POLICY TITLE:	**Care Programme Approach/Care & Treatment Planning**
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Policy Owner:	Kris Irons, Specialist Director Paul Cowans, Specialist Director
Ratified by:	David Watts, Director of Risk Management
Responsible Signatory:	Adrian Cree, Group Medical Director
Outcome:	This policy: • Aims to ensure patient treatment and care is informed by clear communication between colleagues and across agencies.
Cross Reference:	H62 Healthcare Records LE03 Data Protection OP05.2 MCA Deprivation of Liberty Safeguards (England and Wales) OP06 Safeguarding Children OP08 Safeguarding Adults

EQUALITY AND DIVERSITY STATEMENT

Priory Group is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

CARE PROGRAMME APPROACH/CARE & TREATMENT PLANNING

1 INTRODUCTION

1.1 As outlined in the MHA Code of Practice (2015), the Care Programme Approach (CPA) and the Care & Treatment Plan (Wales) (CTP) provides an overarching framework for coordinating care, emphasising the need for a focus on delivering person-centred mental health care and ensuring that crisis, contingency and risk management are an integral part of the assessment and planning processes. The planning of after-care needs to start as soon as the patient is admitted to hospital.

1.2 Mental Health patients, particularly those with complex and enduring needs, often require help with aspects of their lives in addition to care and treatment, such as housing, finance, employment and education as well as their physical health. This places demands on services that no one discipline or agency can meet alone, and it is therefore necessary to have an integrated system of effective assessment, planning, delivery and review, so that all services can work together for the benefit of the patient.

1.3 Where a patient has less complex needs and has contact only with primary care, formal designated paperwork for care planning and review is not required. However, a statement of agreed care should be recorded, either in a discharge care plan or a letter. The minimum requirement is for essential information to be maintained and reviewed regularly.

1.4 CPA/CTP is for patients with a wide range of needs from a number of services, or who are at most risk. It applies to patients within all Priory Healthcare & Partnerships in Care sites if they fall within this category and includes adolescents and older adults.

1.5 For patients admitted for a limited period (emergency, respite etc.) there needs to be close liaison with the referring agency at the time of discharge, but not necessarily a formal CPA/CTP meeting.

2 POLICY STATEMENT

2.1 Priory Healthcare units will comply at all times with the DoH 2008 Guidance on Care Programme Approach and the Mental Health Act 1983: Code of Practice 2015 (For Priory Sites in Wales this guidance is provided by the Welsh Assembly Government Mental Health (Wales) Measure and the Mental Health Act 1983 Code of Practice for Wales Review (Revised 2016)).

2.2 The key principles of CPA are that a whole systems approach should be taken. Services and organisations should work together as stated by The Mental Health Act 1983 Code of Practice (2015), to ensure that the after-care plan reflects the needs of each patient and a thorough assessment is achieved:

(a) Adopt integrated care pathways approaches to service delivery.
(b) Improve information sharing.
(c) Establish local protocols for joint working between different planning systems and provider agencies.
(d) To ensure that services are person-centred, values and evidence based.
(e) Provide an appropriately trained and committed workforce.
(f) Individuals and carers will be involved and engaged.
(g) Ensure that patient risk is appropriately managed, shared and recorded.
(h) Care and Treatment will be holistic.

2.2.1 The Mental Health Act 1983 Code of Practice 2015 states that the CPA care plan is central to CPA "to ensure a transparent, accountable and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs which are associated with a person's mental disorder". The Care Plan should include:

(a) A treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting our patients' needs and promoting recovery and/or preventing deterioration.

(b) Details about any prescribed medications.
(c) Details of interventions to address physical health problems or to reduce the likelihood of health inequalities.
(d) Details of how the patient will be supported to achieve their personal goals.
(e) Support provided in relation to social needs such as housing, occupation, finances etc.
(f) Support provided to carers.
(g) Actions to be taken in the event of a deterioration of a person's presentation.
(h) Guidance on actions to be taken in the event of a crisis.
(i) The Mental Health Act Code of Practice for Wales 2016, states that there should be a clear description of the outcomes agreed with the patient (where possible)[1].

2.3 The focus of assessment and care planning should be outcomes that represent improvements for patients and their families.

2.4 Attention to local audit, performance management, national regulation, and issues of equality are needed to ensure equitable outcomes for all.

