NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST **POLICY DOCUMENT**	
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CARE PROGRAMME APPROACH (CPA) POLICY

The CPA Policy provides guidance to staff on the underpinning values and principles of the CPA, outlining that the CPA is the principal vehicle and framework of care assessment and planning for those service users receiving mental health care from North Essex Partnership NHS Foundation Trust.

1. Introduction

1.1 The CPA process was introduced in April 1991 as the cornerstone of the Government's Mental Health Policy to provide a framework for effective mental health care. The Department of Health's revised CPA policy and guidance 'Refocusing the Care Programme Approach' was issued in March 2008.

1.2 The CPA process is a model of assessing, planning, implementing/delivering care, and then evaluating the effectiveness of that care or intervention. It aims to promote effective liaison and communication between agencies, thereby managing risk and meeting the individual needs of those with mental health difficulties so that they are better able to function in society.

1.3 The term 'service user' will be used throughout this policy to refer to those individuals who receive a mental health service from our Trust.

2. Scope of the Policy

2.1 This CPA policy applies to **all** working within the Trust, and the provisions of the policy are mandatory across the whole Trust. It is the responsibility of all those involved with a service user to ensure that all others working with that service user are kept fully informed of all significant changes or events.

2.2 Whilst CPA is applicable to all adults of working age in contact with the secondary mental health service, NEPFT acknowledges that the principles of the CPA are relevant to both the care and treatment of younger people through our Child and Adolescent Mental Health Service (CAMHS) and to older adults; thus embraces the CPA process throughout the whole Trust.

2.3 **Single Level of CPA -** The revised DoH CPA guidance 2008 revokes the two levels of CPA (standard and enhanced) in favour of one CPA level and a "non-CPA level". The Trust have agreed that all individuals referred, assessed and accepted into the Trust's services for **secondary mental health** care will be subject to the new single level of CPA. All individuals who receive their care in a primary care setting for minimum mental health needs will be not be subject to CPA.

2.4 **Equality & Diversity** - The policy endorses that working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, disability, gender, sexual orientation, race and ethnicity and religious beliefs**.** *(Please refer to the Equality & Diversity Policy).* In addition, the policy supports 'Valuing People', the Government's plan for improving the life of people with learning disabilities.

2.5 **Electronic Recording** - NEPFT use CareBase as its primary recording instrument for all service user clinical activity, and it is a mandatory

requirement that all activity pertaining to the service user's care is recorded electronically, thus making information available to all those involved with the service user. *(Please refer to the CareBase Operational Policy).*

2.6 **Documentation** - There are standard CPA documentation templates (see appendix 1), which are available on CareBase and also downloadable from the CPA page on the Trust's intranet site. It should be noted that that there are slight modifications to the CPA documentation for the Child and Adolescent Service (CAMHS). In addition, the Drug and Alcohol Service (DAAT) will have their own DAAT agreed documentation with effect from 1st April 2009. It is anticipated that accessible language documentation for people with learning disabilities will become available in 2009.

3. Elements of the CPA

3.1 The four main elements of the CPA are:

- **Assessment** - systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services.
- **Care co-ordinator** – the appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care.
- **Care planning** - the formation of a care plan which identifies the health and social care required from a variety of providers.
- **Review** - regular reviews and, where necessary, agree changes to the care plan.

3.2 **Carers** - Standard Six of the National Service Framework for Mental Health, Caring for Carers, states that all individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs leading to provision of their own care plan. It is important to note that carers are entitled to an assessment of their own needs in order to continue their caring role, even if the person they are caring for refuses support from the mental health service. In addition, children and young people caring for a parent with mental health problems are the group of carers most likely not to be offered a carers' assessment of their needs from either mental health or children and family services. The Carers Act highlights the need to work preventatively with young carers to address impacts before they become acute.

3.3 **Children** – It is important to address the needs of parents with mental health problems and ensure that they and their children receive support. This should be underpinned through the CPA process ensuring that the needs of the parent, the children and the family are assessed routinely at each stage of the care pathway.

4. Principles of the CPA

4.1 The CPA is a person centred approach used to inform partnership working in mental health. This partnership should always include the service user, any carers, the family, the CPA co-ordinator, any health and social care professional and other relevant organisations.

4.2 The CPA is the principal vehicle of assessment and care planning for those service users receiving mental health care. The CPA is aimed at ensuring service users' and their families have access to support and services to meet their diverse needs, strengths, preferences and choices.

4.3 This whole systems approach to care planning and delivery promotes care activity across the service user's life domains (including housing, employment, parenting, leisure, education and other needs).

4.4 The CPA is an inclusive and dynamic process based on effective communication, appropriate information sharing and negotiation between partners. This negotiation is to draw on available resources to deliver an agreed plan of care, which will provide engagement and involvement from all those involved in the partnership.

4.5 The CPA process promotes safety, positive risk taking and recovery through a whole life focused approach and draws specifically on the Ten Essential Shared Capabilities (ESC) (see Appendix 2).

5. Aims of the CPA

5.1 Ensure service users and their carers are involved in the planning to meet their health and social care, parenting, leisure, educational and vocational needs and in planning services which support increased social inclusion and recovery.

5.2 Ensure services are non-discriminatory and promote service delivery sensitive to the needs of all service users and carers regardless of age, gender, ethnicity, culture, spiritual, physical or sensory disability, learning disability and sexual orientation.

5.3 Ensure consistency in the quality of community care by applying CPA to all referrals accepted by the specialist mental health services.

5.4 Promote good communication and the effective co-ordination of services between all agencies involved in the care of the service user.

5.5 Ensure that health and social care agencies work in close collaboration to assess and manage risk through effective discharge planning and the implementation of care plans. This includes co-ordinated care planning between the mental health services, primary care, children and maternity services, prison health care, learning disability services, residential establishments, other statutory services, the private sector and voluntary organisations.

5.6 Make available the option of direct payments to meet social care needs to all those eligible to receive them.

5.7 Enable staff to work in partnership with carers and carer led organisations and other voluntary and statutory agencies.

5.8 Ensure that carers who provide substantial and regular care are offered an assessment, assessed and provided with a separate care plan detailing required support. Assessment of children as carers should be based on a thorough understanding of the developmental needs of children, taking into account the capacities of parents or carers to respond appropriately to those needs and the impact of wider family and environmental factors on parenting capacity and children including the impact on parental mental illness.

6. CPA/Risk Training and Supervision

6.1 **Induction** - All new staff to the Trust will receive an induction to the CPA process as part of their mandatory Trust induction programme.

6.2 **Training** - It is mandatory for all clinical staff to undergo CPA/Clinical Risk Management every three years. The current CPA /Clinical Risk training consists of the completion of two E-learning modules, followed by a half day of classroom training. Booking details are available on the CPA page on the Trust's intranet.

