue taking, they need encouragement to mobilise and exercise, and they need to eat well and without support.

This can be near to impossible.

By using the technology available to us we are able to connect with patients in their homes via phone, Zoom, Skype etc - there is no need for them to be alone. Monitoring their progress is not difficult and while we cannot touch them, we can see and hear them. Caring for their mental wellness is paramount to recovery.

From a funding perspective, managing high cost cases on behalf of insurers remains possible. Gathering clinical information from nursing staff and doctors allows us look for the triggers for discharge and transition of care in order to arrange discharge and plan the journey from hospital to home, whilst at the same time giving the hospitals and doctors peace of mind that the event will be funded. It has been possible to see and visit a patient in hospital by liaising with the hospital staff to use Facetime or Zoom at the patient's bedside.

There is no need for a funder to feel out of control or for the hospital staff to be uncertain. Collaboration works as well using technology as it does face to face; you just have to be creative in your approach and willing to embrace the new normal.

Currently our lock down has been opened from level 5 to level 4: we all have to wear 3 layer cloth masks when leaving home. We are allowed to exercise between 6am and 9am each morning within 5km from home. Hospital visitation is still blocked, but elective surgery has been opened again for 20% of normal theatre allocation.

As the world faces as unknown timeframe for things to get back to what we think was normal, I suggest that we are facing a new normal and technology is going to be our best friend. We just need to be brave enough to embrace it and then use it.

Carol Garner
Chairperson, CMASA

Case Management in Kenya

My journey of a thousand miles began way back in my career of nursing. From a bedside nurse, to inflight nursing and then to this new dispensation, called case management, it's like coming from a caterpillar to a butterfly. Working in insurance was a very new challenge for me. Many of my colleagues and I learnt everything on the job which was a lot more demanding compared to any of my previous roles. I was suddenly the risk manager, gatekeeper, strategist, problem solver, accountant, counsellor, advocate and so much more. It really needed one to be mentally tough to manage all the outlined duties in one outfit as the case manager. As I journeyed, the profession began to grow in our country and many others came in. I had been working for a while growing through the ranks. I began to mentor the new job entrants both within our organisation and externally, and through this process I began to really see and resonate with the pains of learning on the job since I could relate deeply. This lit a fire in me and inspired me to think about how best I could support my colleagues joining the profession.

As opportunities came up to serve in various industry related associations, I took to sharing on case management to shed more light on who we were and what our real "A game" was. At some point, I was given the opportunity to head a sub-committee on training and development, this was a game changer as I quickly took to training on case management based on my experiences. As demand grew I desired to learn more and in 2016 I reached out to the Case Manager's Society of America (CMSA) who were delighted to learn of the passion and desired growth for our profession back in our country. After several engagements they introduced me to Carol Garner of Case Manager's Association of South Africa (CMASA).

Meanwhile back home in Kenya, we were also gaining traction with a group of other likeminded colleagues and in August 2018 we managed to have the first case manager's get together evening meeting which was dubbed 'Sip & Greet'. Why Sip & Greet? We had realised that so many of us within the profession knew each other only by name and really couldn't place a name to the face. We interacted online and also sought advisory services from each other on clinical matters, but more often than not, did not know our fellow case manager. Our evening get together was lit and engaging; however, things cooled off after such an amazing evening of sharing our vision for the profession and agreeing we all needed to be a recognized voice in the industry. But as the saying says in Swahili, our native language "Kidogo kidogo hujaza kibaba" translated to "little by little fills the bucket".

In February 2019, in my usual style of sharing articles and posts on case management, Carol Garner reached out and invited me to their Annual Case Manager's Association Conference; not only to attend but to speak! The conference was an inspiration and a challenge to burst out of my comfort zone. My flight back was turned into a solitude strategy meeting, planning for the inaugural Case Manager's Summit in Kenya, which took place later that year in October.

The summit was a great success. Carol honourably accepted our invite as the key note speaker; she connected with the delegates as she shared real life case manager nuggets, which inspired us all. It was a great opportunity to network, learn, and have fun with industry experts, but more than that, a great milestone for this very critical profession.

Later in November, I was honored to attend the CMSUK conference in Leeds - thanks to Victoria Collins and Carol Garner. What a great honour and opportunity to learn and network and enjoy a vacation amongst friends and family.

As an association, CMAKE soldier on growing, learning and engaging closely and deliberately on this mission that is close to my heart.

