NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST **POLICY DOCUMENT**	
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NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

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 supports person centred recovery and 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 and procedure 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 The principles of CPA are applicable to all service users receiving a service from NEPFT, who are deemed to be suffering from a serious mental illness. Therefore all individuals referred, assessed and accepted into the Trust's services for secondary mental health care will be subject to CPA. Individuals who are subject to minimum mental health needs and are in receipt of a service from NEPFT or in a primary care setting (for example those receiving a service from Veterans First) will be not be subject to CPA. However, the principles and good practice of CPA will still be followed with regards to their assessment, care planning and review of their care.

2.3 **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, race, culture, disability, gender, spirituality, sexuality. *(Please refer to the Equality & Diversity Policy).*

2.4 **Electronic Recording:** It is a mandatory requirement that all activity pertaining to the service user's care is recorded electronically on the Trust's electronic patient record system, thus making information available to all those involved with the service user.

2.5 **CPA Documentation:** The Trust's approved and ratified CPA documentation is outlined in Appendix 1.

3. Components of the CPA

3.1 The four main components 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:** 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. 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. A carers assessment should offer the carer advice on how to manage service users in their own home, and an opportunity to discuss contingency plans setting out what would happen to the cared for person if the carer were to become ill or incapacitated. (*Please refer to the Carers Strategy).*

3.3 **Parents with Mental Health Problems:** 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 care 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 (for example housing, family, employment, benefits, parenting, leisure, spirituality, relationships, 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. The aim of 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) outlined in Appendix 2.

5. Aims of the CPA

- 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.

- 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.

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

- Health and social care agencies work in close collaboration to assess and manage risk and co-ordinate 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.

- The option of Self Directed Support (SDS) to meet social care needs for all those eligible to receive them.

- Staff work in partnership with carers and carer led organisations and other voluntary and statutory agencies.

6. CPA/Clinical Risk Training

6.1 Induction

Trust induction provides an introduction to the CPA process for all new staff.

6.2 Training

The CPA /Clinical Risk training syllabus consists of two e-learning modules, followed by half day classroom training, to be undertaken every 3 years. *(Please refer to the Trust's Training Needs Analysis).*

7. The Trust Monitoring of this Policy

7.1 CPA Training

- Staff should undergo CPA/Clinical risk training every 3 years. (Please refer to the Trust's Training Needs Analysis)/

- When a member of staff books onto CPA/Clinical Risk training, this is recorded on the Oracle Learning Management (OLM) which is linked to the electronic staff record.

- After a training course has taken place, attendance or non-attendance is recorded onto OLM.

- If a staff member has failed to attend, the CPA department will email them and their line manager advising them of the next available course.

- Reports on attendance will be generated by OLM.

- All practitioners are responsible for ensuring they maintain their training in line with their responsibilities under their individual professional codes of conduct, ethics and standards.

7.2 CPA Performance Checklist

- The electronic CPA Performance Checklist monitors compliance with the CPA process and reports on whether there is a record of the following:
  - NHS number
  - Ethnicity
  - Employment status recorded.
  - Marital status
  - CPA assessment
  - Care Plan copied to patient
  - CPA review within the last 6 months
  - CPA review date planned in the future
  - Carer's assessment offered
  - Health of the Nation Outcome Scale (HoNOS) rating and cluster

- A Trust wide report on the CPA Performance Checklist is presented the Risk and Governance Executive every 6 months.

- Findings from the CPA Performance Checklist are fed back to the Trust's CPA Working Group every 6 months.

- Recommendations and an action plan from the report will be forwarded to the Risk and Governance Executive every 6 months.

- The action plan is managed by the Trust's CPA Working Group.

7.3 Supervision

Compliance with CPA policy is managed through supervision and annual Performance Development Reviews where line managers monitor their staff's attendance at mandatory CPA Training and their compliance with the CPA process through the use of the CPA Performance Checklist. *(Please refer to the Mandatory Supervision Policy).*

CPA PROCEDURE – IMPLEMENTING CPA

1. **Referrals to our Service**

(Please cross refer to the Appointments Policy, the Electronic Patient Record Operational Policy and the joint North Essex Partnership NHS Foundation Trust (NEPFT) and Hertfordshire Partnership NHS Foundation Trust (HPFT) North Essex (NELD) 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 Trust's Electronic Patient Record System showing the receipt date *(please refer to the Appointments Policy).*

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.