6.3 **Supervision** - Team managers will ensure that all members of their team have access to clinical supervision facilities. The nature and extent of supervision will need to be agreed between the line managers and the individual in accordance with Trust policy and guidance on clinical supervision. *(Please refer to the Managerial and Supervision Policy for further guidance).*

CPA PROCEDURE – IMPLEMENTING CPA

1. **Referrals to our Service**
(Please cross refer to the Appointments Policy, the CareBase Operational Policy and the Joint NEEPCT & NEPFT Learning Disability Protocol, which are available on i-connect)

1.1 NEPFT receives referrals from a wide range of sources including GPs, local authority social services, the voluntary sector, probation services, police service, carers, family members, neighbours, other organisations, any other professionals (eg district nurse, pharmacist etc) and in some instances, service users may self refer.

1.2 When a referral is received, the receiving team acting as the point of access to services, must enter the referral onto the clinical IT system (CareBase) showing the receipt date.

1.3 On receipt of a referral, information (ie identified risks, physical health, family and household status, current medication etc) must be gathered, including from the GP.

1.4 All referrals should be assessed to determine eligibility and this may be done through duty screening and/or at pre-allocation meetings.

2. **Allocation**

2.1 The allocation process to allocate referrals to an appropriate healthcare professional may take place within the Crisis Resolution and Home Treatment Team or during the Community Mental Health Team's multi-disciplinary referral meeting.

2.2 The team and/or team manager will make a judgement as to the nature of the referral and the degree of urgency. This judgement will take into account the best information available to the worker (ie whether the referrer has stated whether the referral is 'routine' or 'urgent').

2.3 On receipt of referral and prior to assessment, all service users accepted for mental health services will be allocated a care co-ordinator, who will be a qualified and suitably experienced mental health worker from within the multi-disciplinary team. **Note:** An identified care co-ordinator cannot be the name of a professional group or service; it **must be a named individual**. It is not acceptable to joint care co-ordinate.

2.4 The responsibility for ensuring that a care co-ordinator is allocated to a particular case will rest with the **team manager**. He/she will assume the responsibility of the care co-ordinator role on receipt of the referral, until the case is allocated within the team.

2.5 Service users must, at minimum, be given a choice of time and date of appointment and all appointments must be made within the national timeframes, which are set out within the Appointments Policy.

2.6 Where a service user is to be seen for the first time in the outpatient clinic, all such appointments are made through the Appointments Centre as part of the National Choose and Book process. *(Please refer to the Appointments Policy).*

3. The Care Co-ordinator

3.1 The care co-ordinator has responsibility for co-ordinating care, keeping in touch with the service user, ensuring that the care plan is delivered and ensuring that the plan is reviewed as required.

3.2 The care co-ordinator must be a **qualified** health or social care professional, eg a community mental health nurse, social worker, psychologist, psychiatrist or occupational therapist), and the role of the care co-ordinator should usually be taken by the person who is best placed to oversee care planning. Consideration needs to be given to choice of gender and take into account cultural or religious needs.

3.3 The care co-ordinator's **core functions** are:

- Comprehensive needs assessment;
- Risk assessment and management;
- Crisis planning and management;
- Assessing and responding to carers' needs (including young carers);
- Care planning and review; and
- Transfer of care or discharge.

3.4 Examples of the **role** of the care co-ordinator are as follows:

- Ensuring a comprehensive **assessment** of the person's health and social needs is carried out (including an assessment of risk and any specialist assessments, alongside other agencies as appropriate).
- Co-ordinating the formulation and updating of the **CPA care plan**, ensuring that the service user and all those involved have a copy and all involved understand their responsibilities and agree to them.
- Ensuring that **crisis and contingency plans** are formulated and updated.
- Monitoring the delivery of the services, arranging and ensuring that regular **reviews of care** with the service user take place.
- Monitoring the appropriateness of the service user to continue to receive services under Section 117 of the Mental Health Act.
- Taking responsibility for ensuring **continuity of care** by providing support to the service user irrespective of setting (ie inpatient unit, residential care, prison etc) by ensuring regular contact and monitoring their progress.
- Ensuring that **carers** and other agencies are involved and consulted where appropriate.
- Ensuring that the service user is **involved** and has **choice**, and assisting them to identify their goals.
- Identifying any **unmet needs** and communicate any unresolved issues to the appropriate managers.
- Exploring **direct payments,** with eligible persons and carers, with the aim of promoting their independence.
- Considering the impact of mental illness on parenting capacity.
- Identifying if a service user needs the services of an interpreter *(see the Translation and Interpreting Policy).*
- Considering the need for **advocacy** if appropriate and make them aware of any advocacy or self-advocacy schemes taking into account the Mental Capacity Act 2005.
- Explaining the CPA process to the person, their relatives and informal carers and ensuring that the service user understands the care co-ordinator role and knows how to contact them and **whom to contact in their absence**.

- Ensuring that, where possible, they attend assessments under the Mental Health Act with the Approved Mental Health Professional (AMHP), and where this is not possible, there should at least be a conversation to ensure that the AMHP is properly informed about the background and perceived risks.
- Ensuring that other care systems requirements are met where necessary, including consideration of local eligibility criteria in respect of FACS (Fair Access to Care Services), care management, Person Centred Planning (PCP), Single Assessment Process (SAP) and the Common Assessment Framework (CAF). (Please refer to appendix 3).
- Ensuring that any service user who is a parent/carer is appropriately supported and that the impact of parental mental illness on parenting capacity is explored.
- Ensuring that the health and well-being needs of children are considered and appropriate action is taken when additional needs are identified which may include use of the Common Assessment Framework (CAF) and/or referral to other services.

3.5 Where a service user receives more than one service from NEPFT and delivery of these services is shared with another service (eg the service user is seeing a CPN and attending the drug and alcohol team), the role of care co-ordinator will be undertaken by the most appropriate worker within the mental health team or the drug and alcohol team, dependent upon the service user's needs.

3.6 Due to the complexity of certain client groups and the co-morbidity of their illness (eg those being seen being seen by the eating disorders nurse), consideration should be given to **joint working** with the Community Mental Health Team (CMHT). For those seen within the Drug and Alcohol service, please refer to the *Dual Diagnosis, Mental Health Needs & Substance Misuse Protocol*. For those with learning disability, please refer to the joint *protocol between NEEPCT and NEPFT and Appendix 7.*

3.7 If a **change of care co-ordinator** is necessary, either within the existing team or to another team within the Trust, the current care co-ordinator can only relinquish responsibility through a CPA review (which can be at the service user's request) and the following process must be followed:

- Once a new care co-ordinator has been identified, all information relating to the CPA care plan will be made available and a review date agreed.
- At the handover CPA review, the service user's care plan needs to be updated and re-issued to the service user.
- When a service user moves to a different area within NEPFT and thus requires a change of care co-ordinator, this should take place as soon as possible and in accordance to the service user's need, but no later than one month.
- Any disputes as to who the care co-ordinator is must be resolved in the first instance by team managers. Failing a satisfactory resolution, the operational Associate Directors must intervene and resolve regarding appointing a care co-ordinator.