Article by
Effie Kagendo
Chairperson, CMAKE

FEATURE ARTICLE:

Walking the Tightrope between Claimant and Defendant sides

All case managers will have the best interests of their client as their absolute priority, but making appropriate recommendations and guiding both sides through the complex, varied and dynamic process of the client's recovery often requires great skill. Understanding the drivers and goals of the claimant solicitor, defendant solicitor and insurer can help the case manager maximise the benefits for their client whilst the litigation process moves forwards.

This article attempts to pull together opinions on several key aspects of the wider context of a serious injury claim to help case managers to navigate these often-stormy waters.

What are the differences between joint and single instruction?

Matthew Claxson of claimant firm Moore Barlow explains: "The key difference is that a single instruction is by one party only which is usually the Claimant. The rehabilitation is then funded by interim payments so the Case Manager must be alive to ensuring the Claimant has adequate funds available to meet any recommendations. This is in stark contrast to the joint instruction by both parties where the paying party, typically an insurer with deep pockets, will be part of the decision making and funds will be available where authority is given for a recommendation.

In my experience, I find that a Joint Instruction for the implementation of the Code works very well for the benefit of the injured person who has access to rehabilitation much sooner than otherwise might have been the case and therefore achieves better outcomes. This has an obvious benefit to the Defendant who, where they are found to be liable, can have a better relationship with the Claimant team and likely will pay less in damages if the rehabilitation has improved the Claimant's situation, for example they are able to return to some level of work rather than none at all."

Hilary Wetherell of Irwin Mitchell is a little more cautious: "It is important first to distinguish between Rehab Code and non-Rehab Code instruction; the former will routinely involve joint instruction as it will often be at a relatively early stage before liability has been resolved and therefore before interim payments of damages are accessible to the claimant to allow him to choose and appoint his own case manager. However, the main difference is present in both scenarios: joint instruction relies on an open and collaborative relationship between the legal representatives because the jointly instructed case manager cannot progress goals (and therefore spend money) unless both parties agree.

This relationship is not always present for all manner of reasons – some justified and some not - and there can be long delays while the case manager seeks to secure agreement. This takes the case manager away from their primary role as a clinical specialist co-ordinating and arranging rehabilitation for the claimant and sometimes into the role of mediator between legal representatives. There are many excellent examples of joint instruction and collaborative working but there are still many case managers who report difficulties in this situation.

Norma Marley of Kennedys offers the defendant side view: "A joint instruction assists the insurer in maintaining some control and insight into the Claimant's injuries and recovery. It should help avoid delays by allowing both parties to be kept fully in the loop and agree any recommendations. It may also allow the insurer some input in the case manager instructed. Conversely a single instruction can sometimes have the opposite effect."

How do claimant solicitors decide which to go for (JI or SI)?

This decision is highly case-dependent, as Matthew Claxson explains: "Rule 1.1.2 of the Civil Procedure Rules 1998 states "all parties are expected to consider the Serious Injury Guide in any claim to which the Guide applies". As such, the Court is expecting the Parties to consider rehabilitation in some form whether it be the Rehabilitation Code, the Serious Injury Guide or other form. The manner of the instruction can often depend on the stage of the proceedings. For instance if it is an early instruction where the insurer is not yet identified, the Claimant solicitor, through other means of funding, may get on and instruct a Case Manager so that an INA can be obtained sooner rather than later whereby the instruction later changes from a single instruction to a joint instruction once the insurer is identified and agrees to be part of the instruction.

How do claimant solicitors decide which to go for (JI or SI)? (continued)

A Claimant may also choose to proceed by way of a single instruction where a Defendant who has admitted liability seeks to "pick and choose" rehabilitation recommendations [when we might consider] it would be more in the interest of the Claimant to have all of the recommendations as appropriate."

Hilary Wetherell adds, "The best interests of the claimant are paramount. All options are discussed and a number of factors are considered. If liability is firmly denied and therefore the only route to accessing the specialist input and therapy that the claimant needs is via a Rehab Code joint instruction, then in most cases this is absolutely the right option. The caveats to apply to this are that the parties should endeavour to identify a suitably experienced and qualified case manager who is within a reasonable distance of the claimant (ideally no more than an hour away) and has good local knowledge of available services, both statutory and private. This should ensure a comprehensive assessment and sensible recommendations. It is also evident in many cases that following a joint instruction under the Rehab Code, the claimant establishes a good working relationship with the case manager and may well be happy to continue with that even after a liability admission for as long as it is productive and working for him/her.

