*NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST*

**POLICY DOCUMENT**

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# CPA and STANDARD CARE POLICY

## 1 Purpose

1.1 This policy sets out how the North Essex Partnership University NHS Foundation Trust will meet national guidance and Care Quality Commission standards related to implementation of the Care Programme Approach (CPA) & Non-CPA (Standard Care) as summarised below. It is accompanied by procedural guidance for staff to assist them in undertaking their duties.

1.2 This CPA and Standard Care policy and procedure applies to all staff working within secondary care mental health services provided by the Trust and the provisions of the policy are mandatory across all secondary mental health services within the Trust.

## 2 Introduction and background

2.1 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. It is a framework for assessing, planning, implementing/ delivering care and then evaluating the effectiveness of that care/intervention.

2.2 'Refocusing the Care Programme Approach: Policy and Positive Practice Guidance' (DH, March 2008) was the outcome of a national review which had the intention of ensuring the national policy is more consistently and clearly applied and that unnecessary bureaucracy is removed. It recommended that the category of standard and enhanced CPA is replaced with CPA and Non-CPA level (standard care).

2.3 This document sets out the policy governing the operation/delivery of CPA & Non-CPA (standard care) within the Trust. It supersedes any existing CPA policies within the Trust.

2.4 This approach to organisation and management of care has been developed from the concept of "case management". It supports person centred care and/or 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. In practice, the CPA process is often referred to as "case management" by clinicians.

2.5 The service user/carer is put at the centre of service planning and delivery. These rights have been enshrined in the NHS constitution, at the same time providers are expected to provide comprehensive information to help service users make informed choice with regards to their care and treatment.

2.6 The latest guidance on bringing mental health services within the scope of Payment by Results (PbR) was outlined by the DoH in 2012. It stipulates that:

- The use of mental health clusters was mandated for use from April 2012.

- The clusters are for most mental health services for working age adults and older adults (pilot work is taking place with CAMHS providers to develop a suitable approach for children).
- Mental health providers are expected to develop and agree the components of these cluster care packages with their local commissioners.
- Service users have to be assessed and allocated to a cluster by their mental health provider.
- This assessment must be regularly reviewed in line with the timing set out in the mental health clustering booklet.
- The clinical rating outcome measure based on the Health of the National Outcome Scale (HoNOS) Mental Health Clustering Tool (MHCT) is recommended for use.

2.7 Since April 2011, public bodies have been required to comply with the public sector Equality Duty. The three aims of the Equality Duty are to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- promote good relations between people who share a protected characteristic and those who do not.

2.8 The Equality Duty covers the following protected characteristics:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation.
- marriage and civil partnership (but only in respect of the requirement to have due regard to the need to eliminate discrimination)

## 3 The Four Components of CPA and Non-CPA (Standard Care)

The four main components of the CPA and Non-CPA (standard care) are:

- **Assessment**
  Systematic arrangements for assessing the health and social care needs of people referred to our service.

- **Case management**
  The appointment of a care co-ordinator/lead professional 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.

## 4 Who is subject to CPA?

The term CPA describes the approach used in secondary mental health and social care services to assess, plan, review and co-ordinate the range of treatment, care and support needs for people who have **complex characteristics**, as outlined below in Table 1.

**Table 1 - Characteristics to consider when deciding if support under CPA is needed** (the list is not exhaustive and there is not a minimum or critical number of items on the list that must indicate the need for CPA)

- Severe mental disorder (including personality disorder) with high degree of clinical complexity;
- Current or potential risk(s), including:
  - Suicide, self-harm, harm to others (including history of offending);
  - Relapse history requiring urgent response;
  - Self-neglect/non concordance with treatment plan;
  - Vulnerable adult; safeguarding.
- Exploitation e.g. financial/sexual;
- Financial difficulties related to mental illness;
- Disinheriting;
- Physical/emotional abuse;
- Cognitive impairment;
- Child protection issues.
- Current or significant history of severe distress/instability or disengagement;
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse;
- Multiple service provision from different agencies, including: housing, physical care,
- employment, criminal justice, voluntary agencies;
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team;
- Significant reliance on carer(s) or has own significant caring responsibilities;
- Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities;
  - Physical health problems/disability;
  - Unsettled accommodation/housing issues;
  - Employment issues when mentally ill;
  - Significant impairment of function due to mental illness;
  - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious
  - practices);
  - Sexuality or gender issues.

## 5 What is the difference between CPA & Non-CPA (Standard Care)?

Following the initial assessment, an individual deemed to have complex needs, a higher risk profile and/or requiring multi agency input should be placed on CPA. Whereas an individual with more straightforward needs, one agency input or no problems with access to other agencies/support and lower risks must be placed on Non CPA (Standard Care). Table 2 below gives more detail on what service users on CPA and Non CPA should expect.