4. CPA Assessment

4.1 All mental health service users will receive a **comprehensive holistic assessment of their mental health and social care needs;** this **must always include an assessment of risk**. The assessment will be carried out by a professionally qualified member of the mental health team using the Trust wide multi-disciplinary CPA Assessment Guidelines.

4.2 The assessment will involve the service user and carer (where appropriate), and must evaluate the **service user's strengths,** and identify their goals, aspirations and choices to promote recovery and to improve their quality of life. The assessment should take into account the service user's own beliefs and opinions about their mental health issues.

4.3 **Personal Details** – A service user's personal details must be collected at assessment (eg marital status, address, GP, family and household composition, parenting responsibilities, carer, next of kin, employment status, ethnicity etc – please refer to the CPA Personal Details Form).

4.4 A full assessment of need should cover the following aspects to identify where specific support and further specialist assessments are required:

- Psychiatric functioning
- Psychological functioning
- Physical health needs, including dietary requirements taking into account the impact of mental ill health on physical health and vice versa *(please refer to Physical Health care Policy)*
- Co-morbidity and co-existing problems, such as substance misuse *(please refer to the Dual Diagnosis Protocol)* or learning disabilities (*please refer to the joint protocol between NEEPCT & NEPFT)*
- Social functioning, social needs and social circumstances
- Personal circumstances (including family or other carers), family and welfare circumstances including activities of daily living
- Child care issues, child protection (being aware that children and families services may have relevant information that should be included in the assessment/risk assessment (*please refer to the Safeguarding Children Policy)*
- Impact of mental ill health on parenting or carer functions *(please refer to the Safeguarding Children Policy and Folder and the Safeguarding Adults Policy)*
- Health and wellbeing needs of any children for whom the service user has parental responsibility
- Risk to the individual or others (including previous violence and criminal record)
- Occupational status, vocational aspirations and employment needs, training, education and leisure *(please refer to the North Essex Employment Strategy)*
- Housing status and needs
- Financial status
- Need for medication management *(please refer to the Medicine Policy & Procedure)*
- Experience of violence, abuse and sexual abuse
- Communication, cultural, gender and access needs *(please refer to the Equality & Diversity Policy)*
- Advocacy and legal advice
- Religious and spiritual needs *(please refer to the Spiritual & Religious Care Policy)*
- Interpretation/translation needs *(please refer to the Translation and Interpreting Policy)*
- Carer's involvement *(please refer to the Carers Strategy)*
- Needs of vulnerable adults *(please refer to the Vulnerable Adults Policy)*
- Level of support and intervention required
- Informal support network
- Ability to self manage their mental health problems
- Service user's own caring responsibilities

4.5 **Information Gathering** - It is imperative that the assessment must include the gathering of information on family members, particularly where risks are indicated, and/or where they are currently being seen within the Trust's service. *(Please refer to the CareBase Operational Policy).*

4.6 A **Genogram** should form part of the holistic assessment, including details of family members noting that full names should always be used *(please refer to the Safeguarding Children Policy and Safeguarding Adults Policy). A*t a minimum, this should detail who is living in the same household including any lodgers.

4.7 **Carers** - Any carers of the service user should be identified at the assessment and advised that they are entitled to a carer's assessment, which should then be offered to the carer at the earliest opportunity *(please refer to the Carers Strategy).*

4.8 **Advance Decisions/Lasting Power of Attorney (LPA)** – Service users must be asked at their initial assessment whether they have an Advance Decision or Statement and whether they have appointed a personal welfare LPA and/or a property and affairs LPA or whether any individual is a Court of Protection Deputy on their behalf *(please refer to the Mental Capacity Act Policy).*

4.9 **Confidentiality** – All service users must be informed at their initial assessment that information that is collected about them will be stored electronically and may need to be shared with other Trust staff, in particular the rest of the multi disciplinary team involved in providing care or service to them. They should be advised that all our staff are required to abide by a strict code of conduct on confidentiality (*please refer to the Confidentiality and Information Sharing Protocol).*

4.10 **Crisis Cards** - All service users and/or their carers should be given a crisis card at assessment. It should be noted that crisis cards are for service users and their carers only and should not be handed out to members of the public. *(Please see Section 22 of this procedure for details on where to obtain crisis cards).* Please note that currently crisis cards are only available to adults of working age.

4.11 If following the CPA assessment, the person is deemed not to require any further intervention from our mental health service; they should be discharged from CPA back to the referrer/GP with a copy of the assessment outcome and advice on re-direction to other services if required.

4.12 **Other Assessment and Planning Frameworks -** A number of key assessment and care and support systems can interlink with assessment and care planning systems in secondary mental healthcare, as follows:

- Community Care Services
- Fair Access to Care Services (FACS) framework.
- Single Assessment Process (SAP) for Older Adults
- Common Assessment Framework for CAMHS
- Common Assessment Framework for Adults
- National Treatment Agency (Drug & Alcohol Teams)
- Person Centred Planning (PCP) for people with Learning Disabilities
- Criminal Justice
- Direct Payments

- Self Directed Support
  Please refer to Appendix 3 for more detail.

5. **Risk Assessment**
(*Please refer to the Trust's Clinical Risk Management Protocol)*

5.1 Risk assessment is an essential and ongoing part of the CPA process and there must be a specific assessment of the level of risk posed to self and/or others using the Trust's approved risk assessment tool.

5.2 Risk assessments should take into account all the available information from the service user and other sources, such as GP, carers, family members, other professionals and agencies who have knowledge of the individual.

5.3 All members of the multi-disciplinary team have a responsibility to consider risk assessment and management as a vital part of their involvement and to record those considerations.

5.4 Risk assessments should include an estimation of the degree of risk presented in respect of:
- aggression/violence;
- child protection;
- hazards;
- neglect;
- self harm;
- suicide;
- vulnerability; and
- adult protection.

5.5 Risk management and crisis plans should include any identified potential risks to the children, in and out of crisis and over time, and the steps being taken to safeguard the child. They should ensure that parents and children/young carers can recognise when to ask for help and who to ask if they are worried about their parents or themselves.

5.6 Risk must always be communicated to colleagues on a need to know basis.

5.7 A service user's key life events should be identified as part of the crisis plan.

5.8 The outcome of the risk assessment must form the basis of a clear crisis and contingency risk management plan, which forms part of the CPA care plan.

5.9 The assessment of risk is a continuous and ongoing process which should be considered on an individual basis. It is a mandatory requirement whenever a review takes place, or an individual's circumstances change, (eg through admission to an inpatient unit or on discharge), to consider the risk implications to self and others and address accordingly through the CPA care plan.

5.10 Risk must be reviewed at each CPA review and a written record made. All those involved with the service user can contribute to identifying any risk issues and events. All risks **must** be shared with all professionals involved with the service user.

5.11 A review of the current risks must be carried out at least six monthly, irrespective of the stability of the individual's situation.

6. Internal Referrals

6.1 All internal referrals to another team/service within our Trust must be to a named individual and should be accompanied by the following:

- CPA referral, outlining the reasons for referral to that service;
- The CPA assessment; and
- Up-to-date assessment of risk.

