NHS Solent NHS Trust

Care Programme Approach (CPA) Policy

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2		17-18	3.4 Three day follow-up requirement amended to 48 hours, in line with governmental policy	
3		18	3.4.2 updated care plan review to consider uncontrolled symptoms	

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Include details of when the document was last reviewed:

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Executive Summary

This policy provides a description of the Care Programme Approach (CPA) used with Service Users who are known to Mental Health Services. This includes the development, application and changes to the CPA, with explanations and aims.

Key policy issues:

- The function of the CPA in bringing Service Users and professionals together for manage care planning for Service Users with complex mental health needs

- The roles of Care Coordinator and Lead Professional, and the role Service User and Carers, in planning Service User care

- The use of CPA to ensure safe, effective and comprehensive care for those Service Users with more complex mental health needs

- The importance of the CPA in risk management, crisis management and contingency planning

Key documents are referred to, acknowledging historical and foundation principles of the CPA.

Abbreviations

AMH	**-**	Adult Mental Health
CAMHS	-	Child and Adolescent Mental Health Services
CPA	**-**	Care Programme Approach
HCP	**-**	Health Care Professional
LD	**-**	Learning Disability / Learning Disabilities
MCA	**-**	Mental Capacity Act 2005
MHA	**-**	Mental Health Act 1983
OPMH	**-**	Older People's Mental Health
SMS	**-**	Substance Misuse Services

Glossary of Terms

- **Advance Decision**
  To refuse treatment (legally binding).

- **Advance Directive, or Advance Statement**
  Inclusive of wishes (not legally binding).

- **Approved Clinician (AC)**
  A clinician approved by the Secretary of State to act as approved clinician for the purposes of the Mental Health Act (1983).

- **Care Contributor**
  This applies to any person contributing to a Care Plan for a Service User regardless of service area of origin, for example, with AMH, Third Sector or Informal Carer.

- **Care Coordinator**
  The person responsible for co-ordinating the care a Service User receives under a CPA when they are living in the community, an inpatient in hospital or serving a prison sentence. This is the person a Service User will have the most contact with and is usually a Community Psychiatric Nurse, Social Worker or Occupational Therapist.

- **Care Programme Approach (CPA)**
  A package of care designed to improve the delivery of care to people with complex mental health needs. It requires health and social care services and other agencies to work together with Service Users to provide an agreed programme of care.

- **Carer**
  Informal carers who provide regular and important support to the Service User. This includes those under the age of 18 who provide care and support.

- **Lead Professional**
  A Lead Professional is allocated to Service Users who are not under the CPA. The Lead Professional can be from any professional group.

- **Named Nurse**
  The person responsible for a Service User's care when they are admitted to an inpatient setting.

- **Responsible Clinician (RC)**
  The Approved Clinician with overall responsibility for a Service User's case under the Mental Health Act (1983). Certain decisions, such as renewing detention or allocating supervised community treatment, can only be taken by the RC.

- **Service User / Client / Patient**
  These terms are regularly used by staff working across health and social care. This document applies the term "Service User".

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CARE PROGRAMME APPROACH POLICY

1. INTRODUCTION & PURPOSE

1.1 The Care Programme Approach (CPA) is the integrated Health and Social Care planning process used in Adult Mental Health Services.

CPA emerged from a number of influential Government-led Health and Social Care publications and guidance which were concerned with providing joined-up holistic care planning to prevent those who access secondary care services from “slipping through the net” or being subjected to repetitious assessments. This improves the overall quality of care and Service User experience.

‘Refocusing the Care Programme Approach: Policy and Positive Practice Guidance’ (DH 2008) states the underpinning message as:

> *“Services should aim to develop one assessment and Care Plan that will follow the Service User through a variety of care settings to ensure that correct and necessary information goes with them”* (p.18)

This has been the intention of CPA since its inception. However, this policy includes fundamental changes, most significantly the removal of levels of CPA, and a standard care planning (non-CPA) process to sit alongside this.

The CPA ensures that the needs of Mental Health Service Users are assessed and that appropriate care is delivered, regardless of the setting, for example, residential, community or prison. In addition, Service Users should be viewed “in the round”, that is, in their diverse roles, and the needs they have, including family, parenting, relationships, housing, employment, leisure, education, creativity, spirituality, self-management and self-nurture, with the aim of optimising mental and physical health and well-being.

Care planning processes start at the first point of contact with the Service User and only end once they are discharged from the service.

The guidance in this document refers to the implementation across Solent NHS Trust and Adult Social Care at Portsmouth City Council.

2. SCOPE & DEFINITIONS

2.1 What is the Care Programme Approach (CPA)?

The CPA is a package of care for those of working age in contact with specialist secondary care Mental Health Services and Adult Social Care. It was introduced in 1991 to provide a framework for effective mental health care, including a care plan and someone to co-ordinate the care. All care plans must include a crisis plan.

The four main elements are:

- A systematic process/arrangements for the integrated assessment of health and social care needs of those accepted into Secondary Care Mental Health Services
- The formation of a holistic Care Plan which identifies the care required from a variety of providers
- The appointment of a Care Coordinator, to keep in touch with the Service User to monitor and coordinate their care
- Review in a timely manner, facilitating agreed changes if needed

From October 2008, CPA no longer has two levels (standard and enhanced). CPA now only applies to Service Users with the most complex characteristics, as outlined below.

2.1.1 No CPA

Service Users with more straightforward needs, formerly under standard CPA, are designated as "no CPA". The planning and review process for Service Users who require specialist secondary Mental Health Services, whose needs are not assessed as complex, does not require a complicated system of support. Their rights to an assessment of their needs, the development of a care plan and a review of that care will continue to be good practice for all.

2.1.2 Allocation of Care Coordinators / Lead Professional

The Care Coordinator is crucial to the successful implementation of the CPA and Care Management processes.

The Care Coordinator has the authority to:
- Coordinate the delivery of the Care Plan
- Call a review
- Access resources

Professionals who undertake the roles
Social Workers, Nurses, Occupational Therapists, and Psychotherapists or Psychologists in specific parts of the service, for example, Early Intervention in Psychosis (EIP) will usually be the Care Co-ordinator or Lead Professional.

Allocation of Care Coordinator
The Care Coordinator role should usually be taken by the person who is best placed to oversee care planning and resource allocation. Consideration should also be given to the Service User's needs matched against staff skills, qualification and experience.

Allocation of Lead Professional
The Lead Professional role will be undertaken by the clinican taking responsibility for the Service User's treatment and care when the Service User has been assessed as not needing a CPA. For further information on the Care Coordinator / Lead Professional, see Appendix 7.

2.2 Values and Principles

2.2.1 A Statement of Values and Principles in 'Refocusing the CPA' (DH 2008) is used as a basis for local discussion. It provides the primary focus of reviewing approaches for care planning in line with relevant contemporary guidance.

2.2.2 The following summary will apply to Service Users who are accepted by secondary Mental Health Services.

2.2.3 All Service Users have the right to a holistic assessment of their individual health and social needs and risks.

2.2.4 Risk assessment will be undertaken in line with Solent NHS Trust and Portsmouth Health and Adult Social Care Department and Portsmouth City Council guidance on clinical risk assessment. The evidence on which the judgement is made should be recorded on the central records system for the service. This should be available to all relevant professionals.

Best practice indicates the benefits of Service User self-assessment and care planning in conjunction with professional assessment.

2.2.5 All Services Users will have either a Care Coordinator or Lead Professional, usually an individual known to the Service User, who will co-ordinate or facilitate the care programme.

2.2.6 Ideally, all Service Users will have an agreed and signed Care Plan. This may not always be possible and the care team should seek alternative methods to ensure Service User and Carer understanding.

2.2.7 Where a Service User has straightforward needs and contact with only one agency, the designated Lead Professional is responsible for facilitating the Service User's care, and may record a Statement of Care agreed with the Service User in the patient record. This will constitute a Care Plan and will need to be signed off by the Service User and stored on their electronic patient record.

2.2.8 All Service Users will be informed whether they are subject to the CPA. This will be based on an 'in the round' approach to their care needs.

2.2.9 The CPA describes the approach used in specialist secondary Mental Health Services for Service Users whose needs involve more complex characteristics.

2.2.10 It is well recognised that Carers often provide the majority of care to people with mental illness. Carers are entitled to a personal assessment and Care Plan, as well as contributing to CPA planning meetings. Young Carers' needs must be considered at all points of the process.

2.2.11 All Carers who required an assessment and received a Care Plan must have a regular review at least yearly, applying local standards. Best practice recommends that a Carer's self-assessment is completed with the Care Act (2014).

2.2.12 Reviews, as with care planning, must place the Service User at the centre of the process and be conducted in line with individual needs. This should be regarded as an ongoing process and be provided in a timely manner. Those with the most complex and changing needs will require more frequent reviews. All reviews must take into account the safeguarding of vulnerable children and adults, and should ensure skills and resources are available to improve the wellbeing of vulnerable people.

