Essex Partnership University
NHS Foundation Trust

CPA PROCEDURE

Procedure Reference Number:	CLPG30
Version Number:	2
Key Changes From Previous Version:	Inclusion on senior and MDT review following DNA and complex care. Review undertaken prior to implementation of Community Mental Health Framework and move from CPA.
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Implementation Group:	1st July 2017
Amendment Date:	April 22; March 2023
Last Review Date:	March 2023
Next Review Date:	May 2026
Approved by Clinical Governance and Quality Sub Committee	January 2023
Ratification by Policy Oversight & Ratification Group:	March 2023
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Procedure Summary
This procedure provides guidance on the implementation and operation of the CPA Policy for Essex Partnership University Foundation Trust (EPUT) The main components of the CPA framework outlined in this procedure are: Assessment Risk assessment and planning Care planning (including crisis and contingency plan) Coordinating care Reviewing Transitions This policy will remain operational while the transformation of services in line with The Community Mental Health Framework is underway.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
Trust Safeguarding Group Local Care Group Accountability Framework Overarching EPUT KPI monitoring governance arrangements.

Services	Applicable	Comments
Trust wide		
Essex MH and LD	✓	
CHS		

The Director responsible for monitoring and reviewing this is procedure is the Executive Chief Operating Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA PROCEDURE

1.0 INTRODUCTION

1.1 This procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust and will continue to serve as guidance during the planning period for the transformation of the Community Mental health Framework for Adults and Older Adults.

2.0 COMPONENTS OF CPA

The main components of the CPA framework are as follows:

- Assessment
- Risk assessment and planning
- Care planning including crisis and contingency plan
- Co-ordination care
- Reviewing
- Transitions

3.0 ASSESSMENT

3.1 What is assessment?

The assessment is the starting point for all patient care. Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical and social care needs in line with the Care Act 2014 and must always include a risk assessment.

3.2 Who can undertake the assessment?

All assessments are undertaken by qualified clinician, including nurses, occupational therapists, social workers, psychologists and medical staff. On occasions it may be appropriate to organise a joint assessment for example where there are complexities and/or high risks.

3.3 Confidentiality

All those assessed (and those with parental responsibility for those young people seen in our service) must be informed at their initial assessment that the information collected about the, will be stored electronically and may need to be shared with other Trust staff. In particular the MDT providing care to them. They must be advised that all our staff are required to abide by a strict code of confidentiality.

3.4 Purpose of the Assessment

The purpose of an assessment is to:

- Provide an initial assessment of needs and how they may be met (including identification and review of S117 health and social care needs)
- Evaluate the individual strengths.
- Identify the person's goals and, aspirations and choices.
- Assess the level of risk and safety.
- Identify any safeguarding concerns.
- Identify the need for a specialist assessment, complex trauma, and substance misuse and where appropriate refer to relevant service, agency or profession.
- Determine if interventions from the service are appropriate.
- Identify a person's need for CPA, Non-CPA or other care process which can support.
- Establish an information base.

3.5 The full assessment should take into account the following:

Psychosocial Factors	**Personal Circumstances**
Reason for referral	Persons strengths, views and goals
Presentation	Personal circumstances
Impact on daily living	Family including genogram
Recent life events	Caring responsibilities
Precipitating factors	Childcare issues
Psychiatric history	Relationship status
Forensic history	Religious and spiritual needs
Pre-morbid personality	Gender, sexuality and orientation
Significant life events	Advance decision and end of life choices
Team specific assessment	Statement of wishes
Experience of violence and abuse	Lasting power of attorney
Risk to self or others	Personalised budget
Learning disability	Consent to share information with family and other agencies
Support network	Physical health needs
Housing and accommodation needs	Medical history
Financial needs	Allergies
Carer and family involvement	Accidents

Involvement with other agencies	Hospitalisation
Advocacy needs	Weight ,BI ,Height
Employment status	Smoking status
Training and education	Current medications
Leisure	Disability
Social function and needs	Protected characteristics
Communication and cultural needs	

3.6 Outcome Scale

Outcomes measures, as required by the service, must be completed at the point of assessment and at review.

3.7 Assessment Outcome

All assessments should conclude with the assessment outcome and a summary of what happens following the assessment.

This could include advice, information and guidance or the formulation and plan for what happens next. All assessments must be dated and include the name and the designation of the assessor.

3.8 Transition Back to Primary Care

If following the assessment, the person is deemed not to require any further intervention from our specialist mental health service; they should be transitioned back to their GP with a copy of the assessment outcome and personalised advice, information and guidance on re-direction or signposting to other support if required.

4.0 RISK ASSESSMENT AND PLANNING

4.1 Assessing Risk and Safety Planning

The assessment and management of risk and collaboratively safety planning provides the services to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others. Risk is dynamic and is constantly changing in response to circumstances, in particular treatment and management decisions are likely to be influenced.