6.2 If a referral made using the clinical electronic record (CareBase), communication must be made from the referring team to the receiving service/team to advise them that a referral has been made. The receiving team must acknowledge receipt of an internal referral and advise the referring team of the plan of action. *(For those on a waiting list, please refer to the procedure outlined in Appendix 4).*

7. The CPA Care Plan

7.1 Once the CPA assessment has been completed and the service user's needs have been determined, the care co-ordinator, in conjunction with the service user, develops the overarching the CPA care plan.

7.2 The CPA care plan is the overall view of the service user's care, outlining a record of needs, actions and responsibilities and must be written in a jargon free way. It is the formal record setting out what is going to be done, why, when and by whom.

7.3 A service user should only have one current CPA care plan at any time and this outlines:

- The Summary of needs and how they are to be met
- Interventions and services (eg community visit re anxiety, outpatient re meds) and frequency
- Crisis plan
- Contingency plan
- Unmet needs/service deficits
- Service user comments
- Carers comments

7.4 The CPA care plan should be an integral part of a person centred plan that may be held by people with learning disabilities. *(Please refer to the joint protocol between NEEPCT and NEPFT)*.

7.5 A CPA care plan should include how the needs of the adults, as a parent, and their child are addressed separately and together.

7.6 Any Direct Payment or Personal Health Budget, enabling service users to buy in the care and support they need, should be outlined in the CPA care plan. *(Please refer to ECC Direct Payments Policy and Guidance).*

7.7 If a service user is receiving aftercare services under Section 117 of the Mental Health Act, this should be outlined in the CPA Care plan. *(Please refer to the Section 117 Procedure)*.

7.8 The overarching CPA care plan should always be signed, dated and timed and a copy given to the service user and where appropriate the carer, the GP and all others involved. **Care Plan Folders** are available for all service users to keep their care plans in, and staff should ensure that these are given to

service users. *(Please refer to section 22 of this procedure on where to obtain care plan folders).* Please note that care plan folders are currently only available for adults.

7.9 It should be noted that there is a translation and interpretation service available so that care plans can be made available in the service user's accessible language (*please refer to the Translation and Interpretation Policy).*

8. Specialist/Clinical Care Plans

8.1 A clinical/specialist care plan is the specific care a person or team will deliver. It is the clinical procedure detail of the overall CPA care plan.

8.2 All the services identified in the overall CPA care plan above must have a specialist/clinical care plan (there could be several specialist/clinical care plans, eg day hospital service, drug and alcohol team, psychology, parenting role etc).

8.3 Clinical/specialist care plans will be discussed and agreed with the service user and will include:

- The assessed needs;
- The plans/goals;
- The implementation/action required; and
- The evaluation date.

8.4 The role of the care co-ordinator is to co-ordinate the various specialist/clinical care plans to ensure they are reflected in the overarching CPA care plan. All those involved with specialist/clinical care plans must ensure that their specialist/clinical care plans are available at the time of the CPA review.

9. Contingency Plans

9.1 Contingency planning attempts to prevent a crisis developing by detailing the arrangement to be used at short notice, for example the care co-ordinator is not available, a service user feels they are approaching a crisis, or part of the care plan cannot be provided,

9.2 The contingency plan should include the information necessary to continue to implementing the care plan in an interim situation, for example telephone numbers of service providers, or the contact details of substitutes who have agreed to provide interim support.

9.3 If a service user is a parent, the contingency plan should always include how many children the parent has, their ages and gender, and the arrangements for their care to be put in place if the parent is not able to care for them at any time.

10. Crisis Plans

10.1 Crisis plans should set out the action to be taken if the service user becomes ill or their mental health deteriorates rapidly. It should outline the explicit plan of action that must be implemented should a crisis occur, and will often be based on previous strategies which have been successful.

10.2 Crisis plans should include:

- Early warning, relapse indicators and triggers.
- Key life events (the anniversary date of the loss of a loved one, physical illness, loss of a job etc) which may trigger a relapse.
- Services available and how these can be accessed in a crisis.
- Who the service user is most responsive to and how to contact that person.
- Previous strategies which have been successful in working with the service user.
- Advance decisions or statement of wishes. *(Please refer to Advance Decisions and Statements Guidelines).*
- Any particular risks to be taken into account during a crisis.

10.3 Crisis plans must ensure that all service users know how to contact the service out of hours. Carers, family members and significant others should know who to contact when a crisis occurs at all times. Crisis cards are available for this purpose *(please see section 22 of this procedure for guidance on where to obtain crisis cards).*

11. Advance Decisions/Statements

(Please refer to the Advance Decisions & Statements Guidelines and the Mental Capacity Policy)

11.1 An **advance decision** is where the service user has made an advance decision to refuse medical treatment should they lose capacity in the future. The CPA care plan must indicate whether the service user has an advance decision.

11.2 **Statements of Wishes** – is where the service user has indicated their treatment preferences, childcare, accommodation and clarification of who to give information to.

12. Consultant Care Plans/Copying Letters to Patients

(Please refer to the CPA page on i-connect for full details on Consultant Care Plans)

12.1 The initiative to copy clinicians' letters to patients is part of the Government's policy to increase patients' involvement in their care and treatment, and all letters written from one doctor to another doctor should be copied to service users as of their right.

12.2 For those service users who are seen only in the outpatient clinic, the letter written to the GP by their consultant/doctor following their outpatient appointment will represent their CPA care plan. The Trust has developed a template letter for this purpose.

13. CPA Reviews

13.1 At the time the CPA care plan is produced, the date of the CPA review must planned with the service user, which should be within the maximum timescale of **six monthly intervals** for all service users.

13.2 The purpose of a CPA review is to consider:

- any progress the service user has made;
- the views of the service user, carer and professionals;

- how the service user has responded to the service being provided;
- reassessment of risk factors;
- ways in which their needs may have changed; and as a result
- the extent to which the care plan (including the crisis and contingency plan) requires amending.

13.3 A CPA review can be called by the service user or anyone else involved in the service user's care, but must take place whenever there is a change of care co-ordinator or when the service user is being discharged from CPA.

13.4 The format of a review depends on the amount of support being offered to the person and their needs, and may be a simple clinic appointment when the service user is seeing only one member of staff, or maybe a multi-disciplinary review comprising a meeting of all concerned.

13.5 The responsibility for arranging the CPA review lies with the care co-ordinator. The date, time and venue of the review should be negotiated with the service user who must be consulted and agree to the presence of those invited. The care co-ordinator must give adequate notice/invitations (using the Trust's recognised CPA review invitation letter, which is available on CareBase) to all those involved in the care.

13.6 A record of all present at the review and apologies received should be recorded. If key people are unable to attend they should provide an up-to-date report.

13.7 At each review, it is important to check with the service user whether they have or want to change or amend their Advance Decision/Statement of wishes, and the impact on the crisis and contingency plan, which may need amending in the light of any changes to the Advance Decision/Statement of wishes.