2.2.13 It is particularly important that the need for CPA is considered by Lead Professionals at review.

2.2.14 In the event of sudden relapse or concerns for a Service User's health and safety, all care team members providing input or support have a responsibility to notify the Care Coordinator or Lead Professional of such concerns.

2.2.15 It is the responsibility of the Care Coordinator or Lead Professional, after discussion with care team, to arrange a review of the Care Plan/Statement of Care. Although reviews should be timed according to Service User needs, best practice suggests this should happen at least 6 monthly.

2.3 Equality of Opportunity and Diversity

2.3.1 The CPA and Care Standards Handbook (3rd Edition, 2008) states:

> "*The wider principles, areas and factors to consider in equality of opportunity and diversity are set out clearly and should be considered in conjunction with local policies/guidance*." (pp5-6)

2.3.2 This policy is subject to the protected characteristics set out in the Equality Act (2010), prohibiting discrimination on named grounds.

2.3.3 Equality of opportunity relates to four main areas:

- The development of policy and procedures, where '..*the Department of Health (DH) is required to assess the impact of any policy proposals on different groups in the community in terms of equality of access and impact on the rights and needs to those groups'*
- The need for Mental Health Services '*to develop and demonstrate cultural competence'*
- The provision of services and resources to support access, for example, '*an interpreter, or in the last resort a family member will be necessary when language is a barrier'*
- Once within the service, the provision of treatment to '*ensure that quality mental health services are provided to all, appropriate to their needs. Services must also pay attention to the potential for inequalities in outcomes of individual care assessment and planning, and the service they provide'*

2.3.4 Discrimination and bias factors:

- The discrimination people experience may contribute to their mental distress and ill health
- There have been significant over-estimates of non-white Service Users assessed by mental health professionals as being violent, compared to white Service Users in contrast to their subsequent behaviour

- There has been a tendency to organise services generally in ways which are ‘blind’ to the actual needs of such individuals and the groups to which they actually belong; and

- In relation to Carers, services need to be sensitive to different cultural models, particularly an appreciation of the role of kinship networks and extended families, and to the impact of age, for example, young carers

To ensure that the needs of Service Users are met, Care Coordinators and Lead Professionals have a duty to work in a ‘critical’ way. This involves being sensitive to and continually challenging:

- Their own assumptions, including unconscious bias
- How people interpret any individual’s language and behaviour, and
- The impact of discrimination on individuals

2.3.5 In summary, Values and Principles, Equality and Diversity cover key themes in the ethos and development of Mental Health Services as follows:

- Social inclusion and recovery
- An ‘in the round’ view of individuals
- Self care
- Carers’ needs
- Partnership working
- Engagement

3. PROCESS/REQUIREMENTS

3.1.1 Initial Assessment Process

Individuals referred to secondary Mental Health Services will receive a systematic assessment of their individual mental health needs. This initial assessment aims to identify needs and where they may be met and must include all elements necessary to make a decision about CPA or no CPA care planning.

The process should take account of the following:

3.1.2 The assessment will be:

- carried out with the Service User, enabling them to identify their own needs
- undertaken with due regard to confidentiality
- thorough and comprehensive, including unified health and social care domains to prevent repetitious assessments and provide the most holistic and relevant information (commonly agreed for risk assessment)
- a single assessment which provides access for both health and social care, based on a single point of access
- undertaken to take account of the Service User’s needs, strengths and choices, not only what the professional and services can offer
- explained to the Service User in an appropriate format and setting

3.1.3 The process will include:

- the involvement of Service User and Carer (where appropriate), including writing their own views of their illness, perhaps in the notes/Care Plans
- a prompt assessment for young people with the first signs of psychotic illness
- identification of any Advanced Statements and Advance Decisions, including reference to the Mental Capacity Act (2005) where appropriate
- the assumption that the Service User has capacity, unless it is established they lack capacity
- identifying whether or not the Service User has a lasting power of attorney or a deputy appointed by the Court of Protection (COP), or an order has been made by the COP on a specific issue
- a discussion about any caring responsibilities of their own that a Service User may have. These responsibilities should be explored and any appropriate support, including Contingency and Crisis Plans, should be put in place for both the Service User (as Carer) and the person they care for

3.1.4 Components of an assessment will include the following information (detailed explanations for each can be found in Appendix 2):

- Referral
- Passport Details
- Initial Needs and Risk Assessment
  (*A full Risk Assessment should be completed for every client at the first assessment and reviewed every 6 months thereafter, unless a significant event dictates that this is done sooner.* *Any* ***significant incident*** *must also be entered in the* ***risk history*** *promptly. A standard risk assessment document, available on the electronic patient record system, will be used by all services*.)
- Current Situation
- Psychological/Mental Health
- Whether there are any impairments or disturbances in the functioning of the mind or brain that are likely to affect capacity and if so, detailing any steps that can be taken to promote capacity and support decision-making
- Medication
- Co-morbidity and co-existing problems
- Previous Mental Health History
- Personal and Family History
- History of any physical, sexual or emotional abuse
- Children’s needs (see Appendix 3 for further information)
- Medical History and Physical Health
- Social History
- Diversity/Cultural/Spiritual/Religious Needs
- Daily Living
- Accommodation
- Employment, Leisure, Occupation Status
- Benefits/Financial Status
- Special Needs
- Carer’s Needs

3.1.5 Additional areas to consider:

- Level of support (practical and emotional) and intervention required
- Use of Personalised Budgets or Direct Payments to support additional needs
- Informal support network
- Ability to manage self care of mental ill health
- Likelihood of maintaining appropriate contact with services
- Service User's strengths and aims
- Cultural, gender and access needs
- Advocacy and legal advice

3.1.6 **Risk Assessment and Risk Management Plan**

Assessing and managing risk should always be based on the principle that assessment of risk is structured (as part of the assessment process), evidence based, and as consistent as possible across a range of settings, and across service providers. A clear Risk Management Plan should always follow the Risk Assessment and Needs Assessment. This is essential for good communication between practitioners and agencies. Local policies and procedures relating to the management of risk should be informed by relevant guidance (see Appendix 2 for further information).

3.1.6.2 Risk assessment tools, while helpful, should be used to augment an overall clinical judgement as part of assessment conducted with the Service User.

3.1.6.3 'Clinical Judgement' is a balanced summary of prediction derived from knowledge of the individual, present circumstances and what is known about the individual's mental health disorder.

3.1.6.4 Information from tool-based assessments must be combined with information gathered on the many other aspects of the Service User's life and situation in the comprehensive initial and ongoing assessment.

3.1.6.5 Risk Assessment is an integral part of the assessment process beginning at the initial assessment stage. At any point of the assessment process, Service Users who present with sufficient risk to cause concern must be discussed with the relevant manager and/or service and may need urgent action. A Risk Assessment Summary and Management Plan should always follow a risk assessment.

3.1.6.6 Any relevant information should be shared with other professionals directly involved in the care, under information sharing guidelines.

3.1.6.7 Local safeguarding policies for adults and children are to be applied when physical, verbal, sexual or financial abuse is suspected.

3.1.6.8 An essential part of ensuring as safe a service as possible is a formal process for identifying risk factors, and managing services and people to minimise those factors. Risk assessment and management is not a precise science and the elimination of risk is not an achievable objective. Moreover, an element of positive risk-taking is essential for individual personal development and choice.

3.1.6.9 A risk history detailing significant events and incidents in the past which may have a bearing on the assessment should be made available. Details of assessed risk must be included and recorded in the agreed documents or on the electronic patient

record. If assessment shows no evidence of risk, or below levels of risk which warrant action, this should also be recorded. It is equally important to record the absence of risk and positive risk taking following an assessment.

3.1.6.10 Taking these guidelines into consideration, the risk assessment and subsequent plans should include the following areas:

- Risk history (used to inform Risk Assessment and Management Plan)
- Intentional self-harm
- Unintentional self-harm
- Risk from others (to include Safeguarding Children and Adults)
- Risk to others (to include Safeguarding Children and Adults)
- Forensic history and current circumstances
- Positive risk taking

3.1.7 Assessment Summary and Outcomes:

- The summary of the assessment should include all aspects of need identified from the initial assessment process. In addition there should be proposed plans to meet the need and an indication of outcomes. The outcomes will also reflect the level of care planning required:

  1. No CPA (Lead Professional)
  2. CPA (Care Coordinator)
  3. Discharge from Adult Mental Health Services

3.1.8 The basic principles of good practice for discharge are:

- Involving Service User and family members
- Identifying all agencies that will need to be involved in ongoing care, including GP
- Arranging a multi-agency discharge planning meeting to ensure that all parties are clear about the Care Plan, risks, Crisis and Contingency Plan, roles and responsibilities

The safeguarding of children and adults should also be included at this stage.