[On the other hand] if liability is admitted, a general interim payment can be secured, and the claimant advised that he could use those funds to pay for case management, care and therapies. In that situation the claimant should be advised that the choice of case manager is his and that meetings will be arranged with 2 or 3 possible candidates to allow him to make an informed choice. Support for those lacking capacity in making that choice should also be arranged."

What is the large loss handler's view of JI?

Hilary Wetherell: "my experience is that most of them have similarly mixed views to those that claimant lawyers have. Joint instruction depends on the relationship between the legal representatives being a good and collaborative one and being able to find the right person with the necessary experience in the best location. Generally defendants seem to prefer joint instruction on mid value claims but are realistic about single instruction on catastrophic or more complex claims."

An experienced technical claims manager partially agrees: "It depends on the nature of the case, especially the liability position. In my view, JI rarely works in clear liability cases. JI can make meetings with CM difficult for example, a conference with counsel, as all parties should be present and outcomes from meetings are relevant to the case and therefore must be disclosed for review by any medico-legal advisers on either side. It can be better to concede to the claimant lawyer to control the rehab via unilateral instruction, on the understanding, agreed in initial discussions, that we can have such joint meetings with the case manager and ask reasonable questions. All with the aim of managing the case collaboratively to achieve the right focus for the rehabilitation and move towards an agreeable settlement. Of course this requires a culture of mutual professional trust and goodwill from the outset"

Equally, the view from the defendant side can indeed come down in favour of JI, Norma Marley again: "In my opinion, a joint instruction should be preferred pre-issue to a single instruction. This allows retention of an element of control and provides a good insight for reserving purposes. It also assists in building up a relationship with the family (and where possible the injured person) which can be a source of great comfort in a large loss claim particularly when children are involved"

What is the large loss handler's view of JI? (continued)

A senior claims adjuster agrees: "Joint instructions are preferable as keeps you informed as to progress, past histories and motivation and control of updates. I would [also] expect joint is more collaborative with funds being more available. Whilst I've seen some raise that the recommendations would be simply agreed, I'm not of that opinion. I'll always raise an issue if I feel it is disproportionate or beyond the CM's remit."

For Lauren McCluskey, Corporé's Clinical Delivery Manager and amputee-specialist case manager, clear communication of the clinical needs of the claimant framed in the context of the claim is vital when under JI: "I had a case where I recommended surgery where NHS waiting times were around 6 months. The insurer was initially hesitant to authorise, on the grounds that this was not an unreasonable timescale for such a procedure. But I used a case conference call with all the parties to demonstrate that acting now would result in an earlier return to work and reduce the clinical risk of auxiliary symptoms like back pain and psychological issues developing. The insurer was then able to see mitigation of the surgery cost by managing the potential reduced loss of earnings. And sure enough, the gentleman did indeed return to work 6 months earlier than predicted."

How should a case manager take account of a contributory negligence or pre-existing condition scenario?

These situations can turn a "straightforward" rehabilitation programme into a complex minefield. Hilary Wetherell advises: "This is a tricky issue encountered in many cases. Two important legal principles need to be appreciated first.

The court will assess damages at the end of the case on a 100% basis and then make any reduction for contributory negligence at the end but the court will also not allow more than a reasonable proportion of the final capital sum likely to be awarded to a claimant to be paid by way of interim payments and has to take contributory negligence into account when determining how much should be paid as an interim payment during the case. Inevitably therefore in cases where there is an e.g. 25% recovery of damages, the case manager has to be aware that the claimant will recover only 25% of what he needs, and the money will run out. Should this mean that the case manager should only progress 25% of his recommendations? No! A more sophisticated approach is needed. This should involve a more detailed consideration (that might need to involve independent financial advice and medical specialists if surgery or expensive treatment is recommended) about how the interim funds should be spent and what other source of support and input (statutory and charity) can be used to supplement the private package. This is a complicated exercise that requires a team approach involving the claimant's solicitor, case manager, medical advisors and any professional appointed to manage the funds such as a Deputy or Trustee.

The focus must be upon making the money that is available work as hard as possible for the remaining years of the claimant's life.