13.8 At each review, a service user's personal details (eg marital status, address, family and household composition, GP, carer, next of kin, employment status etc), must be checked to ensure that they are still up-to-date. This should include whether the service user has appointed or changed their LPA for property and affairs and/or personal welfare *(please refer to Mental Capacity Act Policy).*

13.9 At each CPA review, the appropriateness of the service user continuing to receive Section 117 aftercare under the Mental Health Act must be considered *(please refer to the joint NEPFT & SEPT Section 117 Procedure for details on discharging from Section 117)* .

13.10 At each CPA review, any service users subject to a Supervised Community Treatment (SCT) under the Mental Health Act must have their SCT reviewed; this should cover whether the SCT is meeting the treatment needs and whether the service user continues to satisfy the criteria for an SCT (*see the Supervised Community Treatment Policy).*

13.11 At each CPA review, consideration of whether a Deprivation of Liberty Safeguards Authorisation is required must be considered *(see Deprivation of Liberty Safeguards Policy).*

13.12 At each CPA review, consideration of whether any assessments of capacity in respect of specific decisions (accommodation, treatment, management of finances) must be considered *(see Mental Capacity Act Policy).*

13.13 The care co-ordinator has the responsibility of monitoring and reviewing the care provided, and it is recommended that HoNOS (Health of the Nation Outcome Scale) which is available on CareBase is used as part of the review process.

13.14 All attending the review (including the service user/carer) should have an opportunity to give their views. Changes in the CPA care plan, crisis and contingency plan and risk assessment and management should be agreed and recorded, and a new CPA care plan drawn up. All parties involved in their care must receive a copy of the updated care plan, even if they were unable to attend the review.

13.15 It should be noted that in certain circumstances, it may be appropriate to hold a more informal review with the service user and the key person involved with that service user, and this may constitute the formal CPA review. However, it must be noted that the review must still be appropriately documented and recorded in line with Trust policy and procedure.

13.16 At every CPA review the date of the next review must be planned and appropriately recorded.

14. Multi-Disciplinary Professional Meetings

14.1 It may be necessary on occasions to hold a multi-professional meeting to discuss and decide on the management of service users who may present with a complex or difficult case to manage, which could result in unacceptable levels of risk should there be differences of opinion within the multi-professional group.

15. Continuity of Care

15.1 When a service user is removed from their normal place of residence (eg they go into a residential home, nursing home or hospital), it remains the responsibility of the care co-ordinator to review the quality and appropriateness of their care in accordance with Trust policy and procedure.

15.2 The care co-ordinator should always ensure that they remain in contact with their service user (whether this is through the prison in-reach team or the staff at the residential home or inpatient setting) and ensure that reviews are still carried out in accordance with Trust policy. This is particularly important when preparing for example for release arrangements from prison or discharge from hospital.

16. Inpatient Care

16.1 When a service user is new to the service in an inpatient setting, as there will be no previously assigned care co-ordinator, the consultant psychiatrist will assume the care co-ordinator responsibilities during the admission period. The inpatient team should liaise with the relevant community team leader (or in the case of CAMHS the CAMHS Crisis Outreach Team) to identify a **potential** care co-ordinator and this should be organised within 48-72 hours post admission.

16.2 When a service user is known to our service and there is an existing care co-ordinator in the community, during the inpatient episode, the **named nurse/key worker/ward team** will work collaboratively with the existing care co-ordinator ensuring they are aware of the admission and liaise closely with them during the service user's stay in hospital.

16.3 **Ward Stay Care Pathway Checklist** - Arrangements for discharge from hospital should be initiated as soon as the service user has been admitted to hospital. The "Ward Stay Care Pathway Checklist" (see Trust CPA Documentation on the CPA page on i-connect) must be completed during the service user's admission, which will identify the needs of service users that will require some form of intervention when the service user is discharged.

17. Discharge from Inpatient Care

17.1 Care co-ordinators must meet face to face with ward staff and the consultant psychiatrist to develop and agree the discharge CPA care plan, taking into account the needs of the service user and their family/carer's wishes. It is the responsibility of the care co-ordinator (in conjunction with the ward and others involved in the care package) to oversee all arrangements for discharge.

17.2 **Discharge CPA review** - Ward staff on the inpatient unit must communicate with care co-ordinators in the community to alert them of discharge from the inpatient setting.

17.3 **Discharge CPA Care Plan** - On discharge from the inpatient unit, all service users must have a current and coherent discharge CPA care plan that includes any changes in need or circumstances and risk factors that were not considered or included in their previous care plans. The discharge care plan must include details of follow up arrangements.

17.4 **Discharge in the absence of the service user** – On occasions a service user may be absent when they are discharged from the inpatient unit (eg in cases of not returning from leave or non-engagement). In this instance, those involved must hold a professionals meeting and carry out an assessment of the risks involved, and the outcome must be relayed to the service user's GP.

17.5 **Delayed Discharge** – On occasions a delayed discharge may occur. Please see Appendix 5 of this for the Department of Health's definition of a delayed discharge. *(For more detailed guidance please refer to the Trust's Inpatient Discharge & Transfer of Care Procedure).*

18. Follow up from Inpatient Care

18.1 For service users who have been at high risk of suicide during the period of admission, **a face to face** follow up must be within 48 hours of discharge.

18.2 For all other service users discharged from the inpatient unit, **a face to face** follow up must be made within 7 days of discharge.

18.3 In addition to the above face to face follow up, a follow up telephone call must be made within 48 hours of discharge by the ward manager or by a delegated clinical member of staff to all service users discharged.

19. Disengagement from the Service

(Please refer to the Non-Attendance procedure contained with the Appointments Policy)

19.1 Should a service user refuse to engage with the services, then every effort needs to be made by the care co-ordinator to ascertain the reasons why and address any concerns raised. This should be promptly discussed within the team and communicated to the GP.

19.2 An assessment of the risks that the service user presents must be undertaken and plans made accordingly. Where there are serious concerns regarding the safety of the public, liaison with the Police and the Probation Service may also be appropriate in certain circumstances.

19.3 For service users on Section 117 (aftercare) or Section 7 (Guardianship) of the Mental Health Act, the care co-ordinator, in consultation with the team, will instigate a formal review with all professionals involved. For service users who are not subject to MHA legislation every reasonable effort should be made to maintain contact and re-negotiate a new care plan.

19.4 In all cases, an action plan will be formulated following discussion within the team and where appropriate family members and/or carers should be consulted/informed. The action plan should state how often an attempt to make contact/visit will take place, ie an attempt to offer an outpatient appointment every three months, and this must be clearly documented in the service user's health and social care record, and the referrer should be written to. It should be noted that carers are still entitled to an assessment of their needs regardless of the fact that the person they care for has declined services.

20. Discharge from CPA

20.1 When a service user is discharged from CPA following their CPA Review, this must be recorded on the electronic patient system and their package of care should be completely closed down.