2.5 The MDT will ensure that colleagues:
(a) Ascertain a clear definition of individual needs.
(b) Focus on areas of assessment, risk and care.
(c) Have systems that can support multi-agency delivery to meet the range of individual needs.
(d) Access training in CPA/CTP.
(e) Undertake an annual local audit of CPA/CTP documentation and processes.
(f) Provide data to the internal compliance inspectors to demonstrate that the local audit results were satisfactory.

3 PATIENT INVOLVEMENT

3.1 The Mental Health Act 2008 Code of Practice states that the CPA care plan "should be prepared in close partnership with the patient from the outset, particularly where it is necessary to manage the process of discharge from hospital and reintegration into the community"[2].

3.2 All of our patients will be involved in the CPA/CTP process. If possible they will be involved in the organisation of the CPA/CTP meeting, e.g. time, location, who is invited and the chairing of the meeting.

3.3 If they are not able to do this themselves, as a minimum they are to be asked who they would like to be invited, supported in completing the patient views and feedback form and be provided with a copy of the report prior to the meeting.

4 CONFIDENTIALITY

4.1 Information that is to be shared between different agencies should be gathered in compliance with the Data Protection Act (see LE03 Data Protection).

4.2 Reports should not contain the private addresses and phone numbers of individuals, except with express consent in the full knowledge of who the document is to be shared with.

5 EFFECTIVE CARE CO-ORDINATION

5.1 If the care co-ordinator role is clearly identified within the community team it is imperative that the MDT team closely liaise with them regarding the CPA/CTP process and take responsibility for arranging review meetings and circulating minutes and care plans.

5.2 The MDT team will agree a CPA/CTP meeting date which is suitable for as many of the invitees as possible in liaison with the care co-ordinator.

[1] The Mental Health Act Code of Practice for Wales 2016
[2] The Mental Health Act 2008 Code of Practice

5.3 Subject to the patient's views invitees may include:
(a) The patient's responsible clinician.
(b) Nurses and other professional involved in the patient's care.
(c) The patient's general practitioner and primary care team.
(d) Any carer who will be involved in looking after the patient outside of hospital - See section six - Carer Involvement.
(e) The patient's nearest relative.
(f) A representative of any relevant voluntary organisations.
(g) In the case of a restricted patient, the multi-agency public protection arrangements (MAPPA) coordinator.
(h) In the case of a transferred prisoner, the probation service.
(i) A representative of housing authorities, if accommodation is an issue.
(j) An employment expert, if employment is an issue.
(k) The clinical commissioning group's appointed clinical representative (if appropriate).
(l) An independent mental capacity advocate, if the patient has one.
(m) The patient's attorney or deputy, if the patient has one.
(n) Any other representative nominated by the patient.
(o) Anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf[3].

5.4 Once a date has been agreed the service specific draft CPA report needs to be completed:
H Form: 10A for CAMHS
H Form: 10B for Adult Acute
H Form: 10C for EDU
H Form: 10D for Forensic Services
H Form: 10L for Brain Injury Services
H(RR) Form: 06 for Rehabilitation and Recovery
H(RR) Form: 06A for Rehabilitation and Recovery (Wales)

5.5 The Carers Feedback section from the CPA/CTP Report is sent out to the carer with the invitation to attend the meeting. Once the form has been completed the results are incorporated into the final report. If a carer requires assistance to do this a time needs to be arranged with the patient's named nurse/keyworker (For Rehabilitation and Recovery use **H(RR) Form: 06B** and **H(RR) Form: 06C**).

5.6 The patient will be supported to complete their feedback for the report by the named nurse/keyworker so that this can be incorporated into the report.

5.7 The MDT team will complete the relevant sections of the draft report. All reports are then collated by the co-ordinator (as identified by the MDT) for the hospital.

5.8 The draft report is circulated one week prior to the CPA/CTP meeting to all relevant parties. No part of the report must be left blank (apart from the discussions and outcomes sections that are required to be completed at the CPA/CTP meeting). If the section is not applicable or there is another reason for it not being completed this must be documented on the form.

5.9 The named nurse/keyworker needs to ensure the patient understands as much as possible of the contents of the report prior to the meeting.

5.10 The CPA/CTP meeting will be attended by all relevant professionals, the patient and carer(s) where not contra-indicated.

5.11 The purpose of the meeting is, in discussion with the patient, establish an agreed outline of the patient's needs, to formulate/review the care plan, set longer term goals and agree a timescale for the implementation of the various aspects of the plan. Elements of risk and how the care plan manages the identified risk must always be recorded. The care plan must be outcome focussed.