Abbie Udall, Associate Specialist Catastrophic Case Manager at Corporé goes further: "In these instances it is essential for the case manager to identify what treatment and support is required and establish what can be provided by statutory services to avoid occurring high levels of costs to the insurer party. Communication is the key when working alongside NHS and social care to help to move the referrals and treatment forward at the earliest opportunity. I have many cases such as this where I focus my time on increasing the communication between hospital and community teams, sharing information and advising of my recommendations to ensure the right treatment and support is put in place as soon as possible. I will liaise with a client's G.P. to instigate referrals to specialists, again, speeding up this process with minimum cost to the insurer.

How should a case manager take account of a contributory negligence or pre-existing condition scenario? (continued)

I also spend time researching local and national charities to secure support where it is not readily available through statutory services.

There are many great support networks available through charitable organisations to help with the recovery process and helping a client to deal with moving forward from their accident.
Many organisations have patient support groups where they can meet with other individuals and share their experiences if they wish and this can be a very therapeutic process for clients. Additionally, funds can also be secured to purchase specific pieces of equipment, which would support recovery, increase function and maintain safety."

Matthew Claxson sees potential conflict in these situations: "If the case is funded under the Rehabilitation Code 2015 then any recommendation approved by the parties is paid in full irrespective of contributory negligence. However, a Defendant who wishes to raise contributory negligence might withhold authorization for recommendations under the Code for this very reason because they would want the benefit of any cost saving if contributory negligence is proven. The Claimant will need to either agree to a "pick and choose" approach to joint rehabilitation or remove themselves to one of a single instruction funded by interim payments so they have free reign as to what rehabilitation is implemented.

A different approach is for the parties to agree on what is funded under the Code and what is not funded under the code but instead by way of interim payments. [In other words] a blended approach. The Case Manager will need to be aware of any such agreement between the instructing Parties because this again can influence funding."

Norma Marley is concerned about these scenarios too: "The aim of case management and rehabilitation is to enable the injured party to maximise their recovery. To make any allowances for contributory negligence is contrary to that goal." But how do case managers facilitate this?

The technical claims manager suggests, "Open and engaging "Way forward" meetings with both sides and the CM can help get a feel for the trajectory of a case, where it is going. We recently had a paraplegic catastrophic injury case with some pre-existing psychological issues, where the CM worked hard to manage both sides' expectations and was trying to get buy-in from all parties as to what was required. This is especially important in difficult cases like this where we have to look at causation as well as the obvious needs. Looking at the case in detail with the case manager and collaborating openly with the claimant solicitor, helped us to conclude that we couldn't argue confidently that part of the care requirement was already pre-existing, therefore we settled at an elevated level for this type of injury. The outcome was a much better quality of life for the claimant, and we had the benefit of a mutually agreeable settlement on a major claim."

How do the Rehabilitation Code and Serious Injury Guide fit in?

You might think that both sides would be ardent supporters of these two beacons of collaboration, but again, it is highly case-dependent and opinions vary.

Matthew Claxson: "As touched upon above, both the Code and the Guide fit within the parties' duties under the CPR to consider rehabilitation. It therefore encourages engagement and collaboration where it is appropriate to do so. The Code can be applied to all cases of any value whereby the Guide is specifically drafted for cases likely to be valued above £250,000. In my experience even where the Guide is adopted it usually has a distinct feel to the Code."

Hilary Wetherell: "The Code and Guide are excellent tools that both sides should deploy at the earliest opportunity particularly if the case is likely to be hard fought on liability and/or a significant finding of contributory negligence is likely. Some insurers are not signatories to the guide but will adopt the spirit of the guide. If used properly and sensibly, they can be of significant benefit to the seriously injured claimant in the early stages of a case."

However, the technical claims manager voices caution over the Code and Guide but agrees on the "spirit": "Codes can sometimes drive the wrong behaviour, if you already operate a collaborative approach and more, the Code and Guide could prove restrictive and change the way a case is handled, potentially to the detriment of the claimant. It's up to us to build the trust levels. If the claimant side or we behave badly, that jeopardizes collaborative and consensus working on future cases. For example, even on cases with questions around liability, there is still value in making an offer whilst investigations are on-going to offset any commercial risk of the claim going to litigation further down the line.