20.2 The service user is discharged from CPA when:

- The service user no longer requires specialist mental health services and is discharged to the care of his/her GP.
- The service user leaves the area and is discharged to the care of services in the new area.
- The service user declines further intervention from specialist mental health services and is not at risk of harming themselves or others or at risk of exploitation.
- The service user has lost contact with the service for not less than 6 months and despite every effort, contact has not been resumed *(please refer to the Appointments Policy).*

21. Transfer of Care Between Mental Health Organisations

21.1 For the transfer of service users between Mental Health Organisations, please see Appendix 6 which is the CPA Association's Good Practice Guide in the Transfer of Service User Care between Mental Health Districts. (*Please also cross-refer to the Trust's Transfer of Service Users Policy. For transfer to specialist Learning Disabilities service, please refer to the joint protocol between NEEPCT and NEPFT).*

22. CPA Information across the Trust

22.1 Information on CPA is available on the Trust's intranet site i-connect on the designated CPA page:
http://nww.eastern.nhs.uk/scripts/index.asp?pid=56916&id=56925

22.2 The CPA Department is located at the Linden Centre where stocks of the following CPA literature are held:

- Care Plan Folders
- CPA Information Leaflets
- Crisis Cards for the 3 localities of the Trust (Central, West, East).
- Crisis Support Leaflet for the 3 localities of the Trust (Central, West, East).

- Please email the CPA Department on cpa@nepft.nhs.uk for supplies of the above.

22.3 The following are useful websites:

- Trust Site www.nepft.co.uk
- CPA Association www.cpaa.org.uk
- Carers www.carers.gov.uk
- Department of Health www.doh.gov.uk
- Essex County Council Direct Payments
  www.essexcc.gov.uk/directpayments

Appendix 1

CPA DOCUMENTATION

The CPA documentation is on CareBase and may also be downloaded from the CPA page on the Trust's intranet site:
http://nww.eastern.nhs.uk/scripts/index.asp?pid=56964&id=57010

The CPA documentation consists of:

- **CPA Personal Details**
  (to record the service user's demographic details)
- **CPA Referral**
  (to be completed for both external referrals to the Trust and all internal referrals within the Trust)
- **CPA Assessment & CPA Guidelines**
  (the CPA assessment guidelines should be followed when undertaking the CPA assessment)
- **CPA Care Plan**
  (the overall view of the service user's care, including the crisis and contingency plan and any unmet needs)
- **CPA Clinical/Specialist Care Plan**
  (the specific care or treatment to be delivered by each service that the service user receives)
- **Carers Assessment**
  (to collect the details of the carers assessment)
- **CPA Review**
  (to record the details of the CPA review)
- **CPA Service User Self Assessment (not on CareBase)**
  (to be completed by service users (optional) to record their needs)
- **CPA Inpatient Admission (not on CareBase)**
  (to be completed when a service user is admitted to the inpatient setting)
- **Ward Stay Care Checklist (not on CareBase)**
  (to be completed when a service user has an inpatient episode)

CPA Documentation for CAMHS, Drug & Alcohol Service and Learning Disabilities

It should be noted that that there are slight modifications to the CPA documentation for:

- the Child and Adolescent Service (CAMHS);
- the Drug and Alcohol Service (with effect from 1st April 2009);
- those with learning disabilities (it is anticipated that accessible language documentation for people with learning disabilities will become available in 2009).

Signed, Dated & Timed

All CPA documentation must be signed, dated and timed.

Electronic Recording

It is essential that all information recorded manually on the CPA documentation corresponds with that recorded electronically on CareBase.

Filing of CPA Documentation

All CPA documentation should be held on the service user's health and social care records and filed in the appropriate CPA section at the front of the file.

Appendix 2

TEN ESSENTIAL SHARED CAPABILITIES

Department of Health – A framework for the whole of the Mental Health Workforce

1. **Working in Partnership -** Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

2. **Respecting Diversity -** Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. **Practicing Ethically -** Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. **Challenging Inequality -** Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in communities they come from.

5. **Promoting Recovery -** Working in partnership to provide care and treatment that enable service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying People's Needs and Strengths -** Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

7. **Providing Service User Centred Care -** Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

8. **Making a difference -** Facilitating access to and delivering the best quality, evidence based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

9. **Promoting Safety and Positive Risk Taking -** Empowering the person to decide the level of risk they are prepared to take with their health and safety and positive risk taking including assessing and dealing with possible risks for service users, carers, family members and the wider public.

10. **Personal Development and Learning -** Keeping up to date with changes in practice and participating in lifelong learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Appendix 3

OTHER ASSESSMENT AND PLANNING FRAMEWORKS

Community Care Services - The Community Care Act 1990 imposes a duty on Local Authorities to carry out an assessment of need for community care services with people who appear to them to need such services, and then having regard to that assessment decide whether those needs call for the provision of services by them. This is referred to as a Community Care Assessment.	**Common Assessment Framework for CAMHS** - The Common Assessment Framework for children & young people (CAF) is a shared assessment tool used across agencies in England. It can help practitioners develop a shared understanding of a child's needs, so they can be met more effectively. It will avoid children & families having to tell & re-tell their story.
Fair Access to Care Services (FACS) - Assessments for service users presenting with complex needs should take account of physical, sensory, cognitive, behavioural and social care needs, and eligibility for social care provision against these needs must be assessed against the Fair Access to Care Services (FACS) framework.	**Common Assessment Framework for Adults (CAF)** - The CAF for Adults with longer term support aims to deliver a more person-centred and integrated approach to assessing people's need for support from health & social care services and the support needs of their carers.
Direct Payments - The aim of direct payments is to promote independence and social inclusion. The purpose of a direct payment is to give service users more control over their own lives and is an alternative to mainstream social care or carer provision. A direct payment is a cash payment which enables the flexibility for service users to choose and arrange their own support or to use the Direct Payments Support Service to manage this for them. It allows the service user/carer to be creative with the type of support they engage with, in for example, employment, education, leisure activities as well as support with personal, domestic and daily living needs. Since April 2003, it has been mandatory to offer people, assessed as eligible for community care services, the opportunity of having all or part of their support via direct payments.	**Single Assessment Process (SAP) for Older Adults** - The Single Assessment Process (SAP) was developed following recognition that many older people have a wide range of health and social care needs, and that agencies need to work together to ensure that assessment and subsequent care planning are effective and co-ordinated, thus the aim of the SAP is to ensure a person centred approach to assessment and care planning for older adults, regardless of operational boundaries. SAP provides a platform to reduce duplication or repetition by a variety of health and social care agencies, with its tiered assessment model of contact, overview, specialist and comprehensive assessments.
Self Directed Support - In the Trust we are about to embark on a self directed support project. Self directed support gives service users even more control over the way their social care support is organised. It focuses on what people want to achieve rather than simply finding out about their needs and provides a broader range of outcomes which can include direct payments and individual budgets. For further information contact [I/S], Consultant Social Work Practitioner on [I/S] or [I/S] on [I/S].	**Person Centred Planning (PCP) for people with Learning Disabilities** - This is a method of supporting and working with people who have a learning disability. It helps to work out what the individual wants from life (e.g. housing, education, welfare benefits) and how best to achieve it, the kind of support a person will need and how it would be best given The CPA process must take full account of any person centred plan so that care and treatment is holistic in its delivery.
National Treatment Agency - The National Treatment Agency (NTA) endorses the CPA framework as an approach to co-ordinating the care of people with a severe mental disorder and substance misuse problems within the mental health service.	**Criminal Justice** - The DoH's Offender Mental Health Pathway 2005 sets out the Care Pathway for prisoners with mental problems highlighting the need for both CPA care co-ordinators and Offender Managers to ensure that relevant and vital information must accompany the offender/service user during transition through the offender pathway.