[3] The Mental Capacity Act 2005 (MCA)

5.12 Particular consideration should be given to care planning if there are any actual or potential risks to the patient's own or other children, when discharge would mean resumed contact with them. See OP06 Safeguarding Children.

5.13 The Mental Health Act 1983 Code of Practice 2015 states that care planning requires a thorough assessment of the patient's needs and wishes.

5.14 It is likely to involve the consideration of:
(a) Continuing mental health care, whether in the community or on an outpatient basis.
(b) The psychological needs of the patient and where appropriate of their carers.
(c) Engagement and progress in therapy including family therapy, the impact of any non-engagement and the measures to be taken in response to this.
(d) Physical healthcare.
(e) Daytime activities or employment.
(f) Appropriate accommodation.
(g) Identified risks and safety issues.
(h) Any specific needs arising from, e.g. co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder.
(i) Any specific needs arising from drug and alcohol or substance misuse (if relevant).
(j) Any parenting or caring needs.
(k) Social, cultural and/or spiritual needs.
(l) Counselling or personal support.
(m) Assistance in welfare rights and managing finances.
(n) Involvement of authorities and agencies in a different area, if the patient is not going to live locally.
(o) Involvement of other agencies, e.g. the probation service or voluntary organisations (if relevant).
(p) For a restricted patient, the conditions which the Secretary of State for Justice of the first-tier Tribunal has - or is likely to impose on their conditional discharge.
(q) Contingency plans (should the patient's mental health deteriorate) and crisis contact details[4].

5.15 All discussions taken and actions agreed are to be documented on the appropriate CPA/CTP report form and circulated to all involved, subject to the consent of the patient. This provides evidence that the patient's needs are being assessed, and that action plans are being developed, agreed and shared with those involved.

5.16 The draft report is finalised and agreed at the CPA/CTP meeting. Any changes should be included in the minutes of the meeting.

6 CARER INVOLVEMENT

6.1 With the patient's agreement, carers are to be included in the CPA/CTP process. They are to be asked to complete the Carers Feedback section of the CPA/CTP report form prior to the CPA/CTP so that their views can be included. It is however imperative that consent is sought from the patient about the information that can be disclosed to their carer. This will affect the amount of involvement they can have and whether they can attend the meetings.

7 CPA STANDARDS

7.1 **Young Persons Services -** Care Planning should take account of the patient's age. A CPA/CTP review is to be arranged on admission to take place within the first four weeks of admission.

7.1.1 The standard for ongoing CPA/CTP review within the adolescent services are:
(a) Acute YP units - 4 to 6 weeks.
(b) PICU YP services - 4 weeks.

[4] The Mental Health Act 1983 Code of Practice 2015

(c) Low secure YP services - 10 weeks.

7.1.2 The patient's named nurse/keyworker is to ensure that the young person has a copy of the report and understands its content.

7.1.3 All young patients subject to the CPA/CTP process must have a CPA/CTP discharge planning meeting attended by all agencies involved in the patient's care and wherever possible attended by the parents or those with parental responsibility.

7.2 **Forensic Services -** For patients who are detained under a section of the Mental Health Act and whose admission is expected to last six months or longer, CPA/CTP reviews will be held at six monthly intervals. However, this is a guide and timescales of admission can change due to many factors. See paragraph 8.4 for details of events that may trigger a CPA/CTP review meeting.

7.2.1 Patients whose admission may be shorter in time period, such as S.2 MHA, a CPA/CTP will be held on admission and upon transitional planning, such as discharge or change of legal status.

7.3 **Rehabilitation and Recovery Services -** A CPA/CTP meeting will be arranged within six weeks of a new admission and used to review the service provided from all agencies. Thereafter CPA/CTP meetings will be held at 3-6 monthly intervals. See paragraph 8.4 for events which may trigger a review.

7.3.1 Rehabilitation and Recovery Services will provide MDT meetings at a minimum period of every six weeks to review treatment. ABI services may differ slightly in frequency and terminology in terms of MDT.

7.4 **Eating Disorder Services -** A CPA/CTP meeting is arranged on admission to take place within the first four weeks of admission.

7.4.1 The standards for ongoing CPA/CTP meetings within the Eating Disorder Services are every six weeks.

7.5 **Acute Services, including PICU -** For patients placed within an acute site by the NHS, the MDT team will liaise with the patient's community team to ascertain whether the patient is already on CPA/CTP as part of the admission process. Records of the last meeting will be obtained to ensure that plans already in place are followed.