4.2 Risk Assessment Tools

Risk assessment tools are fluid and developing nationally. The risk assessment carried out must be in line with Trust approved guidance.

4.3 Gathering Risk Information

Risk assessments must take into account all the available information from the patient, and other sources, such as the GP, carers, family members, forensic, other professionals and agencies that have knowledge of the individual.

It is essential to seek information on the patient's past behaviour and any previous potential triggers for dangerous behaviour, and to consider the information in the context of the patient's present circumstances, as well as considering what previous strategies have worked.

All concerns raised by family and/or carers must lead to a review of the risk assessment and the Multidisciplinary Team (MDT) should be informed or a senior clinical member of the team for discussion.

4.4 Risk Categories and Indicators

Suicide	**Self-Harm**
Previous attempts	Current recent episodes of self-harm
Threats	Deliberate self-harm
Opportunity	History of self-harm
Means	Accidental harm
Internet and access to information and suicide promoting groups	Alcohol, drug and substance misuse
Expressed intent	Food and eating issues
Plans	Cutting, burning
Chronic persistent pain	Binge drinking
Recent discharge from hospital	Dependence and withdrawal
Recent diagnosis of life changing/ending illness	Change or increase in method
Family history of attempted and actual suicide	Deliberate sexual promiscuous behaviour
Deliberate avoidance of prescribed treatment	Sleep disturbance
Red Flag alerts "Connecting with People" and "STORM".	Sleep disturbance
Aggression and Violence	**Vulnerability and Neglect**
violence to others	Inability to care for one's self
Domestic violence	Lack of carer support
Access to potential victims	Falls
Specific threats made	Cognitive impairment and confusion
History of sexual assault	Capacity issues
Paranoid delusions	Fire risk
Verbal aggression	Social isolation
Escalation of threats	Social media
Responses associated with withdrawal	Recent discharge from hospital
	Lack of health education around health behaviours and prevention
	Poverty

	Recent bereavement
Safeguarding	**Hazards**
Exploitation from others	Exploitation from others
Vulnerability to abuse	Neighbourhood
Bullying and harassment	Unsafe buildings
Domestic abuse	Hoarding
Risk of being radicalized	Hazardous surroundings
Financial abuse	Unsafe buildings
Institutional abuse	Aggressive pets
Sexual abuse	Inadequate information on patient
Physical abuse	Location
Female Genital Mutilation (FGM)	Bad lighting
Patient is carer of their own relatives	No mobile phone network
Patient is directly or indirectly providing support to a child	Parking difficulties/issues
Being cared for by carers with mental illness/addiction problems	Other members of the household have aggressive/intimidating behaviour
Mental Health History	**Personal**
Previous admissions to hospital	Age
Previous risk taking behaviour	Gender
Detention under the Mental health Act	Social situation, redundancy, divorce for example
	Key life events
	Relapse indicators
	Triggers
	Anniversary date of significant other, person, pet.
	Non- concordant with treatment plan
	Failure to attend appointments
	Incidents involving the criminal justice system
	Reluctance to engage with services
	Substance misuse

4.5 Documenting, Planning and Sharing of Risks

All identified risks and plans must be documented in the electronic patient record.

All risks must be shared with all professionals involved with the patient. It is essential to record all considerations and risk plans and ensure that the relevant professionals are kept informed. All members of the multi-disciplinary team have a responsibility to consider risk and how these risks will be planned and managed.

The outcome of the risk assessment must form the basis of a clear crisis and contingency plan.

4.6 Reviewing Risk

The assessment of risk is an essential and continuous ongoing part of the CPA process and must be considered on an individual basis.

It is an essential mandatory requirement whenever a review takes place, or an individual's circumstances change (e.g. through admission to an inpatient unit or on transfer back to the community) to consider all the risk implications and how these will be planned and managed.

5.0 CARE PLANNING

5.1 Person Centred Care

Person centred care planning is about listening to the patient and finding out what he/she wants and needs.

It is about helping people to think and plan what they want from their life now and in the future, and to enable friends, family & professionals to work together with the person to achieve these goals.

A person's care plan is a record of the agreed care and treatment for the person and should focus on their identified recovery goals.

5.2 Jargon Free

In developing care plans in partnership with the patient and their family and/or carers, it is important that they must be created using language and terminology that the patient and their family or carer is able to understand.

5.3 Specialist Care Plan Intervention

When a range of services are identified in the overarching personalised care plan, each service, in partnership with the service user, must agree their specialist care plan which outlines the specific care a person, team or service will deliver. All those involved with specialist care plans must ensure that progress is communicated to the care coordinator/lead professional.