3.1.9 Signatures

People involved in the initial Needs and Risk Assessment should be identified, e.g., Service User (the person assessed), Practitioner(s) as assessor(s), Carer or representative, and a signature obtained. If this is not possible, the reason must be recorded.

The permission to share form should be used at this assessment.

Copies of the Identified Needs and Risk Assessment or Assessment Summary should be made available to all those involved, including providing a copy for the GP.

3.1.10 Specialist Assessments

If necessary, a specialist assessment would be requested by the Care Coordinator or Named Nurse. As an example, the following services can be referred to individually or jointly to provide additional specialist assessment:

- Medical
- Psychology
- Social Work/Social Care Children/Adults services
- Occupational Therapy
- Substance misuse
- Leaning Disability and Adult Mental Health
- Art Therapy
- Health Services
- Specialist Nurses
- Older People's Mental Health Service
- Housing
- Third Sector Services

This list is not exhaustive.

3.1.11 Other Assessments

Also consider the need for assessment in the following areas:

- Safeguarding Adults
- Safeguarding Children, including any potential long-term effects of parental mental illness on children
- Mental Health Act (1983) Assessment
- Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (DoLS) (Liberty Protection Safeguards (LPS) from 2020)
- Care Act (2014) Assessment

3.2 Care Planning

3.2.1 A Care Plan is:

- A formal record of needs, actions and responsibilities made with a Service User (or Carer) at the centre of the process
- A summary of the identified needs and how they are to be met, setting out what is going to be done, why, when, and by whom
- Informed by the needs identified in the assessment as care planning requirements
- To be recorded in the appropriate part of the electronic patient record
- For Service Users with no CPA, where a Statement of Care may be seen as a Care Plan and should be documented in clinical practice notes and in a format that is accessible to the Service User, for example, a letter. This will also need to be accessible within the electronic patient record system.

The Service User must be given a copy of their Care Plan, including Crisis and Contingency arrangements.

3.2.2 The agreed Care Plan must include:

- Statements written in first person
- Identified interventions and anticipated outcomes
- A record of all actions necessary to achieve the long- and short-term goals towards recovery
- Service User disagreements with any part of the planned care, with reasons for disagreement recorded on the Care Plan
- Estimated timescales for outcomes or goals to be achieved or reviewed
- Details of the contribution of all involved agencies
- Appropriate Crisis and Contingency arrangements
- A focus on recovery by recognising, reinforcing and promoting Service User's strengths at individual, family and social levels. Care Plans should take into account the diverse needs of the Service User, reflecting the protected characteristics of the Equality Act 2010. It should include actions and outcomes in all aspects of a Service User's life where support is required, seeing them "in the round"

3.2.3 Care planning needs to take account of:

- Choice for individuals
- Advance decisions, Advance Directives and statement of wishes
- Direct payments within context of care management provision
- Individual budgets
- Any unmet needs. Identifying and recording unmet needs has two important aspects:
  - To ensure a robust, person-centred, collaborative Care Plan is in place to support the Service User
  - To identify areas relating to current provision and/or potential service development for commissioning consideration

3.2.4 Crisis and Contingency Plans

Crisis and Contingency plans are a crucial area for all assessment and planning processes. This applies to Service Users who are accepted into specialist Mental Health Services, in both community or inpatient settings, and including those on CPA and no CPA.

3.2.4.1 Crisis and Contingency Planning should include areas of the services involved. Service Users and Carers with their own assessment or Care Plans should be reflected in each others' plans.

3.2.4.2 When a Service User is not on CPA, the Crisis and Contingency Plan will be included in the letter from the Lead Professional.

3.2.4.3 Crisis and Contingency Plans form a key element of the overall Care Plan and must be based on the individual's wishes and circumstances. It is important to include advanced decisions and directives. Contingency planning can reduce the likelihood of crisis developing by detailing arrangements to be used where at short notice,

either the practitioner involved is not available, or part of the Care Plan cannot be provided. Further information is available in Appendix 3.

3.3 Acute Care Pathway / Community Interface

If the Service User has been admitted to a residential unit, the Named Nurse will either:

- Refer to the appropriate Recovery Team as soon as possible following an admission. If the Service User has no existing Care Coordinator, the Recovery Team will allocate a Care Coordinator within 24 hours according to current operational arrangements,

  Or

- Contact the existing Care Coordinator within 12 hours of admission (excluding weekends and Bank Holidays) to ensure the recovery and discharge planning process begins as soon as possible following admission. Staff should refer to the relevant Acute Care Pathway and Operational Policies.

3.3.1 Within a residential unit, the Named Nurse will coordinate the care planning by reviewing Care Plans in collaboration with the Care Coordinator. A flexible approach is imperative at the interface between services, as resources in each area may vary. Any operational issues impinging on care planning must be taken to appropriate service managers within the service structure.

3.3.2 A care planning meeting must be held prior to discharge from the Acute Care Pathway. This may be an initial care planning meeting if a Service User is new to the service, or a review if it is an existing Service User. The Care Coordinator remains responsible for the completion of the joint agency Care Plans. Consideration to uncontrolled symptoms of mental illness must be taken at this stage, including the impact of this on the individual and their risk profile.

3.3.3 It is essential that the Care Coordinator and Named Nurse work together in recovery and discharge planning, sharing responsibilities and ensuring there is a coordinated approach to the Service User's care and treatment.

3.3.4 An important aspect of care planning is to include all those who contribute to the Care Plans in any discussions and reviews. The Care Contributor format indicates what areas need to be considered when recording contributions to care for clinical entries and reviews.

3.3.5 Health Care Support Workers and any other staff on units who provide care should be involved in the CPA process.

3.4 Discharge from Hospital

There is potential for increased risk upon discharge or leave from hospital settings.

3.4.1 48 hour Follow Up

The first 48 hours after discharge are a high risk period for Service Users, with an increased likelihood of:

- Disengagement

- Loss of contact
- Disruption of services
- Harm to self and others

It is therefore required that all Service Users risk histories are reviewed prior to discharge and they are followed up within 48 hours of discharge.

3.4.2 Inpatients going on leave should have close community follow up with a co-ordinated Care Plan. This should include more intensive provision for the first three months following discharge from inpatient care, specifically for the first 48 hours after discharge for Service Users who have a severe mental illness or history of self harm in the previous 3 months (DH 2001).

3.5 Reviews

3.5.1 Care Plans will be reviewed and evaluated on an ongoing basis to monitor progress in meeting identified needs. The needs of people with mental health difficulties can change rapidly and it is important that planned reviews are carried out. Review meetings should be brought forward if there is marked and unexpected change in the Service User's situation, or if there is a marked divergence from the plan of care. All Service Users should have a Care Plan review on at least a 6 monthly basis, where needs remain unchanged. All those involved have a responsibility to advise the Care Coordinator or Lead Professional of any problems or issues that they observe, to ensure that an appropriate review meeting is arranged to discuss them.

The review meeting will be planned in advance and is for everyone involved in providing the Care Plan. It is a shared process in which everyone's opinion, need for information and opportunities for choice are respected.

3.5.2 The purpose of the review is to:

- Assess the needs of the Service User against all areas defined in the Care Plan
- Assess the effectiveness of the Care Plan
- Assess the progress made and relevant outcomes
- Consider whether there are uncontrolled symptoms of mental illness and the impact of this on the individual and their risk profile
- Amend the Care Plan as necessary, including review of purchased care package
- Amend the Crisis and Contingency arrangements as necessary
- Review Section 117 arrangements (where appropriate)
- Discharge the Service User from the service when appropriate

Good practice guidelines in relation to reviews are available (Appendix 4).

Where change in a Service User's risk, presentation or medication is identified, leading to a significant change in a Service User's management plan, there will be a conversation with the Primary Care provider outlining these changes with clear reasoning.

3.6 Implementation of Care Plan

The Care Coordinator or Lead Professional is responsible for the co-ordination and implementation of the Care Plan, including the time, duration, frequency and the person responsible for each allocated resource.

3.7 Monitoring

The purpose of monitoring is to ensure that planned care continues to meet assessed needs. It is the responsibility of the Care Coordinator or Lead Professional to ensure the plan of care is monitored. This will take the form of face-to-face discussion with the Service User at a frequency agreed at the care planning meeting.

Although the Care Coordinator or Lead Professional is responsible for monitoring the Care Plan, it may be another individual who has regular face-to-face contact with the Service User. The Care Coordinator or Lead Professional will remain in close contact with this individual to ensure changes are reviewed quickly and Care Plans altered accordingly.

3.8 Care Contributors' Role in Care Planning and Reviews within CPA

Care Contributors are practitioners within AMH, Third Sector or other statutory organisations who provide an element of care for Service Users as part of the CPA. It is essential they are included in the development and review of care planning to ensure a seamless and holistic approach within a multi-agency and multi-disciplinary context. There is a separate CPA form for a Carer's contribution to the CPA.