7.5.1 If a patient is subject to CPA/CTP, then a CPA/CTP meeting is to be arranged to take place, where possible, within the first four weeks from admission. The ward team are to take responsibility for arranging this whether there is a care co-ordinator identified or not.

7.5.2 Ongoing standards for frequency of CPA/CTP will be agreed within this first CPA/CTP meeting.

7.5.3 If an NHS funded patient who is subject to CPA/CTP is recalled to the NHS, the named nurse/keyworker and Responsible Clinician will ensure an appropriate handover occurs in the means of a verbal handover at the time of transfer and a discharge summary.

7.5.4 If it has been agreed that an NHS funded patient completes their treatment within a Priory acute service, a discharge CPA/CTP will be arranged prior to discharge so that an effective discharge and contingency plan are developed in consultation with the patient and community team.

8 PLANNING AT TIME OF CRISIS

8.1 Patients who are subject to CPA/CTP will have, as part of their care plans, contingency and crisis plans.

8.2 Contingency plans should set out the action to be taken based on previous experience if the patient becomes very ill or their mental health is rapidly deteriorating.

8.3 The contingency plan will include information necessary to continue implementing the care plan in crisis, i.e. telephone numbers of service providers, names and contact details of other professionals. The plan should also include who the patient is most responsive to, how to contact them and previous strategies that have been successful in engaging the patient.

8.4 **Triggers which may prompt a CPA/CTP review**:

(a) Occasions when urgent review of care is required, a crisis or contingency plan may cover such arrangements.
(b) If a patient's needs change and a review has been requested by the patient, carer or any other member of the care team.
(c) Prior to a patient being discharged.

9 ONGOING CPA/CTP

9.1 The date of the next review will be set and recorded at each review meeting if possible, but will be no later than the standards described previously.

10 QUALITY AND AUDIT

10.1 All CPA/CTP reports need to meet the standards of documentation expected within Priory and the CPA/CTP guidelines.

10.2 CPA will be covered for relevant colleagues in their induction process.

11 REFERENCES

11.1 DH (2008) Refocusing the Care Programme Approach: Policy and positive practice guidance
DH (2015) Mental Health Act 1983: Code of Practice
Welsh Assembly Government (2016) Mental Health Act 1983 Code of Practice for Wales Review
NHS England - Information on Cross-Border Healthcare for the NHS in England and Wales
Welsh Assembly Government (2012) Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
Ministry of Justice (2014) Guidance with Multi-Agency Public Protection Arrangements (MAPPA)

Associated Forms

H(RR) Form: 06 -	CPA Review Meeting (Rehabilitation & Recovery)
H(RR) Form: 06A -	CTP Review Meeting (Rehabilitation & Recovery)
H(RR) Form: 06B -	My CPA/CTP Report (Rehabilitation & Recovery Patient Questionnaire)
H(RR) Form: 06C -	Family and Carers Questionnaire for CPA/CTP Meeting (Rehabilitation & Recovery)
H Form: 10A -	CPA Report (Adolescent Services)
H Form: 10B -	CPA Report (Adult Acute Services)
H Form: 10C -	CPA Report (Eating Disorder Units)
H Form: 10D -	CPA Report (Forensic Services)
H Form: 10L -	CPA Report (BIS Services)

Appendix 1 - For Welsh Sites - Guidance on the Use of the Recovery Model CPA/CTP Forms

Appendix 1

FOR WELSH SITES - GUIDANCE ON THE USE OF THE RECOVERY MODEL CPA/CTP FORMS

1 The purpose of the CPA/CTP report is to accurately reflect a patient centred and multi-disciplinary approach to evaluating and planning an individual's treatment whilst under our care. The approach is based on the recovery model which emphasises functional improvements and social goals over symptomatic treatment.

2 OVERVIEW OF THE RECOVERY MODEL CPA/CTP

2.1 Instead of having several independent professional reports presented at CPA/CTP meetings, there will be one single multi-disciplinary report (**H (RR) Form: 06** or **H (RR) Form: 06A** for Welsh patients). The report is divided into 11 sections.

2.2 The first two parts of each section are to be completed prior to the CPA/CTP meeting.

2.3 Each section starts with the patient's views about their own care, treatment and progress. This is explored using a patient questionnaire prior to the CPA/CTP meeting.