5.4 What should be considered in a Care Plan

Need	Action/Goals/Outcomes
Diverse needs and preferences	Interventions
Translation, interpretation requirements	Contributions of all agencies involved
Specific needs arising from co-existing physical disability, sensory impairment, and learning disability/autism.	Agreement of all professional or services to undertake their aspect of the care delivery.
Physical healthcare	SMART goals
Parenting or caring needs	Patients actions necessary to achieve the agreed goals
Specific needs arising from drugs and/or alcohol misuse	Agree desired outcomes with patient and carer
Consideration of self-directed support personalised budgets.	An estimated time scale by which the outcome goals will be achieved or reviewed.
Any unmet needs and service deficits	
Easy read format care planning	
Risk, Contingency and Crisis	Patient/Carers and Staff Involvement
Triggers and relapse indicators	Patients/carers responsibility to achieve the agreed goals
Key events	Patients comments
Advance decisions and statement of wishes	Copy given to patient
Crisis contact details	Copy given to carer where appropriate
Outline of who the patient best responds to the crisis	Dated and timed
Contact numbers to ring in a crisis	A note if the patient does not wish to receive a copy
Identify risks and safety issues	
Things to take into account when a crisis happens, children, caring responsibility, and pets.	

5.5 Copy of Care Plan Given to the Person and the GP

A copy of the care plan must be offered to the patient, and made available to all those involved in the care plan. It is essential that practitioners maximise the extent to which the patient knows and understands their care plan and agrees with it. Any disagreements should be recorded.

The care plan must be shared with the GP.

5.6 Care Plan for People on Non-CPA

For those patients who are placed on Non-CPA, their care plan will often be in letter format (for example a copy of the letter from the consultant/clinician sent to their GP is copied directly to them).

6.0 CO-ORDINATING CARE

6.1 Co-ordinating care is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care by the appropriate agency or provider.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.
- The term Lead Professional is used for those working with individuals on Non-CPA.

6.2 Who Can Care Co-Ordinate?

6.3 The role of the CPA care co-ordinator or Lead Professional will be allocated to the practitioner who, after consideration of the initial assessment, is best qualified to oversee and to support the care needs of the individual. Care co-coordinators will be qualified professionals who are employed by or seconded to EPUT.

6.4 The responsibilities of the care co-ordinator remain in place whatever the setting, especially during the period of inpatient treatment or when the patient is receiving intensive support from specialist services, such as community teams or residing in a residential home.

6.5 Absence/Leave arrangements

When a care coordinator/lead professional is on leave, arrangements must be made as to who will cover their absence.

6.6 Co-ordinating Care – Main Responsibilities

The main duties and responsibilities for the care co-ordinator are outlined in the table overleaf and have been divided into the following categories:

- Assessing
- Planning
- Co-ordinating
- Reviewing

Assessment	**Planning**
Carry out a thorough assessment of the person's physical, social, emotional and psychological needs	Agree goals with the patient
Assess any immediate risk to the person or others	Identify and agree actions and interventions
Assess the impact on others in the household (particularly children)	Develop risk management plans to support the individual's independence and daily living
Ensure the identified carer has been informed of their rights to a Carer's Needs Assessment, and where relevant undergo this assessment	Work with the person, their families and carers to identify measures to be taken to prevent a crisis developing and develop a **personal** crisis and contingency plan
	Encourage the person to write an Advance Decision/Statement of Wish
Co-ordinating/Implementing	**Reviewing**
Ensure regular contact is maintained to monitor the person's progress (whether at home/in hospital or prison) taking into account their needs & risks	Review the effectiveness of the therapeutic interventions and recovery/ living well strategies with all involved
Ensure the patient understands the care co-ordinator role and knows how to make contact and who to contact in their absence	Review where there is deterioration in the patient's mental health or where problems may arise in the delivery of the care plan or if significant new risk factors are identified in the course of delivering the care plan
Ensuring all those involved understand and are implementing their identified responsibilities	Discuss the options for transfer of care or discharge
Work with the patient & their families/ carers during times of crisis, ensuring crisis situations are responded to timely, effectively and safely	Agree transfer/discharge plan and the arrangements including the support needs upon transfer/ discharge
Arrange advocacy for those unable to represent their own interests	Care plans are revised and updated after a review and re-issued to those involved
Support patients on their caseload to have an annual health check	Review of S117 needs at every review

Work in collaboration with carers and ensure information, advice or signposting to services is given	Risks assessment will be review on receipt of concerns from family and/or carers and shared with the MDT or with a senior member of the clinical team for discussion.

7.0 REVIEWING

7.1 Review is the way we find out if the care plan is working, look at progress the patient has made and the ways in which their needs may have changed.

7.2 Who Attends The Review?

The level of complexity of each case will determine who needs to be present at the review. It may not be practical to have all those individuals involved in the care plan attend the review meeting, and it is essential that the patient's feelings and views are taken into account, as large meetings can be intimidating. In some cases, the review may consist of just the patient and the care co-ordinator.
However, the care co-ordinator should ensure the views of others are represented.