3.9 Recording

All clinical information should be recorded on the electronic patient record system. For Service Users without a CPA, letters and other relevant documents should be uploaded to the electronic patient record system.

3.10 Discharge and Transfer from Community Teams

When discharging or transferring a Service User's Care Plan, accurate and timely communication with all involved is essential.

The Care Coordinator or Lead Professional is responsible for ensuring that the responsibility for the care and treatment of the Service User is formally transferred in a rapid, accurate and secure manner to the receiving services from whom confirmation will be requested either at the CPA transfer meeting or in writing. The Transfer Protocol (Appendix 5) outlines information to be received or provided in light of a transfer of care from or to another Mental Health Service.

When discharge or transfer is felt to be appropriate, the Care Coordinator or Lead Professional should arrange a Discharge Planning Meeting to be attended by all relevant people, including a representative from the receiving service. At this meeting, a Relapse Plan will be agreed and placed in the GP letter and also given to the Service User. As a minimum, it will include:

- Diagnosis
- Indicators of relapse
- Roles and responsibilities of all parties in the event of relapse, including family and carers

Reasons for discharge or transfer should be clearly documented and recorded on the electronic patient record system, noted on any relevant forms and in care notes (if appropriate).

When a Service User moves to another health provider unit, the Psychiatrist (as Approved Clinician) from AMH is responsible for ensuring that the information from case recording is transferred to, and accepted by, the new provider unit.

- The Service User will be informed of their new Responsible Clinician, Named Nurse and Care Coordinator before transfer
- Until such confirmation is received, care of the Service User remains the responsibility of the previous service
- If the Care Coordinator encounters difficulties securing responses from people involved in the transfer, this should be reported to their line manager
- Information systems should be updated to show any discharges and transfers in and out of the service

3.11 Discharge from After Care (MHA 1983: Section 117)

After-care refers to the care and treatment a Service User receives in the community when they are subject to Section 117 Mental Health Act 1983 (this applies to Service Users detained in hospital under Sections 3, 37, 45a, 47 or 48 of the Act) (see Section 117 flow chart, Appendix 6).

3.12 Eligibility and Criteria for Care Management Funding

Practitioners should reassure Service Users and Carers that refocusing CPA into standard care (no CPA) and CPA will not impact on eligibility for care management funding. This is part of assessment under the Care Act 2014.

In Portsmouth, a Care Management Panel considers requests for financial assistance for Service Users and Carers (Carers' grants).

3.13 CPA and Other Care Processes

CPA applies across a range of services, including CAMHS and OPMH, where the principles in this policy apply. Further information can be found in Appendix 8 on:

- Older Adults – Single Assessment Process
- Health Action Planning (HAP) for People with Learning Disabilities
- Person Centred Planning (PCP) for People with Learning Disabilities
- Performance Assessment Indicators for Service Users with a Learning Disability
- CAMHS and CPA

4. ROLES & RESPONSIBILITIES

4.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.1.2 Operational Directors (Adult Services, Substance Misuse Services and Adult Mental Health Services) have the responsibility of ensuring that this policy is cascaded to their Service Managers as appropriate for dissemination and implementation within their community and inpatient environments.

4.1.3 Operational Managers are responsible for the dissemination an implementation and monitoring of this policy in the areas that they are accountable for.

4.1.4 Community Services Managers, Clinical Managers, Service Leads and Lead Nurses are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff receive appropriate training, support and guidance on how to follow the guidance in this policy and will monitor for breaches of this policy and take action as appropriate to rectify this.

4.1.5 All staff are responsible for being aware of and following the guidance in this policy. They should raise potential clinical, service or management problems that may arise from this policy with their line manager to enable a review of its contents and suitability. They are also responsible for ensuring new starters to the team and NHS Professional, Bank and Agency staff are aware of this policy.

4.2 Committees / Groups

4.2.1 The Trust Management Team Meeting has the responsibility of policy ratification and will seek assurances from clinical services that it represents best practice and is based on relevant evidence and guidance.

5. TRAINING

5.1 To support the CPA process, Line Managers will identify staff needs through supervision and/or appraisal and ensure that staff receive relevant support and/or training, for example, offered by Care Coordination Association (CCA).

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality Impact Assessment (EIA) form has been completed (Appendix 10).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 **Outcome Measures:**
"*All practitioners must ensure rigorous evaluation of goals and outcomes of the individuals Care Plan. Individual practitioners will need the skills and be given the support to identify ineffective quality systems and approaches*" (DH 2007a)

7.2 Outcomes measures are a means of both assessing the severity of each Service User's problems, and monitoring how the effective services have been. Outcome measures are available that can be used routinely by professionals, and by Service Users and Carers.

7.3 An outcome measurement tool will also be used where agreed with the Service User to help inform the Care Planning process, for example Dialog currently used in AMH. Other outcome measurement tools are highlighted in the CPA Handbook.

7.4 The Care Quality Commission provides indicators for NHS Trusts providing Mental Health Services in relation to performance assessment.

7.5 **Audit**

As part of ongoing review, the CPA processes in core areas of the service are audited on a quarterly basis. This will be refined and updated following national guidance. It will be compulsory for each service to complete the audit at the required intervals.

8. REVIEW

8.1 This policy can be reviewed at any time at the request of either staff side or management representatives, but will automatically be reviewed three years after initial approval and thereafter on a biennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES

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DH (1999) Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach

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Mental Capacity Act (2005) Code of Practice

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Local Policies: Solent NHS Trust

AMH004 Clinical Risk Assessment and Management Policy and Procedure AMH (June 2020)

CLS01 Advance Decisions to Refuse Treatment (April 2020)

CLS02 The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy (April 2020)

CLS04 Consent to Examination and Treatment Policy (April 2020)

GO27 Safeguarding Children, Young People and Adults at Risk Policy (April 2019)

Learning Disability Healthcare Services – Process for the Use of the CPA in Learning Disability Healthcare Services (May 2018)

Joint Working Protocol: Safeguarding children and young people whose parents / carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress (2011) Hampshire Safeguarding Children Board, Isle of Wight Safeguarding Children Board, Portsmouth Safguarding Children Board, Southampton Local Safeguarding Children Board.

References: Criminal Justice and Offenders

DH (2001) Changing the Outlook: A strategy for Developing and Modernising Mental Health in Prisons

Discharge Arrangements and Ongoing Care for Prisoners with Mental Illness: Liaison Between the NHS and The Prison Service. Joint Prison Service/NHS Guidance (2000)

The CPA and Care Standards Handbook (3rd Ed) (2008) CCA Section 11: Criminal Justice and Offenders

APPENDICES

Appendix: 1

Characteristics and Criteria for Levels of Care Planning Processes

Once accepted by specialist Mental Health Services, **a full assessment of needs will include the need for support under CPA.**

Care Programme Approach
Revised CPA criteria apply to Service Users with more complex needs and higher risk factors. The following is guidance in relation to this as defined in 'Refocusing' documentation.

Characteristics to consider when deciding if support of CPA is needed:

- Severe mental disorder with high degree of clinical complexity
- Current or potential risk(s) including:
    - Suicide
    - Self harm
    - Harm to others
    - Relapse history
    - Self neglect
    - Non-concordance
    - Vulnerable adult; adult/child protection e.g.,

        - Exploitation, e.g., sexual/financial abuse
        - Financial difficulties related to mental health issues
        - Disinhibition
        - Physical and emotional abuse
        - Cognitive impairment
        - Child protection issues

    - Current or significant history of severe distress/instability or disengagement
    - Non-physical co-morbidity., e.g., substance/alcohol misuse/prescription drugs misuse, learning disability
    - Multiple service provision from different agencies, e.g., housing, employment, third sector services, criminal justice, physical care
    - Currently/recently detained under Mental Health Act, or referred to Acute Care (CRHT Team)
    - Significant reliance on Carer(s), or has own significant caring responsibilities
    - Experiencing disadvantage or difficulty as a result of:

        - Parenting responsibilities
        - Physical health care problems/disability
        - Unsettled accommodation/housing issues
        - Employment issues when mentally ill
        - Significant impairment of function when mentally ill
        - Any of the protected characteristics (Equality Act 2010)

CPA is no longer automatically applied in hospital or prison.

‘Key Groups’ refers to those who should meet characteristics of CPA but are not routinely or consistently being identified and therefore do not receive the level of support they need. The following list refers to key groups who would normally be under CPA:

Key Groups are Service Users:

- Who have parenting responsibilities
- Who have significant caring responsibilities
- With a dual diagnosis (substance misuse)
- With a history of violence or self-harm
- Who are in unsettled accommodation

The DH (2008) suggests that:

“*The default position for individuals from these groups would normally be under CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records*” (p.14)

All Service Users who are subject to supervised community treatment (SCT) or subject to guardianship under the Mental Health Act (Section 7) status should be supported by CPA.