**Table 2**

| Service users needing CPA | Service users placed on non CPA |
|---|---|
| **An individual's characteristics**<br>Complex needs; multi-agency input; higher risk. | **An individual's characteristics**<br>More straightforward needs; one agency or no problems with access to other agencies/support; lower risk |
| **What the service users should expect**<br>• Support from CPA care co-ordinator<br>• (trained, part of job description, co-ordination support recognised as significant part of caseload)<br>• A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks<br>• An assessment of social care needs against Fair Access to Care Services (FACS eligibility criteria (plus Self Directed Support)<br>• Comprehensive formal written care plan: including risk and safety/contingency/crisis plan<br>• On-going review, formal multi-disciplinary, multi-agency review within the maximum timescale of the mental health care cluster review period<br>• At review, consideration of on-going need for CPA support<br>• Increased need for advocacy support Self-directed care, with some support if necessary<br>• Carers identified and informed of rights to own assessment | **What the service users should expect**<br>• Support from professional(s) as part of clinical/practitioner role. Lead professional identified.<br>• Service user self-directed care, with support.<br>• A full assessment of need for clinical care and treatment, including risk assessment<br>• An assessment of social care needs against FACS (plus Self Directed Payment)<br>• Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter)<br>• On-going review as required<br>• On-going consideration of need for move to CPA if risk or circumstances change<br>• Carers identified and informed of rights to own assessment |

## 6 Principles of Care under CPA & Non-CPA (Standard Care)

The care delivered within the framework of CPA and non-CPA (standard care) is underpinned by the following principles:

- A person centred approach used to inform partnership working in mental health. This partnership must always include the service user, any carers, the family, the care co-ordinator/lead professional, any health and social care professional and other relevant organisations.

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

- 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).

- 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.

- The 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.

## 7 The Care Co-ordinator/ Lead Professional

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

- 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.

- The lead professional is the term used to differentiate the professional responsible and accountable for the care of a service user who is on non CPA (standard care). This professional is responsible for delivering the main clinical or psychosocial intervention.

- Clinicians will either take on the role of the lead professional for people who are on Non CPA or act as care coordinator for those on CPA. In principle, the professional delivering the main therapeutic intervention will act as lead professional or care coordinator.

## 8 Carers

All individuals who provide regular and substantial care for a person must 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 must 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**).**

## 9 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 must be underpinned through the care process ensuring that the needs of the parent, the children and the family are assessed routinely at each stage of the care pathway.

## 10 Training and monitoring of this policy

### 10.1 Induction and training

Trust induction provides an introduction to the CPA process for all new staff. It is mandatory for all clinical staff (qualified and unqualified) to attend CPA/Clinical Risk training every three years.

### 10.2 The Trust monitoring of this policy

Compliance with CPA is monitored Trust wide through the electronic CPA Performance Checklist and a quarterly report is presented the Risk and Governance Executive. Findings are fed back to the Trust's CPA Working Group and recommendations and an action plan are developed every 6 months. The action plan is managed by the Trust's CPA Working Group.

## CPA and Non-CPA (Standard Care) Procedure

## Implementing the policy

1. **Referrals to our service**

1.1 Referrals are received from a range of sources including GP's, local authority social services, the voluntary sector, probation services, police service, carers, family members, neighbours, other organisations, any other professionals (e.g. district nurse, pharmacist etc) and in some instances service user may self refer.

1.2 When a referral is received into secondary care, the receiving team acting as the single 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 All referrals must be triaged to determine eligibility and this may be done through screening and/or at pre-allocation meetings.

1.4 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, i.e. whether the referrer has stated whether the referral is "routine, crisis or urgent" *(please refer to the Appointments Policy).*

2. **Allocation**

2.1 The allocation for assessment will take place following triage to an appropriate healthcare professional and may take place within the multi-disciplinary referral meeting.

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

**3. Comprehensive Initial Assessment**

3.1 Those accepted for assessment will receive a comprehensive holistic assessment of their mental health and social care needs and 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 "Assessment" Guidelines.

3.2 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 must take into account the service user's own beliefs and opinions about their mental health issues and include any advance decision and Lasting Power of Attorney.

3.3 A service user's personal details must be collected at assessment (e.g. marital status, address, GP, family and household composition, parenting responsibilities, carer, next of kin, employment status, benefits, housing, ethnicity etc).