7.3 Where and When Does a Review take Place?

The patient's wishes about the location and timing of the review and the number of people attending should be respected wherever possible.

All patients on CPA must have their care reviewed no less than once every six month, in response to any change and prior to any transition (e.g. discharge from hospital, concerns raised by the family and/or carers regarding the patient's risks and safety and that of others).

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

7.4 The Review Process

The review process is outlined in the table on the next page and has been divided into the following categories:

- Purpose of a review
- Preparation for a review
- During the review
- Outcome of the review

7.5 The table below outlines the review process.

Purpose of Review	Preparation for Review
Any person involved in the care plan, including the patient or carer, can ask for a review to be held at any time (if refused, this must be recorded in the patient's notes)	Reviews should be prepared for in advance
Ensure the patient's personal details are up-to-date and correct	Respect the patient's wishes for the location and timing of the review and who attends the review
Review the consent to share agreement	Invite all those involved in the patient's care plan
Discussion of any progress the person has made	Where appropriate carers should be involved in the review.
Whether they continue to or now need the support of CPA, S117 aftercare, and/or a Community Treatment Order (CTO)	Care co-ordinator/lead professional must ensure they obtain the views of those involved in the care plan who are unable to attend the review
The extent to which the care plan (including crisis and contingency plan) needs amending	
Reassessment of risk factors	
During the Review	**Outcome of Review**
Record all present and apologies received	Change the amount of support required
Determine views of the patient, carer and professionals. Include any concerns raised by family and/or carer.	Move from or to CPA
Decide upon the best plan of care and setting approximate timescales based on the above discussions	Discharge from the service back to the GP or transfer to another system of care
Consider whether someone continues to have S117 aftercare needs, or if they continue to require a CTO under the MHA & the impact of any user led document (such as an Advance Decision) has on the care plan	Update the care plan, risk plan, crisis and contingency plan and draw up the modified care plan

Any changes must be agreed by all parties and disagreements recorded	Ensure everyone receives a copy of the updated care plan even if they were unable to attend the review

7.6 Professionals Meetings

It may be necessary on occasions to hold a multi-disciplinary professionals meeting to discuss and decide on the support and treatment of patients who may present with complex needs, high risks and probable non-concordance with their care plan, and where there maybe differences of opinion within the multi-disciplinary group.

8.0 TRANSITIONS

8.1 People can experience any number of transitions during their contact with our service, such as discharge from the services, transfer between services, or transfer of care to another provider.

8.2 Examples of transitions:

- Admission to hospital
- Discharge to community from hospital
- Move to a residential home/nursing home
- Imprisonment or release from jail
- Change of geographical area
- Change of care co-ordinator
- Move from the child & adolescent service to the adult service
- Move from the adult service to the older adult service

8.3 Essentials at the time of transfer:

- The process is co-ordinated by the care co-ordinator/lead professional
- The patient and all relevant members of the multi-disciplinary team are involved in the planning of any transition
- Handovers of care are clearly documented with transfers of responsibility agreed in a timely manner
- There are clear plans which have been agreed with all concerned
- Information is shared with all the relevant people

Inpatient Transitions

8.4 If it becomes necessary for the patient to have a period of inpatient care, the care co-ordinator will maintain contact with the patient throughout.

8.5 During the period of inpatient care, the care co-ordinator and the inpatient team will maintain open communication to facilitate full assessments of needs and appropriate plans of care.

8.6 The care co-ordinator will retain his/her responsibility for actively overseeing the patient's CPA care plan in close liaison with the inpatient team throughout the period of the inpatient stay.

8.7 Care Planning for leaving inpatient care

It is the responsibility of the care co-ordinator in conjunction with the inpatient team 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 leaving inpatient care, the patient 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 the previous care plan.

8.8 Follow up arrangements when leaving inpatient care

The care plan must include details of follow-up arrangements and these should be in line with the 7 day follow up policy.

8.9 Change of care co-ordinator

If a change of care co-ordinator/lead professional is necessary, either within the existing team or to another team within the Trust or outside the Trust, the current co-ordinator must arrange to hold a formal CPA review with the patient, any carers if applicable and the new co-ordinator. The care co-ordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team/service.

8.10 T**ransfer to residential homes/nursing homes/prisons**

When a patient is removed from their normal place of residence (e.g. they go into a prison, residential home, nursing home or children being placed into out-of-area foster care), it remains the responsibility of the care co-ordinator to review the quality and appropriateness of their care in accordance with Trust Policy. The care co-ordinator must always ensure that they remain in contact with the patient and ensure that reviews are still carried out in accordance with Trust policy.

8.11 Change of Geographical Area

The national Care Co-ordination Association (CCA) has outlined the procedure for the transfer of patients between Trusts and Local Authority Areas.

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