No CPA

The No CPA Planning Process will apply to those Service Users who have been accepted into Mental Health Secondary Care and following a full assessment of needs (including the need for support under CPA) have been assessed as having more straightforward needs. These characteristics include:

- Need for only one agency to be involved, or
- No problems with access to other agencies/support
- Lower risk
- Only need support from professional(s) as part of clinical/practitioner role. **Lead Professional identified**
- Service User can manage self-directed care with support

Transition between CPA and No CPA

As outlined previously, the formal review process for all Service Users should take into account whether CPA is needed or not. This includes partnership decision-making based on a need for co-ordination support or self-directed care. As a Service User’s needs change, so too will the level of care planning and support needed. Service Users and Carers should be given reassurance that when CPA is no longer needed, this will not remove their entitlement to receive services they continue to be eligible for and need, either from the NHS, Local Council or other services.

When making changes to care planning processes, including risk and crisis planning, a thorough assessment process will involve Service Users and Carers. Services should be careful not to withdraw CPA prematurely because a Service User is stable, where a high degree of support is maintaining wellbeing.

DH guidance suggests CPA should not be withdrawn without:

- An appropriate review and handover, for example, to Lead Professional or GP
- An exchange of appropriate information with all concerned, including Carers

- Plans for ongoing review and support and follow-up if appropriate
- Clear plan and statement regarding action to be taken in the event of a relapse or change which may have a negative impact on the Service User's mental wellbeing.

Where CPA is appropriate in prison or hospital, the same safeguards should be considered if the person is to be released or discharged.

Appendix: 2

Components of an Assessment

Referral
Upon referral into the service, all relevant information required for access to secondary mental health services must be made available. The referral should include comprehensive details about risk, particularly highlighting child protection/safeguarding issues and risks to vulnerable adults/safeguarding issues.

Referrals are usually received from GPs who should be using relevant documentation, or relaying information by telephone to the CHRT or other identified entry points who will process this into defined areas from the form.

Passport Details
Includes basic initial information relating to the Service User at the referral stage of the process. If the Needs and Risk Assessment is ongoing and involves several practitioners' input, the different assessors can enter their details including name and dates of entry. Permission to share should be discussed and obtained from Service Users during this stage of the process.

Initial Needs and Risk Assessment
The Needs and Risk Assessment is started on first contact with the Service User. The areas identified below should be included and contain prompts to help practitioners and Service Users to identify areas of need. The prompts are there as a guide and are not exhaustive. Practitioners may wish to use other assessment tools to augment their assessment of an individual.

The format may change with updates from national guidance and Information Technology system(s) used for recording information. Central records of essential information maintained on all Service Users remains a requirement.

A full Risk Assessment should be completed for every client at the first assessment and reviewed every 6 months thereafter, unless a significant event dictates that this is done sooner. Any **significant incident** must also be entered in the **risk history** promptly. A standard risk assessment document, available on the electronic patient record system, will be used by all services.

Current Situation can include Service User's description, circumstances of onset, impact on Services User, impact on others, coping skills, relationships, Service User's expectations of the service.

Psychological/Mental Health can include appearance, behaviour, speech, thoughts, mood, perceptions, cognitive functions, insight, sleep, appetite, coping strategies, help-seeking behaviour. If an ICD10 Diagnosis has been made, it must be added here.

Mental Capacity
The following question must be addressed, bearing in mind capacity is time and issue specific. Consider are there any impairments or disturbances in the functioning of the mind or brain that are likely to affect capacity and if so, what steps can be taken to promote capacity?

Is an assessment of capacity needed in relation to a specific issue? YES NO

Medication can include contra-indications, side effects, side effect monitoring in place (lithium, clozaril), non-compliance with medication, erratic or inappropriate use of medication.

Co-morbidity and Co-existing Problems can include any needs arising from combined physical health, mental health and substance misuse problems, e.g., drug/alcohol/substance usage (frequency of usage, when last used, trigger factors in usage), Learning Disabilities, Personality Disorders

Previous Mental Health History can include any psychiatric admissions with legal status, diagnosis and treatment given, what has helped in the past.

Personal and Family History can include early years, development, schooling, childhood experiences, family psychiatric history. The following question must be included:

Have you experienced physical, sexual or emotional abuse at any time in your life?

YES ☐	NON STATED ☐	NOT ASKED ☐
	(must be recorded).	
	Brief details of any Disclosure	
	If question not asked, please state reason.	

Children's Needs
Establishing whether a Service User is a parent of children at the initial assessment stage is critical and should be routine. This should also include those who are temporarily separated from their children, for example a prison sentence (see Refocusing the CPA p.28)(DH 2008)

A Service User may be the primary Carer for child(ren) but not necessarily the parent, i.e., guardian. Within the context of this document, the term "parent" is used to indicate any adult in the household acting in a parental capacity, whenever the relationship to the children or child, the child(ren) needs must always take priority. Any concerns regarding children must be reported to and discussed with the Children and Family Services.

Assessment should include Risk Assessment and the actual or potential impact of mental ill health on parenting; the parent and child relationship, the child and the impact of parenting on adults' mental health. Remember Children and Families Services could have vital information that should be included in all aspects of the assessment. Consider needs and risk assessment within the context of the Joint Working Protocol AMH and Child Care.

At this stage it is necessary to establish any caring responsibilities a child or young person may undertake in relation to the parent. This should be further considered within carer's needs.

It is important to remember those with parenting responsibilities are one of the key groups the Department of Health has described as needing to be consistently identified for consideration to be included in the CPA.

Medical History/Physical Health:
Consideration of current physical health status and any medical treatments, NEWS2 observations and recordings, diet and lifestyle factors, non-drug allergies, and taking into account any impact of mental ill health on physical health and vice versa. Risk assessments should include physical health risks. Service Users who return from leave under the influence of alcohol or drugs should also receive a physical health check.

Social can include social functioning, social circumstances, and social needs. Ability to make and maintain relationships, evidence of supportive relationships, intimate relationships, sexual problems, communication problems, ability to handle daily activities, hassles or life events.

Diversity/Cultural/Spiritual/Religious Needs can include cultural diversity, spiritual beliefs which are individual, religious beliefs, any issues relating to mental health including, victimisation, harassment from others, cultural practices and racial awareness. Please refer to the Equality Act 2010 for further details of protected characteristics.

Daily Living can include home, heating for home, essential amenities (to wash, cook, toilet, sleep), ability to look after their home, ablility to keep adequately clean and manage personal care, enough food and fluids, clothing, mobility, ability to use public transport, ability to cope with physical health problems.

Accommodation can include suitability, type (flat/house/rented/hostel), fully supported, residential, 24-hour staffed, bed and breakfast, homeless, not paying rent, debt, unsettled accommodation. Service Users in unsettled accommodation are a key group (Refocusing the CPA, DH 2008, p14) that need to be consistently identified for CPA. It is mandatory to complete this.

Employment, Leisure, Occupation Status can include employed, unemployed, part-time, unpaid, seeking work (employment issues when mentally ill is a key area for information to be recorded). Leisure, occupational status and potential vocational aspirations and employment needs, training and education. It is mandatory to complete this.

Benefits/Financial Status can include income (regular or irregular), adequate, inadequate, enough money to live on, benefit entitlements, receipt of benefits due, personal budgets and direct payments.

Special Needs can include Service User special needs or communication difficulties, physical impairment (including hearing, visual or communication impairment). If English is not their first language, is there any need for an interpreter?

Carer's Needs should include identification of the main Carer, the offer of a Carer's assessment under the Care Act 2014, referral to the Carer's development worker, providing information for Carers (leaflet, verbal). **Has a young person's potential needs as a Carer been identified (children/young people may provide care for parent with mental illness).** This is important as often young carers are likely to be of school age and may not be easily identified.

Service Users caring responsibilities should be explored. If a Carer is unable to attend the CPA meeting then they must be given the opportunity to complete a Carers' contribution form.

Additional areas to consider include:

- Level of support (practical and emotional) and intervention required
- Informal support network
- Ability to manage self care of mental ill health
- Likelihood of maintaining appropriate contact with services
- Service Users strengths and aims
- Cultural, gender and access needs
- Advocacy and legal advice

Risk Assessment and Risk Management Plan:
"*The Best Quality of Care can be provided only if there are established links between the Needs Assessments of Service Users and Risk Assessment*" (Rethinking Risk to Others in Mental Health Services, RCPsych 2008)

"*Risk Assessment is an essential and on-going element of good mental health practice and integral component of all assessment, planning and review processes*" (Capabilities for Inclusive Practice, DH 2007)

"*Risk Assessment is an essential and on-going part of the CPA process"* (Effective Care Co-ordination in Mental Health Service, DH 1999)

"*Risk Assessment is about weighing up both the possible beneficial and harmful outcomes and stating their likelihood*" (Learning Materials on Mental Health: Risk Assessment, University of Manchester/DH 1996)

The above statements concerning risk assessment share the commonality of 'process'.