How do the Rehabilitation Code and Serious Injury Guide fit in? (continued)

This doesn't necessarily mean admitting liability, but it does help stabilise the claimant's situation and therefore has goodwill value. Operating in the Spirit of the Code or Guide is what's important."
Norma Marley firmly believes that the claimant benefits: "The appointment of an independent case manager is completely aligned with the aims of the Rehabilitation Code and Serious Injury Guide. They encourage the parties to work together with the sole aim of addressing the injured party's needs in order to maximise their recovery."

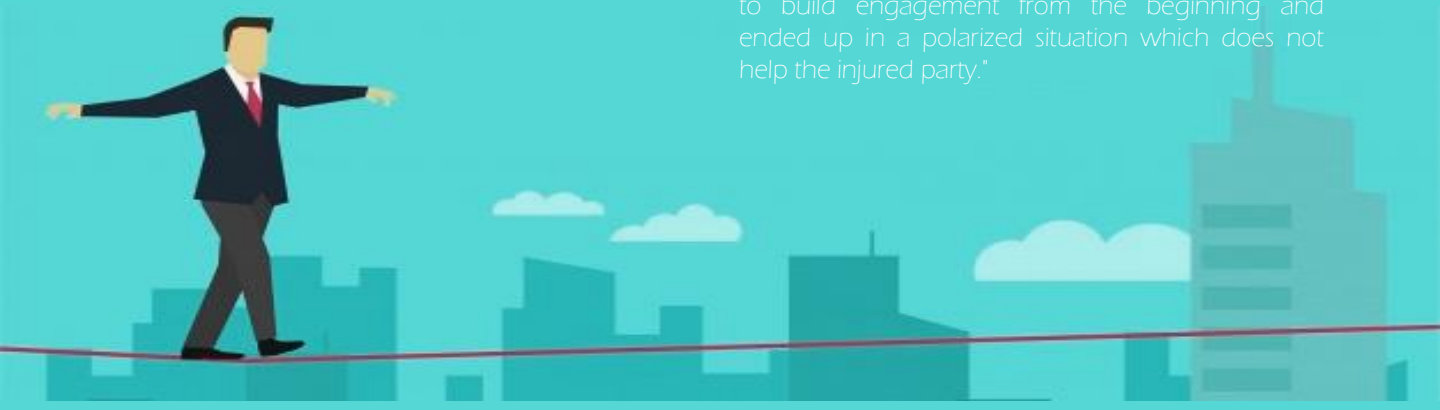
The senior claims adjuster has experienced challenges in this respect: "It's supposed to be a more open and collaborative approach – I'm not convinced the Claimant's solicitors are as big on the mutual trust as they are on the early and continuing interims. There still seems to be a balance to be had between providing the appropriate treatment and the Claimant solicitor's reluctance to release information about the Claimant. Some Claimant solicitors will not respond to rehab offers. Unfortunately, [in my experience] this is often as they are building a case in the background whilst keeping the insurer in the dark. In my opinion, this practice cannot be in the Claimant's best interest as, clearly, early intervention is key to optimum recovery." She adds, "From a Defendant insurer point of view, and one that is a firm advocate of rehab, it would be helpful to better understand Claimant solicitors' concerns or, examples of bad practices they have experienced, to formalise a useful foundation to build the necessary trust upon."

Conclusion

The way we handle injury claims is rooted in our adversarial legal system. It is therefore easy to fall into the trap of "going into battle" until a judge forces the parties to collaborate. What shines through this discussion is the value of open and clear communication to build trust and consensus from very early on in a case to keep the claimant's needs fully central to all parties' activities.

Amandeep Khasriya of Moore Barlow summarises for the Claimant: "My view is that maximising rehabilitation early on is a win-win for all, including the parties, Claimant, NHS and society. With the benefit of rehabilitation, the Claimant recovers more quickly, returning to their pre-accident status, limiting their losses and damages - while reducing the time spent between the parties on the litigation. Getting the Claimants fitter quicker also helps them to return to work sooner, alleviating the burden and reliance on welfare benefits and the NHS. With such profound health and social benefits, we should all be doing our part to drive rehabilitation as on early as possible in these claims."

The technical claims manager summarises the collaborative approach for the Defendant: "The whole job is about engagement. As an insurer if you take the long view on a claim, at point A you receive the claim, point B you settle it, and everything in between is about behavioural management and how you interact with people. You can disagree professionally whilst keeping your eye on the prize, which is an acceptable settlement. Regular meetings and communication to keep moving to a mutually satisfactory settlement are essential, and the skill of the case manager is a critical input to this process. A trial is a failure as an insurer because we have failed to build engagement from the beginning and ended up in a polarized situation which does not help the injured party."