2.4 Next are the actions agreed at the last CPA/CTP meeting or on admission. At the CPA/CTP meeting each should be reviewed and agreement reached on whether these have been achieved, partially achieved or not achieved.

2.5 The professional's opinions follow the patient's views and agreed action.

2.6 Next there is space to record the discussion which takes place at the CPA/CTP meeting.

2.7 Progress, concerns or both are highlighted next.

2.8 Each section concludes with an action plan, which will be agreed at the CPA/CTP meeting. The action plans agreed at CPA/CTP meetings will be carried over to the patient's ward round records. The multi-disciplinary team will check progress against the agreed actions at each ward round to ensure that action plans are completed. Actions are reviewed at the next CPA/CTP meeting.

2.9 In order to drive the recovery process the frequency of CPA/CTP meetings will increase in frequency from once every six months to once every three months. This will ensure that agreed actions are completed quickly. New actions can then be agreed.

2.10 The aim of the increased frequency of CPA/CTP meetings is to speed up the recovery process and ensure that the patient, their family and the commissioners of our services are all part of that process.

3 USING THE CPA OR CTP REVIEW MEETING REPORT FORMS

3.1 This guide sets out who is likely to be primarily responsible for each of the domains on the CPA/CTP Review Meeting report document, but this should not exclude other professionals from contributing where they have useful information to add.

3.2 The CPA/CTP Review Meeting report document will be held on the 'shared drive'; the consultant's secretary will set up the document. All members of the MDT are expected to contribute directly to it.

3.3 The document on the shared drive will be in an editable format. This means that all users will be able to make changes to any part of it. Having a single editable document carries a risk that it may be inadvertently deleted or otherwise rendered unusable. Only one copy of the live document can be open at a time.

3.4 In order that everyone has access to the document a first draft should be compiled in a Word document. Once this is complete the relevant parts should be copied and pasted into the master document. It is strongly advised that all people completing the document keep a copy of their entries in a format that they can re-use if necessary.

3.5 Having an editable document means that the domains on the document may also be modified if that is appropriate for an individual patient and that patient's needs.

3.6 Each individual entry in the document should be initialled and dated by the person making the entry. Whilst there will be one single CPA/CTP review meeting report document, it should be possible for us to know who has expressed which opinions in that document.

3.7 The secretary should send out confirmation of the date and time of the CPA/CTP meeting at least 28 days ahead. A deadline for completion of reports should be included.

3.8 The form should be completed at least five working days before the CPA/CTP meeting. It should be checked for spelling and formatting by the secretary. The contents should be checked by the Consultant before the meeting.

4 THE CPA/CTP MEETING PROCESS

4.1 The 11 section headings should act as the agenda for the CPA/CTP meeting. The agenda should be printed off and shared with all those present at the CPA/CTP meeting. The chair of the CPA/CTP meeting should guide discussion so that it follows the agenda. Failure to control discussion will result in a longer meeting and make minute taking difficult.

4.2 The aim of the CPA/CTP meeting is to discuss progress, identify concerns and address all relevant issues to the satisfaction of those present. Action points must be agreed that are clear, relevant to recovery and achievable. The meeting should be kept to time.

4.3 Patients should be given every opportunity to attend their CPA/CTP meeting. They should be allowed to attend as much of the meeting as they wish to.

4.4 Patient's relatives should attend if the patient agrees. Commissioners and other relevant people should be invited. The CPA/CTP meeting should take place even if there is no attendance by external people.

5 MY CPA/CTP REPORT (PATIENT QUESTIONNAIRE)

5.1 The patient questionnaire **(H (RR) Form: 06B)** is an integral part of the CPA/CTP documentation. It covers the same sections as the **H (RR) Form: 06** and **06A**. The patient should be supported to complete the various sections to the best of their abilities.

5.2 The aim is to try and capture the patient's views about their care and their aspirations for the future. The patient's own words should be used. If the patient's words need interpreting then this should form part of the following discussion section. Colleagues should not write what they think the patient would say, only what the patient (or their relative) actually says.

5.3 It is likely that for patients with cognitive or communicational difficulties it may require several attempts to fully complete the document. There is no reason why the completion of this document should not take place over a period of days or weeks prior to the CPA/CTP meeting.

5.4 Where a patient is incapable of making any useful contribution to the document, then the views of their nearest relative, friends or other relevant people should be sought. If it is not the patient answering the questions then the source of information must be clearly indicated.