Risk Assessment and management thereof should always be based on the principle that assessment of risk is structured (as part of assessment process), evidence based and as consistent as possible across a range of settings and across service providers. A clear Risk Management Plan should always follow the Risk Assessment and Needs Assessment. This is essential for good communication between practitioners and agencies. Any locally agreed policies and procedures relating to the management of risk should be informed by 'Best Practice in Managing Risk' (DH 2007b).

Risk assessment tools, while helpful, should be used to augment an overall clinical judgement as part of assessment conducted with the Service User.

'Clinical Judgement' can be described as a balanced summary of prediction derived from knowledge of the individual, present circumstances and what is known about the individual's mental health disorder.

Information derived from using tool-based assessments must be combined with information on the many other aspects of the Service User's life and situation gathered in the comprehensive initial and ongoing assessments.

Risk Assessment is an integral part of the assessment process beginning at the initial assessment stage. At any point of the assessment process, Service Users who present with sufficient risk to cause concern must be discussed with relevant manager/service and may need urgent action. A Risk Assessment Summary and Management Plan should always follow a risk assessment.

Any relevant information should be shared with other professionals directly involved in the care, under the information sharing guidelines.

The Safeguarding Adults Policy should be applied when physical, verbal, sexual or financial abuse is suspected.

An essential part of ensuring as safe a service as possible is a formal process for identifying individual risk factors and managing services and people to minimise those factors. Risk Assessment and management is not a precise science and the elimination of risk is simply not an achievable objective. Moreover, an element of positive risk-taking is essential for individual personal development and choice.

A risk history detailing significant events and incidents in the past which may have a bearing on the assessment should be made available. Details of assessed risk must be included and recorded in the agreed documents /electronic patient record system and if assessment shows no evidence of risk or levels below which warrant action, this should also be recorded. It is equally important to record the absence of risk and positive risk taking following an assessment.

All Service Users identified in the assessment as no CPA or needing CPA planning will require a Crisis and Contingency Plan. See separate section in this Policy.

Taking these guidelines into consideration, the risk assessment and subsequent plans should include the following areas:

- Risk history (used to inform Risk Assessment and Management Plan)
- Intentional self harm
- Unintentional self harm
- Risk from others (Include Safeguarding Children and Adults)
- Risk to Others (Include Safeguarding Children and Adults)
- Forensic history and current circumstances
- Positive risk taking

Appendix: 3

Crisis and Contingency Plan
A Crisis and Contingency Plan would be useful in circumstances such as the sudden absence of a family member who oversees medication, or the absence of a staff member through unexpected absence.

The Crisis and Contingency Plan should include information necessary to continue implementation of the Care Plan in the interim period, for example, telephone numbers of service providers and the name and contact details of substitutes who have arranged to provide interim support.

The following should be included in a Crisis and Contingency Plan:

- Passport information
- Name of Care Coordinator/Lead Professional as contact during office hours
- Contact arrangements for other service providers and Carers
- The following areas/questions should provide helpful information:

- “What is a crisis for you?” to establish the Service User’s own definition of a crisis, and:
  - “What might help you cope in a crisis?”
  - “What has helped in the past?”
  - “Which people or things are helpful if you become unwell?”
  - “Is there anything that may indicate you are becoming unwell?”
  - “Are there any triggers you can identify?”
  - “Who should take what action if you are becoming unwell/relapsing?”
  - “Who should take what action if you disengage from the Mental Health Service or appointments are missed?”

Childcare issues: it is imperative that care for children is explored.

- Identify whether an advanced directive or decision has been made (give details on Service User’s treatment choices in the event of an acute episode of illness)
- If no advance decision has been made, then explain what these are and support the Service User to create one if appropriate
- Identify (as choice) any person the Service User would NOT want to involved
- Other dependants, relatives, friends, pets
- Obtain signatures of all involved, dates and planned date for review

Appendix: 4

Review Process and Good Practice Guidelines

Service Users and Carers may never have had any contact with Mental Health Services before. The process of assessment, care planning and review could seem strange with unfamiliar language and abbreviations. Explaining the purposes and care process enables people to more fully engage and be active partners in the process which is more likely to lead to successful outcomes. Please be mindful of this and explain as thoroughly as possible the reasoning behind care planning and why a review is taking place. Avoid using jargon and, if appropriate, do simple flow-charts or explanations for people.

Self Assessment is very much integral to the process and should be encouraged at all points. Remember the Care Coordinator is working alongside the Service User or Carer in looking at their own individual needs.

Focus on Service User strengths (within a recovery context). Weaknesses should be managed constructively and referred to as "challenges". A review is an opportunity to set new objectives, goals and outcomes.

The initial care planning will have involved plans reflecting the core areas of the Service User's life, for example, employment, meaningful activity in keeping with recovery focus, housing issues, financial issues including benefits, and medication issues. These core areas should be reflected in any review process, together with any new information in areas of the Service User's life that they would like taken into account.

As well as reporting on any individual areas within Care Plans, of central importance is the risk assessment. It is essential to review risk and modify Crisis and Contingency Plans as appropriate.

An adequate review must also take into account any legal status that the Service User or Carer is subject to. It may be, for example, that a CPA review would consider a Section 117 discharge planning meeting and initiating the protocol surrounding this.

Reviews may also be used to look at other aspects of a Service User's care planning in addition to the CPA. This might include, for example, a review for the Home Office on a Service User subject to a 37/41 Order – it may also include a review for MAPPA levels.

It is important to remember during any review process to also consider other individuals in a Service User's life. It is particularly essential to review **children's and Carer's** needs as part of the process. Remember always to bear in mind **child protection and vulnerable adults protection issues**.

Young people, who may provide aspects of care and/or live with people with mental illness, are sometimes overlooked. It is essential that the on-going needs and perceived impact on children in this situation are identified, included and acted on in reviews They may, for example, need support from Carers and/or Children and Families Services.

Some key points regarding the format of reviews:

- How are they conducted?
- Where should they be held?
- What should be considered?

The minimum number of people involved in a review should be the Service User and Care Coordinator/Lead Professional. For very complex situations, it is possible that a large number of agencies from within AMH and outside AMH (from the voluntary sector, independent sector, Carers etc.) are all involved in the Service User's care.

A CPA review with the many different representatives involved in a Service User's Care Plan can be quite intimidating for the Service User/Carer involved in the process. Therefore, it is helpful to ascertain the views of the Service User or Carer about who they want involved, or what level of involvement they would like in their CPA.

The Care Coordinator will have been actively involved in coordinating the Service User's care so will have had contact and feedback from all of those involved in the care planning process and will have a good overview of what that Care Plan has involved. If reports from each of the areas involved in the care planning are delivered to the Care Coordinator approximately 2 weeks before a planned CPA review, not all contributors need to be present.

This should, of course, prioritise Service User and Carer need, not professionals' convenience at declining to attend a CPA review. Ideally, all agencies and representatives participating in Care Plans should attend to enable a full discussion.

However many people are involved in a review process, the following features should always be present:

- A CPA review should be planned in advance with sufficient notice, an agenda, and an indication of who has been invited and accepted the invitation. If possible, an indication should be given of what reports are being submitted in place of attendance or to supplement attendance.

- Care Coordinators should be mindful of arrangements for the Service User, Carers and significant others in attending the venue for the CPA. The venue should be as close to the Service User's address as possible for accessibility. If this is either undesirable or not possible, adequate transport arrangements must be made.

- Care Plans work better with a Service User's perspective on what they consider to be the strengths or particular difficulties in areas of their care planning.

- Care Plans should be recorded as clearly and simply as possible. Use clear statements of specific intervention, the aim of the intervention in relation to trying to meet the need, and a measurement for clear outcomes as part of the process.

- If Care Plans are recorded well, and are individual and specific, it should be possible for someone else to read the Care Plan and know what care package to deliver in the absence of the Care Coordinator. This is particularly important for crisis and contingency planning for out-of-hours services that need good quality and succinct information to support any crisis and contingency planning intervention.

- Do not complicate plans and statements. Avoid jargon and use plain language that everybody can understand to describe events, situations and planning. Think about the language used when writing a Care Plan – is it easily understood and does it have practical meaning?

- However, it is not adequate, helpful or safe to write single-word sentences, or short phrases that redirect without further explanation, such as “refer to CRHT” (for crisis and contingency). Statements must be clear about the exact focus when an assessment is being conducted. Make clear what components of a Crisis and Contingency Plan will be most helpful for the Service User or Carer involved, noting any specific risks that should be taken into account.

- Include positive risk-taking. For example, it may be that in particular circumstances, together with the Service User and others involved in the care, it has been identified that if particular events occur it would be more positive to take a planned risk than to take a particular action.

- Currently for Service Users with no CPA, who typically only have contact with one professional, the clinical or practice notes may constitute the record of the review. This may be in the form of a letter to the GP, but a copy of this must be made available for the Service User together with a Crisis and Contingency Plan that has been updated during the review. This information must be accessible on the electronic patient record system.