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Together we're better

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GOOD NUTRITION CAN TRANSFORM MENTAL HEALTH

Improving nutrition can improve a person's mental state when suffering from conditions such as depression, says Specialist Nutrition Rehab, a specialist dietetic service that supports people recovering from life changing injuries.

Studies are increasingly showing that poor diet can be detrimental to mental health and suggest that lower rates of mental illness can be linked to healthy diets.

Case management companies that want to incorporate creative, evidence-based approaches that place equal emphasis on both the clients' psychosocial wellbeing and their physical needs, are encouraged to consider nutrition as an essential part of their clients' rehabilitation programmes.

The brain demands a constant supply of nutrients and energy in order to function optimally, and according to Sheri Taylor, director of Specialist Nutrition Rehab, some simple changes to diet can considerably improve and maintain good mental health.

Sheri adds: "Many mental health conditions are accompanied by changes to food intake for example, loss of appetite or bingeing on sugary snacks. It has also been noted that various unhelpful food patterns that occur during depression also precede depression. These may include poor appetite, skipping meals, and an overwhelming desire for sweet foods. "As a result, inadequate consumption of vitamins, minerals, and healthy fats will have a negative effect upon mood and brain function."

Sheri offers the following tips on how to up your intake of brain-healthy foods:

- Eat at least 5 portions of fruits and vegetables daily. This helps to reduce cellular damage as well as provide the body with essential vitamins and minerals.
- Include healthy fats in your diet. The brain has one of the highest levels of lipids (fats) in the body and so essential fatty acids are necessary to fuel the brain. Consume healthy fats such as olive oil, nuts, seeds and avocado. Oily fish is a great source of the omega-3 fatty acids which are the most important fats for supporting brain health.
- Reduce intakes of saturated fats and trans-fats such as butter, cheese, fatty meats, high fat dairy products and processed foods. These foods are associated with higher rates of inflammation in the body and poor mental health.
- Choose carbohydrates wisely. Carbs such as oats, brown rice, whole grains and vegetables support the production of chemicals in the brain that encourage a greater sense of wellbeing, including serotonin. Slow-release carbs (with a low glycaemic index) will prevent huge swings in blood sugar levels and gradually release energy to fuel the brain.
- Fibre is key. There is a growing body of evidence suggesting good mental health is directly correlated with a healthy gut. Whole grains, fruit, vegetables, legumes, nuts and seeds as well as probiotics (such as kefir or yogurt with live bacteria), feed the bacteria in your gut, which helps to support good mental health.

Sheri says: "Specialist Nutrition Rehab aims to provide the most comprehensive and cutting-edge dietetic service in the country so that issues with nutrition, eating, weight and health don't hold clients back from their recovery.

We specialise in helping extremely complex clients with multiple health conditions (including mental health issues), particularly when these specialist needs cannot be met through statutory services alone. We look at all health parameters, including medication, blood test results, skin integrity, bowel function, swallow, mood, sleep patterns, oral health, food intake and physical activity levels, to understand and address the root cause of any health issues so that we provide long-lasting change."

Working with claimant solicitors, insurers and case managers, Specialist Nutrition Rehab dietitians provide bespoke medical nutritional therapy to help clients recovering from medium to severe category personal injuries or medical negligence events. Dietetic input focuses on helping clients in the following three ways:

1. To manage any underlying health conditions (such as Irritable Bowel Syndrome or Diabetes)
2. To address common concerns such as fatigue, low mood, pressure sores, over/under weight and gut-related problems
3. To ensure the client's nutritional needs are being met to speed recovery and help them get the most out of their other rehabilitation therapies.

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Specialist Nutrition Rehab

www.specialistnutritionrehab.co.uk

RESEARCHING CASE MANAGEMENT

CMSUK-sponsored Masters Student, Heidi Stevens talks to Sue Ford from the Research Committee about her studies so far:

In 2018, the CMSUK Board identified some specific research grant funding to support the development of a high quality evidence base for case management. The initial take-up on the grant funding was rather low, so last year the Research Committee joined forces with the University of York and advertised for a full-time Masters student. The funding was made available on the understanding that the student's research would add to the evidence base for case management, and the work would be available to CMSUK members once completed.