6 ACTION PLANS AGREED AT LAST CPA/CTP OR ON ADMISSION

6.1 Each section should have previously agreed actions listed. All patients should have clear goals in each section that have been agreed with the patient, their relatives and the commissioners of services. Actions are set at the previous CPA/CTP meeting or as part of the assessment or admission process if a CPA/CTP meeting has yet to take place.

6.2 The CPA/CTP meeting should agree whether these have been met. Where they have not been met, or have only been partially met, this should form part of the CPA/CTP meeting discussion.

7 PROFESSIONAL REPORTS

7.1 The purpose of professional reports in the discussion sections is to give an account of how the patient has been during the period between CPA/CTP meetings. Professional reports should identify specific areas of progress or concern and demonstrate how professional input has contributed to progress or mitigated areas of concern.

7.2 Needs identified by professionals should be put in explicit terms: What does the patient need, why, when and from whom? Entries should be brief and to the point. Facts (perceived through the senses; sight, hearing, touch, smell) should be separate from opinions (what you thought).

7.3 Colleagues should avoid using jargon and should spell check their entries. They should ask for help if they need it in order to get across their thoughts. All entries should be initialled by the writer so it is possible to ascertain authorship.

7.4 Professional reports should allow those present at the CPA/CTP meeting to understand why the patient needs treatment at the Priory, how that treatment is delivered and what needs to be achieved in order for the individual to move on.

8 CPA/CTP MEETING DISCUSSION

8.1 The patient's views, actions and professional reports should be discussed by those present at the CPA/CTP meeting. Discussion should focus on issues relevant to the section heading. The discussion must be minuted.

9 AREAS OF PROGRESS OR CONCERN

9.1 These should be identified from the reports and CPA/CTP meeting discussion.

10 ACTIONS AGREED

10.1 Finally actions should be agreed for each section. Actions should be SMART: Specific, Measureable, Achievable, Relevant and Timely. Specific responsibility (who), the action (what), the location (where) and completion date (when) should all be agreed. Actions may be the responsibility of the patient, the hospital, the home team or the relatives.

11 GUIDANCE ON WHO SHOULD LEAD THE COMPLETION OF SECTIONS:

11.1 **Note:** Any professional may contribute to any section if they have relevant information.

11.2 **Section 1:** To be completed by nursing team with additional information contributed by other MDT members.

11.3 **Section 2:** To be completed by the consultant psychiatrist or associate specialist with additional information contributed by other MDT members.

11.4 **Section 3:** To be completed by the OT, SALT, physiotherapist or psychologist. For many patients there will be contributions from more than one discipline in this section.

11.5 **Section 4:** To be completed primarily by nursing colleagues with support from the OT team. Other members of the MDT may wish to contribute if they have had dealings with family and friends that are relevant to this section.

11.6 **Section 5:** To be completed by the nursing colleagues with additional information from the Mental Health Act administrator, social worker or OT.

11.7 **Section 6:** To be completed by OT, in consultation with other members of the MDT.

11.8 **Section 7:** To be completed by the nursing colleagues with advice from the dietician and/or physiotherapist.

11.9 **Section 8:** 8.1- To be completed by nursing colleagues on the ward from the MARS sheets.

11.10 8.2 - All uses of "PRN" medication, with dates and times, to be recorded by nursing colleagues.

11.11 8.3, 8.4 and 8.5 - To be completed by the doctor.

11.12 **Section 9:** All incidents that have been recorded in the ward round sheets will be transcribed into the document so there is a complete list of all incidents of concern relating to that patient during the period between CPA/CTP meetings.

11.13 Nursing and Medical colleagues contribute to the discussion points.

11.14 Nursing colleagues insert the latest risk assessment.

11.15 **Section 10:** To be completed primarily by nursing colleagues with some input from OT and other members of the MDT.

11.16 **Section 11:** If the patient is detained under the Mental Health Act or has been detained from the CPA/CTP period, the Mental Health Act administrator should complete the relevant Mental Health Act section.

11.17 This must include the last tribunal, managers hearing and any planned hearings with dates.

11.18 If the patient is subject to an authorisation under the Mental Capacity Act, the Mental Health Act administrator should contribute.

11.19 Consultant or doctor should complete an up to date capacity assessment. If MAPPA is not relevant the doctor should delete it from the document.

11.20 The Mental Health Act administrator should advise on advocacy and other legal issues.

11.21 Nursing colleagues should insert the date of the latest end of life care plan.

11.22 All those present should agree a rating for the PGCOMS at the CPA/CTP.