Additional requirements:

It is important to consider Service User or Carer need for an advocate during the care planning review process. Advocates should be appointed in line with guidelines on recognised providers for Mental Health Services. The advocate will act independently from providers of care and will represent the best interests of the Service User defined during consultation with them.

Consider any potential need for interpreters, when a Service User’s or Carer’s first language is not English, or where they use sign language or written communication because they are speech or hearing impaired.

It is not always ideal to use Carers or relatives as interpreters as they may have a vested interest in what is being interpreted. The Care Coordinator or Lead Professional should always consider using approved interpreting services in these instances.

For Service Users with no CPA, planning should consider funding implications for any additional services that may be required.

A review of the need for CPA is a requirement and must take into account the complexity of the issues and number of services involved.

It is important to maintain confidentiality when conducting a review of Service User’s needs.

During the initial assessment and care planning process, local policies on confidentiality and risk management should be explained, with consent from the Service User to share information with other parties. It is therefore important to re-visit confidentiality and information sharing during any care plan review.

Service Users and Carers should have a review at least on an annual basis. However, the timing of care planning reviews will very often depend on events and circumstances in Service Users’ lives. It is good practice to make sure that reviews are timely, relevant and

important for the Service User at that time. in particular circumstances such as discharge, leave, transfer of care, or relapsing factors, a review of Care Plans should take place (within 3 day guidance).

If a Service User is unwilling to attend a review of their care needs, it is important to continue with review arrangements and inform the Service User of the review details. Any recording from that review process should be made available to the GP, Service User and Carer as appropriate. Every effort should be made to re-engage the Service User and keep all involved in the Care Plan informed.

Issues or concerns from staff about any aspect of the review should be discussed during the supervision process, and on a more instant need-to-know basis with any available line manager/team manager.

A useful practice is to include individuals from services in an advisory capacity in planned reviews (as appropriate) as well as requesting specialist assessments. Agreement should be sought from the Service User/Carer.

Appendix: 5

Portsmouth CITY COUNCIL

Solent NHS NHS Trust

Protocol for Receiving and Referring Transfers of Care between Solent NHS Trust and External NHS Organisations.

1.1 Rationale

Following several inconsistencies with Service User transfers from out-of-area to the Recovery Team and specialist teams in Solent NHS Trust Mental Health Services, a protocol for transfer was required to use across all teams to maintain and support a smooth and continuous journey of care.

The CPA process is central to any transfer of care and this protocol is written understanding that this process is led from the Service User's perspective. Their safety is central to this process.

Although this document is centred around Service Users on CPA, the standards are applicable to Service Users who require transfer but are not on CPA.

1.2 Prior to transfer

1.2.1 A referral letter from the referring team's Psychiatrist/Care Coordinator to the receiving team's Psychiatrist/Team Manager, including the following basic information:

1. Service User details (DoB, Address, GP)
2. Diagnosis
3. Brief summary of history and present needs
4. Current risk factors and level of risk posed (particularly if risk summary cannot be seen over electronic patient record systems)
5. Current provision of care

1.2.2 The referring team need to ensure that relevant criteria and referral paperwork is complete. This is to include:

1. Risk assessment summary reviewed within last six months
2. Care plans up to date
3. Crisis and Contingency Plans
4. Core Assessment
5. Current Cluster.

It is the responsibility of the receiving team/service to ensure they are in receipt of appropriate records detailing sufficiently historic and present factors before accepting transfer.

1.2.3 Out-of-area Service Users will still need to be assessed by the team for suitability against criteria for the Solent NHS Trust Community Mental Health Services. There is to be no assumption that an out-of-area Service User will automatically fit criteria.

This will involve a review to inform an initial clinical and risk assessment on information received.

1.2.4 Once relevant transfer documentation and a full risk assessment have been seen, the referral is to be discussed at a multidisciplinary level with the outcome recorded on the electronic patient record system. If the referral is appropriate, an assessment is to be offered with the referring team at the earliest juncture. This assessment is to take place with the Service User's **current Care Co-ordinator**.

The results of this assessment are to be taken back to the multidisciplinary team and the final decision to receive the referral and allocate if required is to be made. The decision will be communicated to the referring team as soon as possible. Reasons must be given if referral is declined.

1.2.5 If a referral is declined, any disagreements with the findings will be initially discussed between the team managers of both teams and escalated as appropriate. The final escalation will be to the respective Service Directors where no resolution has been found.

1.3 Handover

1.3.1 Following allocation, a three month handover period will allow continuity of care and a thorough transfer from the referring team. A handover period of less than three months can be agreed by all parties as part of the handover CPA.

1.3.2 Once the decision has been made to transfer the Service User to Solent NHS Trust, it must be recorded clearly on electronic patient record system. A Care Co-ordinator or an appropriate person must be allocated to receive the transfer.

1.3.3 The referring team will arrange a CPA meeting with all relevant parties/stakeholders. This must be face-to-face with Care Co-ordinators from both the referring and receiving team present. This is to take place within the first month from referral. A timescale for transfer to the receiving Care Co-ordinator will be discussed and agreed at this meeting. The recording of the CPA review on the electronic patient record system will be the responsibility of the referring team.

1.3.4 Initially, handover may necessitate joint visits taking place to allow a smooth transfer of care. This is to be discussed as part of the CPA.

1.3.5 There will be an entry made in the progress note by the receiving Care Co-ordinator once the transfer has completed.

2.0 Monitoring

2.1 To ensure these standards are met, an audit will be carried out within each organisation/service, reviewing a random selection of transfers over the past year.

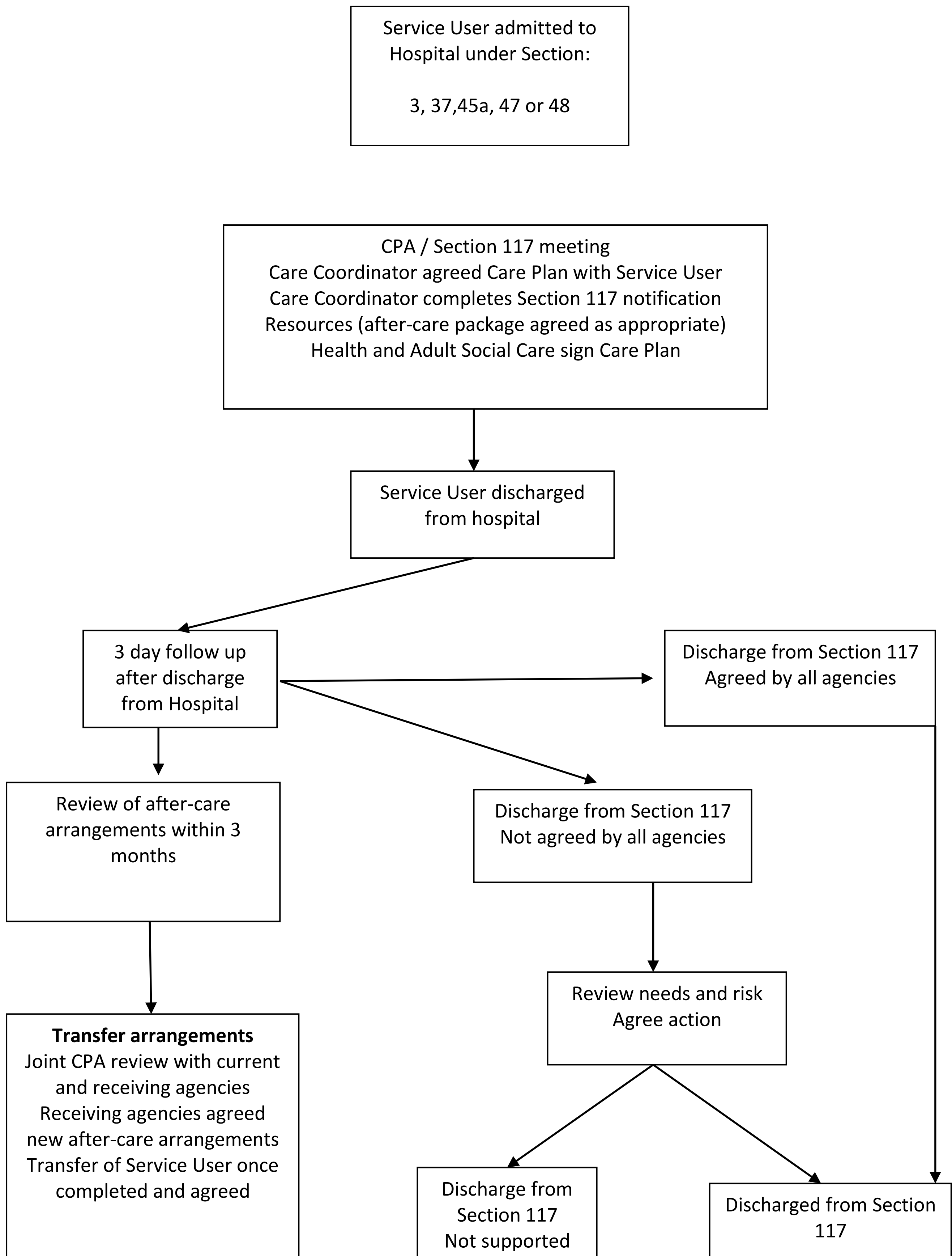
2.2 Audit results will be shared through identified leads from each Trust.