Appendix 4

MANAGING SERVICE USERS ON A CLINICAL WAITING LIST

Introduction

This protocol is designed for managing service users who have needs identified under CPA and are awaiting treatment/assessment from another Trust service.

1. Following the initial assessment the assessing clinician (care co-ordinator) will complete the following:
   - a full CPA assessment;
   - risk screening;
   - a care referral to the service identified as required for the service user; and
   - the CPA care plan.

2. The CPA care plan will be given to the service user and will include:
   - what service they have been referred for;
   - name of the care co-ordinator until treatment commences (see 6 below);
   - emergency contact details; and
   - estimated waiting time or time to review.

3. A crisis card should be issued to the service user.

4. The GP will be informed of the outcome of the assessment and the current care plan.

5. The assessing clinician (care co-ordinator) will now complete the initial CPA assessment, but the Care Programme Approach must remain open and the individual remains on CPA.

Role of the Care Co-ordinator

6. The care co-ordinator can be either the initial assessor or the team manager of the assessment team.

7. The care co-ordinator will retain the overall responsibility of the following:
   - the contact person for the service user on the waiting list and their GP;
   - to ensure that the CPA care plan is managed and reviewed in accordance with Trust policy; and
   - to ensure that the CPA care plan continues to be appropriate and effective for the individual service user.

8. The service user remains under the care co-ordination of the initial assessor until a specialist assessment has commenced by the receiving/specialist team.

Appendix 5

DELAYED DISCHARGES

Please refer to the Trust's Inpatient Discharge and Transfer of Care Procedure

1. **Delayed discharges are defined within the Trust as follows**:
"A delayed discharge definition can only be applied to an informal service user under the care of the Trust who is waiting for a transfer/discharge to another area or service not providing the same care that the service user is currently receiving."

2. Once satisfied that the service user's circumstances are eligible to be classified as a delayed discharge/delayed transfer of care, the following definition should be applied. Only if all of each of the three criteria below can be met can a service user be recorded as a delayed discharge.

   - A clinical decision has been made that the service user is ready for transfer/discharge.

   - A multi-disciplinary team (MDT) decision (between health and other agencies including social care) has been made that the service user is ready for transfer/discharge.

   - The service user is safe to discharge/transfer.

   (DoH, 2006).

3. In the event of uncertainty in respect of whether a service user meets the criteria for delayed discharge the Operational Services Manager should be consulted. Should further guidance or discussion be required, the Operational Services Manager may make contact with the project lead for discharge guidance.

Appendix 6

cpaa
Care Programme Approach Association
Walton Hospital, Whitecotes Lane, Chesterfield. S40 3HW
Tel: [I/S] Fax: [I/S]
Email: cpa.association@chesterfieldpct.nhs.uk

Good Practice in the Transfer of Service User Care between Mental Health Districts

1. Introduction

It is the responsibility of health and social care agencies to collaborate effectively to ensure proper, co-ordinated care is delivered to people with mental health needs. Each district Local Authority Social Services Department and Health Trust jointly operates a Care Programme Approach Policy to ensure a robust systematic framework for the care and treatment of people with mental health needs in line with department of Health Guidance.

Whilst the detail of local CPA policies may differ, the core principles will be the same. A key objective of the CPA is to ensure individuals most in need of care do not slip through the net of service provision. Where service users move from one district to another there is the potential for interruption in the continuity of care and treatment. This has been highlighted in a number of Inquiries in to Serious and Untoward Incidents.

This protocol reflects principles of good practice in transferring service user care between districts.

The following guidelines are proposed to support these principles.

2. Planned Moves

2.1 Service users who move out of one area to another remain the active responsibility of the original authority until a formal hand over can be arranged.

2.2 The decision to transfer responsibility for the care of a service user to another district should take place in a CPA review meeting, unless exceptional circumstances prevent this. The service user should be encouraged to register with a GP in the new area as soon as possible.

2.3 This Review should include consideration of the risks associated with the move, and a judgement made about whether the service user will make contact themselves with services in the new area, or whether this will be carried out by the original Care Co-ordinator.

2.4 Appropriate representatives of the receiving district should be invited to contribute to the Review by attending the meeting or by other means if this is not possible e.g. the proposed new Care Co-ordinator, RMO, Social Services where care management responsibility issues are involved, and Section 117 or other statutory issues, e.g. Guardianship, Sex Offender registration or Public Protection.

A timescale for implementing the transfer should be drawn up.

2.5 The transferring Care co-ordinator should ensure that complete and accurate records are made of the discussions surrounding the move, and that the following has been agreed before transfer:

2.5.1 The receiving team / service have identified a new Care co-ordinator who accepts responsibility for them.

2.5.2 Appropriate services have been set up with the receiving team / service to meet the needs before the transfer takes place, where possible.

2.5.3 Effective communication has taken place and detailed information has been made available to the appropriate professionals in the receiving team / service.

2.6 Detailed information should include:

2.6.1 Assessment of need, including risk assessment, clearly identifying the nature, complexity and content of risk.

2.6.2 Legal status.

2.6.3 Care Plan, including crisis and contingency plans, risk management plan where this exists, including indicators of relapse.

2.6.4 The transferring care co-ordinator should document the information has been sent on the patient's file.

2.7 Timescale

The receiving district should acknowledge transfer of Care co-ordinator responsibility within fourteen days of receipt of documentation.

2.8 Informing the Service User and Others

The transferring Care co-ordinator should write to the service user, carer, where appropriate, and GP confirming the transfer and giving contact details of the new receiving Care co-ordinator. Details should be entered on both the transferring and receiving mental health services databases.

2.9 Contingency Arrangements

Arrangements should be in place to ensure a system of rapid transfer back to the original system if the patient moves back to the originating district. In this case, ideally, the original Care co-ordinator and team should resume responsibility for patient care, where possible, based on level of need, risk, availability etc.

The principles of information sharing, and ensuring that arrangements for receiving the service user is in place should be followed by the transferring area.

3. <u>Unplanned Move</u>

3.1 Some service users will move in an unplanned way between districts. Where this is very local, and the original district is aware of this, it should continue working with that patient, if this is possible within service resources, until formal handover arrangements described above, can take place.

3.2 Where the move is at some distance and it would be impracticable for the originating district to do this, then background information should be sent immediately to the new district and discussion should take place between the teams at the earliest opportunity to effect formal handover.

3.3 The above should be based on team-based consideration of risk factors relevant to the particular service user concerned, weighing the necessity to pass on information against the user's right to confidentiality. Such deliberation should be appropriately recorded on the user's record for future reference.