1.5 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 *(please refer to the Appointments Policy).*

2. **Allocation**

2.1 The allocation process to allocate referrals to an appropriate healthcare professional may take place within the multi-disciplinary referral meeting.

2.2 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.

2.3 The responsibility for ensuring that a care co-ordinator is allocated to a particular case will rest with the team manager/receiving practitioner. 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.

2.4 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.

3. The Care Co-ordinator

3.1 The care co-ordinator is responsible for coordinating the care package of the service user by ensuring that the care plan is delivered and reviewed.

3.2 The care co-ordinator must be a qualified health or social care professional. 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;
- Contingency planning
- Assessing and responding to carers' needs;
- Care planning and review;
- Transfer of care or discharge.

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

- Explaining the CPA process to the service user, 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 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.
- Advising the service user that they may bring a friend/person of their choice to their **CPA review**
- Giving the service user the opportunity to **discuss/prepare** for their CPA review.
- 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.
- Identifying any **unmet needs** and communicate any unresolved issues to the appropriate managers.
- Exploring **Self Directed Support,** with eligible persons and carers, with the aim of promoting their independence and **choice.**
- 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 the service user aware of any advocacy or self-advocacy schemes taking into account the Mental Capacity Act 2005.

- Considering implications of the **Mental Capacity Act** and **Deprivation of Liberty**.
- 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), and the Common Assessment Framework (CAF).
- 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.
- Considering benefits, housing and employment implications.
- Monitoring **physical health**.
- Undertaking **appropriate outcome measures** and **clustering**.
- Arranging for someone to deputise if they are absent and passing on the care coordinator role to someone else if they are no longer able to fulfil it.

3.5 *W*here a service user is seeing a worker from more than one team within NEPFT, the role of care co-ordinator will be undertaken by the most appropriate worker, dependent upon the service user's needs *(please refer to the co-existence of mental health needs and substance misuse (Dual Diagnosis) care pathway liaison and referral protocol and responding to people who have Learning Disability and need mental health care and treatment protocol.)*

3.6 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 and include any advance directives and Lasting Power of Attorney.

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, benefits, housing, ethnicity etc – please refer to the CPA Personal Details Form).

4.4 **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 and the Trust's leaflet "How we look after the information you tell us about").*

4.5 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 co-existence of mental health needs and substance misuse (Dual Diagnosis) care pathway liaison and referral protocol and responding to people who have Learning Disability and need mental health care and treatment protocol.)*
- 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, safeguarding (being aware that children and family 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 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)
- Forensic history
- Occupational status, vocational aspirations and employment needs, training, education and leisure *(please refer to the North Essex Employment Strategy)*
- Housing status and needs
- Employment and benefits
- Financial status
- Appropriate outcome measures *(please refer to the Care Clustering Policy)*
- Need for medication management *(please refer to the Medicine Policy & Procedure)*
- Experience of violence, abuse and sexual abuse
- Communication, cultural, gender 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 Safeguarding 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

4.6 **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.

4.7 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.

4.8 **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).*

4.9 **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).*

4.10 **TRUST Line Cards** - All service users and/or their carers should be given a TRUST (Telephone Response for Urgent Support and Talk) line card at assessment. The new green TRUST cards contain the out of hours' telephone numbers and replace the old orange crisis cards. These cards are for service users and their carers only and should not be handed out to members of the public.

4.11 **Discharged from CPA following Assessment** - If following the CPA assessment, the person is deemed not to require any further intervention from the Trust's secondary 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.

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, forensic, 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 and inform relevant professionals.

5.4 Risk assessments should include an estimation of the degree of risk presented in respect of:

- aggression/violence;
- safeguarding children;
- hazards;
- neglect;
- self harm;
- suicide;
- vulnerability; and
- safeguarding

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

5.6 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.

5.7 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.

5.8 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.

5.9 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 within the Trust

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

- the CPA referral form outlining the reasons for referral to that service;
- the CPA assessment; and
- an up-to-date assessment of risk.

6.2 If the referral is made using the clinical electronic record, 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 3).*

7. The CPA Care Plan

7.1 Once the CPA assessment has been completed and the service user's needs have been identified, the care co-ordinator, in collaboration with the service user, and where appropriate any carers, develops the overarching CPA care plan.