2.3 Any issues arising will be raised between respective teams initially and then escalated as 1.2.5.

Protocol to be agreed through each organisation’s Governance frameworks.

Appendix: 6

Section 117 Flowchart:



Appendix: 7
Care Coordinator / Lead Professional
The main responsibilities are to:

- Co-ordinate ongoing needs assessment and care planning
- Maintain close contact with the Service User, ensuring that the Care Plan is delivered
- Call reviews and monitoring the quality of the care
- Notify members of the care team of changes to Service User circumstances that might require review or modification of the Care Plan
- Co-ordinate the formulation of and updating of an agreed Care Plan, and to ensure that the Care Plan is distributed to all those concerned
- Ensure that a Crisis and Contingency Plan is formulated, updated and circulated
- Ensure that the Service User is equally involved in the process, and has choice and assistance to identify their goals
- Ensure other agencies and Carers are involved and consulted where appropriate
- Ensure that the Service User understands the Care Coordinator role, and knows how to contact them and whom to contact in their absence
- Ensure that each Service User is registered with a GP and that the GP is involved and informed as necessary
- Maintain regular contact with Service User and monitor their progress, whether at home or in hospital. If a Service User who remains vulnerable refuses to take part in the CPA process, all steps should be taken to find out why and to continue to attempt to engage them
- Organise and ensure that reviews of identified needs take place, and that all those involved in the Service User’s care are told about them, consulted and informed of any outcomes. Chair the review meetings if appropriate
- Explain to the Service User, relatives, and Carers what the process is and make them aware of their rights and roles
- Consider the need for advocacy for the Service User, or Carers if appropriate, and make them aware of advocacy schemes in the local area
- Remain in contact with Service Users who enter the prison system and, whenever possible, be aware of the Service User’s location and likely release date, so that appropriate care can be planned prior to release. Prior to release, Community Mental Health Teams can provide inreach and anticipatory support, with the necessary agreement of all services, including the Service User
- Identify areas of unmet need and communicate any unresolved issues to the appropriate managers
- Ensure that care management requirements are met where necessary
- Arrange for someone to deputise if absent, and pass on the Care Coordinator role if unable to fulfil it
- Record necessary data on electronic patient record systems
- Maintain contact with Service User while he or she is on authorised Section 17 leave of absence

Supervision of Care Coordinators
Care Coordinators will receive regular supervision and caseload management within the current system of each agency. Full-time Care Coordinators are to have a caseload of between 35 and 45 depending on complexity. Caseload weighting tools can be applied to determine specific caseload sizes.

Allocation of Care Coordinator

The definition, role, function and allocation of Care Coordinators for Solent NHS Trust Mental Health Services is defined in Operational Policies.

For the core services, the Care Coordinator is nominated at the referral or allocation meeting at the earliest date within the process. The identification of the Care Coordinator is a priority when Service Users are on an Acute Care Pathway, and contact must be established as soon as possible after admission.

It is critical that the Care Coordinator has the authority to co-ordinate the delivery of the Care Plan and that this is respected by all that are involved in delivering it, regardless of agency of origin. It is also critical that the Care Coordinator can understand and respond to the specific needs of the Service User that may relate to their cultural or ethnic background.

The Care Coordinator will be clearly identified on the Care Plan.

Both health and adult social care managers should ensure that the Care Coordinator is able to combine the CPA Care Coordinator and the Care Manager roles by having:

- Competence in delivering mental health care (including an understanding of mental illness)
- Knowledge of Service User/family (including awareness of race, culture and gender issues)
- Knowledge of community services and the roles of agencies
- Skills for case co-ordination and management
- Access to resources

A Care Coordinator may be appointed on a short-term basis, but Service Users with serious mental health problems have enduring needs and involvement may require long-term support. Changes of Care Coordinator should be kept to a minimum. A CPA Review meeting should be arranged to facilitate a change of Care Coordinator.

For dual diagnosis Service Users, with a mental health and substance misuse problem, the Care Coordinator will be allocated from the Recovery and Specialist Services Team for the duration of involvement. Dual diagnosis and/or substance misuse workers involved in the Care Plan will be named co-workers.

A Service User may prefer to receive services from a gender or culture specific Care Coordinator. The wishes of the Service User should be met as fully as possible within the resources available to RSSTs. However, this may be difficult or impossible for teams to achieve.

Appendix: 8

CPA and Other Care Processes
Older Adults – Single Assessment Process (SAP)

The CPAA Handbook describes this process as follows:

The aim of the Single Assessment Process (SAP) is to ensure a person-centred approach to assessment and care planning for older people, regardless of operational boundaries. SAP provides a platform to reduce unnecessary duplication or repetition by a variety of health and social care agencies, with its tiered assessment model of:

- Contact
- Overview
- Specialist
- Comprehensive

Where the older person's needs are being met and managed mainly in primary care and social care, and they have a mental health problem which is neither complex nor includes significant risk, care will be co-ordinated through existing SAP Care Managers.

When an older person's mental health and social care package is complex, predominantly mental health-related, and the person meets the criteria for CPA, they will normally require the support of CPA, and will have a mental health Care Coordinator (Refocusing the CPA, 2008).

In addition to this process, OPMH services in Portsmouth apply the above within the context of the Common Assessment Framework.

Health Action Planning (HAP) for People with Learning Disabilities

This is an Action Plan offered to people with learning disabilities to describe the health services being provided to support them. It is a written plan which forms part of the person-centred plan. It is produced and co-ordinated by the Learning Disability Health Facilitator in partnership with primary care Nurses and GPs.

It is reviewed under the following Service User circumstances:

- Transition from secondary education with a process for ongoing referral
- Leaving home to move into a residential service
- Moving home from one provider to another
- Moving to an out-of-area placement
- Changes in health status, for example, as a result of a period of outpatient care or inpatient treatment
- On retirement, and
- When planning transition for those living with older family Carers

Person Centred Planning (PCP) for people with learning disabilities:

Person Centred Planning is a mechanism for reflecting the needs and preferences of a person with a learning disability and covers issues such as housing, education, employment and leisure.

This is a plan which starts with the wishes and aspirations of the individual with learning disabilities, and which should help the person exercise choice about housing, education, employment, support and leisure.

Performance Assessment Indicators:
The Care Quality Commission requires Mental Health Services to ensure that access to health care for people with a learning disability is tailored to meet their need. The approach to care planning will aim to:

1. Flag all Service Users with a learning disability using clinical coding on the electronic recording system. Pathways of care will need to be reasonably adjusted to meet the needs of these Service Users. This may include joint working arrangements with Integrated Learning Disabilities Services.

2. Provide readily available and comprehensive information to Service Users with a learning disability concerning treatment options (including health promotion), complaints and appointments, involving services/people with a learning disability throughout development of such material.

3. Ensure mechanisms are in place for identifying and considering the needs of family Carers who support Service Users with a learning disability.

4. Support a well-established local carers service across sectors which is able to provide support and information regarding learning disabilities, relevant legislation and carers rights.

5. Provide routine learning and development opportunities for staff working people who have a learning disability including areas such as awareness, relevant legislation, human rights, communication techniques and person-centred approaches.

6. Continue to encourage Service User and carer representation within Trust Boards, local groups and other relevant forums; seeking to incorporate their views and interests in the planning and development of health services.

7. Ensure service assurance systems are in place through audits coordinated by the AMH Business Unit, Governance and Quality Improvement Group of which AMH and Learning Disability Services are represented.

CAMHS and CPA
The NSF for Children, Young People and Maternity Services makes it clear that CPA is the system to be used when children and young people are discharged from inpatient services into the community, and when young people are transferred from child to adult services, as it ensures continuity of approach.

Where a criterion of complexity applies in CPA, there is theoretically no lower age limit for the use of CPA.

Appendix: 9

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Mental Health Services	
Title of Change:	AMH006 Care Programme Approach (CPA) Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Update in line with local and national guidance	
Step 2: Assessing the Impact		

Please use the drop-down feature to detail any positive or negative impacts of this document/ policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	

Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	No	
Have you taken into consideration any regulations, professional standards?	Yes	See Policy reference list

Step 3: Review, Risk and Action Plans			
How would you rate the overall level of impact / risk to the organisation if no action taken?	Low X	Medium ☐	High ☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off			
I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.			
Equality Assessor:	*Ben Martin-Lihou*	*Date:*	*July 2020*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team