4. Service Users who go Missing from Services

4.1 Some service users, for various reasons, may lose touch with services; this may include moving to another district.

4.2 Where a client seems to have gone missing from services there is a duty of care to make all reasonable efforts to locate them to negotiate arrangements for their care and treatment. Actions to achieve this should be clearly recorded.

4.3 The Care co-ordinator should contact other members of the care team, including any Carers and relatives where appropriate, and other known associates to try to locate the client and to offer support and monitor their well-being.

4.4 The Care co-ordinator should initiate a CPA review as soon as the service user loses contact with services to share information and determine action based on an assessment of the risk caused by the person disengaging. Clear recording of this should take place. Use of the National Tracing Service may assist in checking their location via GP registration.

4.5 It will be necessary to take into account the patient's current mental state, previous history, potential and actual risk to self or others, the likelihood that the person has left the local area, and the other available support networks, in order to plan intervention.

4.6 Where a level of risk to the service user or to others is identified, appropriate judgements should be made about the breadth and depth of circulation of personal information within the local and/or non-local areas.

4.7 Local response

4.7.1 The Care co-ordinator, after discussion with their line manager, will make the locally appropriate out of hours mental health and other services e.g. Accident and Emergency, Social Services, aware of the person's details.

4.7.2 Where there is concern that the person may be at risk, or poses a risk, the Police should be contacted with a description of the person and the concerns surrounding their well-being.

4.8 Non-local response

4.8.1 Where it is suspected that a person might be located in another mental health service area, then the Care co-ordinator should consult the manager in his or her own mental health service that acts as the point

of contact for distributing and receiving Missing Persons Alerts, and follow the appropriate course of action.

4.8.2 It is expected that each mental health service, in discussion with their SHA, will arrange for there to be a known point of contact in the service for consultation about sending out Missing Persons Alerts to non local areas. This person will agree with the Care co-ordinator, the appropriate level of information and spread of circulation, and assist in identifying points of contacts in other areas.

4.8.3 If a patient is located in a new district the receiving Care co-ordinator should seek advice in their service about making contact with the originating district to cancel the Missing Person's Alert, and should themselves effect a formal hand over of care as described above.

5. Role of the CPA Office or equivalent

The CPA Office, or equivalent, may become involved in the process of relocation or responding to missing persons depending on local arrangements. This may involve, for example, assisting in decision making if the case is problematic, providing advice about points of contact in other mental health services, and processing Missing Persons Alerts.

6. Prisons

Communication of information regarding prisoners with mental health problems should be made in line with this protocol.

7. Review of arrangements

It is proposed that these guidelines are formally reviewed through the national Care Programme Approach Association, the ADSS Principal Officers Group and the Zonal meetings.

Acknowledgements
Thanks to the CPAA North West Region and the cooperation of the North Western Branch of the ADSS for this guidance.

(November 2004)

Appendix 7

RESPONSIBILITIES OF NEPFT IN RELATION TO PEOPLE WHO HAVE A LEARNING DISABILITY AND NEED A SPECIALIST MENTAL HEALTH SERVICE FROM NEPFT

Introduction

'Valuing people Now ' – a new strategy for learning disability for the 21st century Department of Health January 2009 reiterates the important principle of inclusion into mainstream services for people with learning disability. This national policy is translated at a local level into standards expressed in the Green Light Tool Kit and through the national annual mental health self assessment process. The following broadly outlines the expectations of North Essex Partnership Foundation Trust in relation to people with learning disability who have mental health problems. This is a critical addendum to the current CPA policy and is a precursor to more detailed statements about standards and expectations in the next revision of the policy.

Expected standards

The Green Light Tool Kit states that for people with learning disabilities who also require a specialist mental health service the following should be in place :-

"The local CPA system is person centred in the way it operates and people with mental health problems who have a learning disability are empowered by the process. The local system does include assessment and action planning for all of the following: employment or other occupation, housing, welfare benefits, crisis plans including 24 hour access arrangements. This information is always recorded and there is a clear process for integrating someone's person centred plan into their CPA."

It is recognised that not everyone with a learning disability will have a learning disability person centred plan. This is because they are normally drawn up for people with complex needs who are receiving services from Essex County Council and/either North East Essex Primary Care Trust (specialist learning disability services). However where they exist the CPA must take full account of this person centred plan so that care and treatment is holistic in its delivery.

The national annual mental health self assessment documentation in 2009 expects mental health Trusts to meet the following standards:-

"People who have learning disabilities and mental health problems routinely receive assessments from the specialist mental health service, receive treatment and care in line with local CPA standards and have their care co-ordinated by their care co-ordinator in the specialist mental health service and key worker in the community learning disability team"

It is recognised that not all people with a learning disability and mental health problem will be receiving a service from a health or social care community learning disability team but the principle of working with other agencies, family and friends in the best interests of the service user apply.

Resources

Resources to provide advice and support in deciding upon an individual's care plan, communicating effectively and assessing whether someone has a learning disability are available on i-connect. The site is constantly developing and in addition in spring 2009 a clinical specialist in learning disability will join the Trust to help us meet the

above standards. For people, particularly with complex needs, North East Essex Primary Care Trust staff (specialist learning disability services) may be able to advise or give a direct service through their Home assessment and treatment team. The policy document on responding to people who have learning disability and who require mental health care and treatment applies. This is also available on i-connect.

Requirements

Remember it is likely that you will need to spend more time than usual where a person has a learning disability and more thought may need to be paid to how to communicate effectively. You may also need to engage with people who have an expertise in leaning disability to ensure the most effective care and treatment is being delivered.

RELEVANT TRUST POLICIES AND GUIDANCE

Appendix 8

Access to Health & Social Care Records Policy and Procedures

Advance Decisions and Statements Guidelines

Appointments Policy incorporating Non-Attendance Procedure

CareBase Operational Policy

Carers Strategy

Clinical Risk Management Protocol

Confidentiality and Information Sharing Protocol

Deprivation of Liberty Safeguards Policy

Dual Diagnosis, Mental Health Needs & Substance Misuse Protocol

Equality & Diversity Policy

Getting it Write (a resource guide to electronic and paper-based health & social care records)

Inpatient Discharge and Transfer of Care Procedure

Learning Disabilities Protocol (Agreement on roles and responsibilities of staff in both Trusts when responding to people who have learning disabilities and need mental healthcare and treatment - NEEPCT & NEPFT)

Mental Capacity Policy (Assessment of Mental Capacity)

Physical Health Care Policy

Safeguarding Adults Policy

Safeguarding Children Policy

Spiritual & Religious Care Policy

Supervised Community Treatment (SCT) Policy

Supervision Policy

Transfer of Service Users Policy

Translation and Interpreting Policy

Unified Written Health & Social Care Records Policy

Your Health Records: How we look after them and who can see them Leaflet

ECC Guidance

ECC Direct Payments Policy and Practice Guidance

North Essex Employment Strategy

Section 117 Aftercare under the Mental Health Act Procedure