7.2 The care plan must be written in a jargon free way and should outline:

- Summary of needs and how they are to be met
- Service users goals
- Interventions, services, actions, responsibilities and timeframes
- Crisis plan
- Contingency plan
- Unmet needs/service deficits
- Learning disability
- Physical health
- Self Directed Support
- S117 aftercare
- Cultural, spiritual implications
- Translation/Interpretation requirements
- Advance decision/statement
- Triggers, key events, relapse indicators
- Service user comments
- Carers comments

7.3 The overarching CPA care plan should be agreed, signed, dated, timed and a copy given to the service user and where appropriate the carer, the GP and all others involved.

7.4 If a service user does not wish to receive a copy of their CPA care plan, or refuses to sign, this must be outlined in the care plan and recorded in the service user's clinical record.

7.5 For service users seen only in the outpatient clinic, the letter written to the GP by their consultant/doctor will constitute their CPA care plan.

7.6 Care plan folders are available for service users and staff should ensure that these are offered to service users.

8. Specialist Care Plans

8.1 All the services identified in the overarching CPA care plan must have a specialist care plan which outlines the specific care a person, team or service will deliver (there could be several specialist care plans, eg day care, inpatient setting, drug and alcohol team, psychology, etc).

8.2 Specialist care plans will be drawn up in collaboration with the service user and will include:

- Assessed needs
- Plans/goals/outcome
- Implementation/action required
- Rationale
- Evaluation date

8.3 Specialist care plans should be signed by the service user. If the service user does not wish to sign, then this must be clearly documented in the service user's clinical record.

8.4 The role of the care co-ordinator is to co-ordinate the various specialist care plans to ensure they are reflected in the overarching CPA care plan.

8.5 All those involved with specialist care plans must ensure that progress is communicated to the care coordinator.

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:

- Information necessary to continue to implement the care plan in an interim situation, for example telephone numbers of service providers.
- Contact details of substitutes who have agreed to provide interim support.
- Early warning signs, relapse indicators and key triggers.

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, or risk factors escalate. 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:

- 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. TRUST line out of hours cards are available for this purpose.

11. CPA Reviews

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

11.2 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.

11.3 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.

11.4 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.

11.5 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 and give the service user the opportunity to talk ahead of the review taking place.

11.6 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.

11.7 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.

11.8 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).*

11.9 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)* .

11.10 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).*

11.11 Consideration of whether any assessments of capacity in respect of specific decisions *(see Mental Capacity Act Policy)* and whether a Deprivation of Liberty Safeguards Authorisation is required must be considered *(see Deprivation of Liberty Safeguards Policy).*

11.12 The care co-ordinator has the responsibility of monitoring and reviewing the care provided, and appropriate outcome measures should be used as part of the review process.

11.13 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.

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

12. Multi-Disciplinary Professionals Meeting

12.1 It may be necessary on occasions to hold a multi-disciplinary professionals 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.

12.2 All professionals meetings should be noted and form part of the service user's record. Decisions made at these meetings should be discussed with the service user. A clear rationale must be documented if any aspect of the professionals meeting is not discussed with the service user.

13. Continuity of Care
(Please refer to the Transfer of Care Policy)

13.1 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.

13.2 The care co-ordinator should always ensure that they remain in contact with the 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 transfer from hospital.

14. Transfer between Community & Inpatient Care
(Please refer to the Transfer of Care Policy)

14.1 When a service user is new to the service in an inpatient setting and there is no previously assigned care co-ordinator, the consultant psychiatrist will assume the care co-ordinator responsibilities during the inpatient care period. The inpatient team should liaise with the relevant community team to identify a care co-ordinator.

14.2 When a service user is transferred into an NEPFT inpatient setting and there is an existing care co-ordinator in the community, the role of the care coordinator remains within the community.

14.3 During the inpatient episode, the key worker, ward team and consultant psychiatrist will work collaboratively with the existing care co-ordinator ensuring they are aware of the admission, and agreeing a CPA care plan, taking into account the needs of the service user and their family/carer's wishes.

14.4 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 transfer out of the inpatient setting into the community. At the time of transfer the service user must have a current and coherent care plan that includes any changes in need or circumstances and risk factors that were not considered or included in their previous care plan.

14.5 The care plan must include details of follow up arrangements, which should be as follows:

- For service users who have been at high risk of suicide during the period of admission, **a face to face** follow up must be made within 48 hours of transfer from the inpatient unit into the community, and this must be made by a qualified member of staff.
- For all other service users transferred from the inpatient unit into the community, **a face to face** follow up must be made within 7 days of transfer from the inpatient unit to the community.