Following a successful interview, Heidi Stevens was awarded the grant and she began her one-year full-time course in October 2019. Originally from Manchester and currently living in Whitby, Heidi had returned to the UK six years ago after having been head pastry chef in a range of roles including at Claridge's under Gordon Ramsay, and on Richard Branson's Necker in the British Virgin Islands. Exciting as these places were, Heidi was driven to develop herself further. She completed a BSc in Food Science and Nutrition at Teesside University and found she had a natural aptitude for academic study, achieving a well-deserved first class honours. Determined to stay within the area of health and keen to continue with her studies, Heidi applied for the CMSUK sponsored Masters programme and was thrilled when she was offered the place.

Heidi has been providing blog posts of her progress, which have also been going out on CMSUK's social media; and great progress it has been too, with Heidi obtaining excellent marks in all work she has submitted so far. The final research dissertation is now underway, and Sue Ford from the Research Committee met up with Heidi recently to find out how she has found getting to grips with case management.

Sue: Had you ever heard of case management or CMSUK before you saw this grant advertised? How did you go about finding out what you needed to know for the interview?

Heidi: At the time that I applied for the CMSUK Master's grant I had never heard of case management, but upon reading about it I liked the idea that it has the potential to make healthcare more accessible and efficient. My first source of information was the CMSUK website and similar society websites in the US and Australia. I also still had access to Teesside University's library database so I spent a week researching case management to determine whether it was a subject area I could understand and write about. I found a comprehensive article commissioned by the King's Fund (Ross et al., 2011), which explored core components of case management, potential benefits and detailed some examples of implementation. I also looked on health science databases such as CINAHL for primary RCT studies and systematic reviews. It was good to find conflicting results, which gave scope for critique; I knew I would be asked to critique case management during the interview.

Sue: How easy or difficult has it been to get a sense of what case management is all about?

Heidi: Initially all the information I used to understand case management came from academic databases and the range of definitions could be quite confusing. I now know this is also a debate within the case management community itself. I think I only began to develop a clearer understanding as I met with you and spoke to CMSUK case managers over the phone. I appreciated everyone's time and we had some lengthy conversations while I took notes. I'd been a little confused about how litigation fitted in with case management.

RESEARCHING CASE MANAGEMENT

In addition, I joined the CMSUK Introduction to Case Management webinar, which gave me insight into aspects of case management that may be missed in academic articles, such as the litigation process. The webinar also gave me a qualitative understanding of case managers' perspectives of the process. The motivation of the patient/client was also mentioned during the webinar as a potential to impact outcomes. This is something that I may be able to use in the review. I think I am lucky to have all this support from CMSUK; it's a clear advantage that I am not relying solely on articles for information during the masters.

Sue: What aspects of your research so far have you found most interesting?

Heidi: What I've found interesting is the many ways in which a case manager can positively impact a person's life. I think about someone who has just suffered a shocking and severe trauma, but who still has to deal with all the effects of this on their daily life - that must be overwhelming. The case manager steps in and guides them through the health and social care system. I've heard other interesting areas in which they assist the person that I wouldn't have imagined, but which could make such a difference, something as simple as a dog walker for example. My undergraduate dissertation was on accessibility issues in public health campaigns and I learned about some problems that different groups of people encounter within health care in general. There are so many people who struggle with things, like understanding their medication schedule for example, but a case manager would be there to help that person. The idea of case management having a holistic approach that really can make a huge difference to someone who needs that help…that is what I've enjoyed most about this research. It's also been interesting to discover other areas where case management has been successfully implemented such as with war veterans in the US.

Sue: What do you hope will be the outcome(s) of your research? Are you developing any ideas about important areas for further research?

Heidi: Obviously, I'd like to produce a robust systematic review with gold standard methodology. Ideally, I will include a meta-analysis, depending upon what data is available and I'd like to think that I will be able to identify enough relevant studies to include in the review. My main aim is that the review will be solid enough to contribute to the evidence base and that CMSUK members will feel that the decision to sponsor this research was the right one.

One future recommendation I already thought about was the need for more gold standard primary research into the effectiveness of case management. Primary research should always include a comprehensive explanation of the content of case management and comparison approaches, which can assist with the issue of definitions. I think it's early days for recommendations, but this is what I've thought about so far.

Heidi Stevens
CMSUK-sponsored
Masters Student

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