14.6 In addition to the above face to face follow up, a follow up telephone call must be made within 48 hours of transfer from the inpatient unit into the community by the ward manager or by a delegated clinical member of staff to all service users transferred.

15. Disengagement from the Service

(Please refer to the Trust's Guidance for Service Users who Disengage with Mental Health Services)

15.1 Should a service user refuse to engage with the services, then a professional review meeting with the multi disciplinary team should be called to determine the reasons for disengagement and to decide upon a strategy for management.

15.2 An assessment of the risks that the service user presents must be undertaken and an action plan made accordingly.

15.3 The action plan will be formulated following discussion within the team and where appropriate family members and/or carers should be involved.. The action plan should state how often an attempt to make contact/visit will take place and this must be clearly documented in the service user's health and social care record.

15.4 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.

16. Discharge from CPA

(Please refer to the Discharge Policy)

16.1 The decision to discharge a service user from CPA and NEPFT service should be made at a CPA Review in partnership with the service user and where appropriate relative/carer.

16.2 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.

16.3 When a service user is discharged from CPA all relevant documentation is completed and forwarded onto the GP. The care coordinator must ensure that this is recorded on the electronic patient record and the service user's package of care should be completely closed down.

17. Transfer of Care Between Mental Health Organisations

(Please refer to the Transfer of Service Users Policy)

17.1 For the transfer of service users between Mental Health Organisations, please see Appendix 4 which is the CPA Association's Good Practice Guide in the Transfer of Service User Care between Mental Health Districts.

CPA Literature

CPA Forms
The current CPA documentation consists of:

- Personal Details
- CPA Referral
- CPA Assessment Guidelines
- CPA Care Plan
- Specialist Care Plan
- CPA Review
- Carers Assessment
- Service User Self Assessment

CPA Forms for CAMHS
There are two separate forms for CAMHS (Personal Details and the Referral Form).

Consultant Care Plan Letters
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.

Drug & Alcohol Service
There are modifications to the CPA documentation for the Drug and Alcohol Teams.

Easy Read Forms
The following forms are available in Easy Read format

- Personal Details
- Care Plan
- Review
- Care Plan for CAMHS

Electronic Recording
It is essential that all information recorded manually on the CPA documentation corresponds with that recorded electronically on the Trust's Electronic Patient Record.

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.

I-Connect - CPA Page
Information on CPA is available on the Trust's i-connect and is located under Teams and Services.

CPA Leaflets & Care Plan Folders
The CPA Department is located at the Linden Centre where stocks of the following CPA literature are held:

- Care Plan Folders
- CPA Information Leaflets
- TRUST line out of hours cards (formerly crisis cards) for the 3 localities of the Trust (Mid, North East, West)
- TRUST Support Leaflets for the 3 localities of the Trust (Mid, North East, West)

Please email the CPA Department on cpa@nepft.nhs.uk for supplies of the above, and for further information on CPA.

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.

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 TRUST line 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 4

cpaa

Care Programme Approach Association
Supporting quality care standards and celebrating diversity
Cymdeithas y Dull Rhaglen Ofal
cynnal safonau ansawdd gofal a dathlu amrywiaeth

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
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(2010)

RELEVANT TRUST POLICIES AND GUIDANCE

- Access to Health & Social Care Records Policy and Procedures
- Advance Decisions and Statements Guidelines
- Appointments Policy incorporating Non-Attendance Procedure
- CareBase Operational Policy
- Care Clustering Policy
- Carers Strategy
- Clinical Risk Management Protocol
- Confidentiality and Information Sharing Protocol
- Deprivation of Liberty Safeguards Policy
- Discharge Policy
- Disengage with Mental Health Services (Guidance for Service Users)
- Dual Diagnosis (the co-existence of mental health needs and substance misuse) Care Pathway Liaison and Referral Protocol
- Equality & Diversity Policy
- Getting it Write
- Health and Social Care Records Policy
- Learning Disability Protocol (responding to people who have learning disability and need mental health care and treatment)
- Mental Capacity Policy (Assessment of Mental Capacity)
- Physical Health Care Policy
- Safeguarding Adults Policy and Procedure
- Safeguarding Children Policy and Procedure
- Section 117 Aftercare under the Mental Health Act Procedure
- Spiritual & Religious Care Policy
- Supervised Community Treatment (SCT) Policy
- Supervision Policy, Mandatory
- Transfer of Care Policy
- Translation and Interpreting Policy