3.4 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 must 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").*

3.5 A full assessment of need must cover the aspects outlined in Table 3 below and must identify where specific support and further specialist assessments are required:

**Table 3: Aspects to be considered in the comprehensive assessment**

- 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)*
- Psychological functioning
- Psychiatric functioning
- 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. If a substantial or critical need for social care funding is established under the Eligibility Criteria this must trigger a discussion with the service user about their entitlement to a more detailed social care assessment using the Supported Self-Assessment for the purposes of obtaining a personal budget to meet their needs (1990 Community Care Act)
- 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 must 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
- Service user's own caring responsibilities

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

3.7 All service users and/or their carers must be given a crisis card. These cards are for service users and their carers only and must not be handed out to members of the public.

3.8 If following the assessment, the person is deemed not to require any further intervention from the Trust they must be discharged back to the referrer/GP with a copy of the assessment outcome and advice on re-direction or signposting to other services if required.

## 4. **Risk Assessment**

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

4.1 Risk assessment is an essential and on-going part of the CPA and Standard care 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.

4.2 Risk assessments must 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.

4.3 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.

4.4 Risk assessments must include an estimation of the degree of risk presented in respect of:

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

4.5 A service user's significant key life events must be identified as part of the crisis plan.

4.6 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 or "standard care" care plan.

4.7 The assessment of risk is a continuous and on-going process which must be considered on an individual basis. It is a 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 the risk implications to self and others and address accordingly through the care plan.

4.8 Risk must be reviewed at each 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. Mental Health Care Clustering and HoNOS

5.1 Following assessment all service users accepted for treatment must be clustered using the Mental Health Clustering Tool (MHCT) or the equivalent for children services (HoNOSCA).

5.2 People's needs change over time and over the course of their treatment. It is therefore essential that service users are not only assessed and clustered at point of referral, but also reassessed and re-clustered periodically and within the timeframes outlined in the table below. This will equate to assessing and clustering people at:

- the point of referral
- reviews
- transfer
- periods of crisis and admission
- discharge from the Trust

5.3 Service users within cluster 1, 2, 3, 14, 15 must have a review of their care (whether they are CPA or Non-CPA) within the cluster review period indicated in table 4 below. .

**Table 4**

| Cluster | Mental Health Clusters | Minimum frequency of reviews |
|---|---|---|
| Cluster 1 | Common Mental Health Problems (low severity) | 12 weeks |
| Cluster 2 | Common Mental Health Problems | 15 weeks |
| Cluster 3 | Non-Psychotic (Moderate Severity) | 16 weeks |
| Cluster 4 | Non-Psychotic (Severe) | 26 weeks |
| Cluster 5 | Non-Psychotic (very severe) | 26 weeks |
| Cluster 6 | Non-Psychotic Disorders of overvalued Ideas | 26 weeks |
| Cluster 7 | Enduring Non-Psychotic Disorders (high disability) | 52 weeks |
| Cluster 8 | Non-Psychotic Chaotic and Challenging Disorders | 52 weeks |
| Cluster 9 | Blank Cluster | N/A |
| Cluster 10 | First Episode in Psychosis | 52 weeks |
| Cluster 11 | On-going Recurrent Psychosis (low symptoms) | 52 weeks |
| Cluster 12 | On-going or Recurrent Psychosis (high disability) | 52 weeks |
| Cluster 13 | On-going or Recurrent Psychosis (high symptom & disability) | 52 weeks |
| Cluster 14 | Psychotic Crisis | 4 weeks |
| Cluster 15 | Severe Psychotic Depression | 4 weeks |
| Cluster 16 | Dual Diagnosis | 26 weeks |
| Cluster 17 | Psychosis and Affective Disorder Difficult to Engage | 26 weeks |
| Cluster 18 | Cognitive impairment (low need) | 52 weeks |
| Cluster 19 | Cognitive impairment or Dementia Complicated (Moderate need) | 26 weeks |
| Cluster 20 | Cognitive impairment or Dementia Complicated (High need) | 26 weeks |
| Cluster 21 | Cognitive impairment or Dementia (High physical or engagement needs) | 26 weeks |

## 6 Responsibilities of the care coordinator/lead professional

6.1 The care coordinator/lead professional will be expected to demonstrate that they are competent to deliver a range of functions, specific to their role, some of these tasks are outlined in table 5 below:

**Table 5**

| **Examples of responsibilities of the care coordinator/lead professional** |
|---|
| **Comprehensive needs assessment**<br>• Assess individuals' mental health and related needs.<br>• Identify individuals' strengths.<br>• Identify potential mental health needs and related issues.<br>• Identify the physical health needs of individuals with mental health needs.<br>• Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes of care for individuals taking full account of individuals' recovery plans. |
| **Risk assessment and management**<br>• Develop risk management plans to support individual's independence and daily living within their home.<br>• Assess individuals' needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others.<br>• Assess the need for intervention and present assessments of individuals' needs and related risks. |
| **Crisis planning and management**<br>• Work with families, carers and individuals during times of crisis.<br>• Respond to crisis situations. |
| **Assessing and responding to carers' needs**<br>• Work in collaboration with carers in the caring role.<br>• Assess the needs of carers and families of individuals with mental health needs.<br>• Develop, implement and review programmes of support for carers and families.<br>• Empower families, carers and others to support individuals with mental health needs. |
| **Care planning and review**<br>• Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances taking full account of the personalisation agenda and individualised budgets.<br>• Regularly review commissioned services to ensure assessed needs are consistently met.<br>• Plan and review the effectiveness of therapeutic interventions and recovery strategies with individuals with mental health needs.<br>• Implement, monitor and evaluate therapeutic interventions within an overall care programme. |
| **Transfer of care and discharge**<br>• Plan and implement transfer of care and discharge with individuals who have a long term condition and their carers.<br>• Work with others to facilitate the transfer of individuals between agencies or services. |

## 7 Refocusing the role of the care coordinator

7.1 Central to the revised CPA guidance was the intention to remove unnecessary bureaucracy; the introduction of Non CPA (standard care) level in itself will not reduce the administrative or bureaucratic workload. This requires a more significant change in practice with some of the non-clinical aspects of the role being undertaken by other staff within the multidisciplinary teams.

7.2 Some of the roles may be undertaken by other team members to free up more clinical time. These are outlined in appendix 3. There are potentially three groups of staff who can assist in taking on these roles namely, the associate practitioner, support time and recovery workers and administrator/clerical staff.

7.3 Professional accountability cannot be delegated and professionals will remain accountable for the care they deliver and manage. However, it is imperative that resources are used more efficiently and the skills of other colleagues within the Multidisciplinary team are used effectively to help them to fulfil either the lead professional or the care coordinator's role adequately.

7.4 This updated policy re-establishes the expectation that all qualified clinicians must act as care coordinator or lead professional whenever they are the clinicians offering the main treatment or clinical intervention.

7.5 *W*here a service user is seeing a worker from more than one team within the Trust 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.)*

7.6 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 the Trust and thus requires a change of care co-ordinator, this must take place as soon as possible and in accordance with 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 Area Directors must intervene and resolve regarding appointing a care co-ordinator.

## 8 Internal Referrals within the Trust

8.1 An internal referral to another team or service within the Trust must be made using the Trust's electronic clinical system.

8.2 When an internal referral is made, it is imperative that there is a comprehensive assessment and an up-to-date risk assessment available.

## 9 The CPA Care Plan (for those on CPA)

9.1 Once the comprehensive 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.

9.2 The care plan must be written in a jargon-free way and must 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

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

9.4 Care plans are available in easy read format for Learning disability and CAMHS service users.

9.5 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.

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

## 10 Non CPA (Standard Care) Care Plan

10.1 The care plan must be created collaboratively with the service user (and carers if appropriate) and must provide a summary of how the needs identified from assessment will be met.

10.2 It must provide a clear description of the agreed care and treatment, including any arrangements for managing crisis, promoting choice through Individual Budgets and any form of Advance Planning or Self-Directed Care where applicable.

10.3 A clinician's letter must be used to communicate the plan of care or treatment and this must be written in a format that the service user best understands and which also enables understanding by any carer and/or others involved in the person's care.

10.4 There is an approved Trust template care plan letter available on the Trust's clinical record for the non-CPA (standard care). This letter outlines the following::

- The date of assessment and care planning
- A summary of the assessment, including any safety issues
- A description of the care or treatment, including actions, responsibilities and timescales (what, when, how)
- Contact details for the service, including a 24 hour contact number
- The date for the next planned review
- Identification of the Lead Professional
- Details of who is receiving a copy of the letter
- Identified needs that cannot be met through current service provision must be recorded as unmet needs.

10.5 The contents of the non-CPA (standard care) care plan must be agreed with the service user, and where appropriate the carer, the GP and all others involved.

## 11 Specialist Care Plans

11.1 When a range of services are identified in the overarching care plan, each service in partnership with the service user must draft and agree a specialist care plan which outlines the specific care a person, team or service will deliver based on identified needs (in practice there could be several specialist care plans, e.g. day care, inpatient setting, drug and alcohol team, psychology, etc.).

11.2 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

11.3 Specialist care plans must 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.

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

11.5 All those involved with specialist care plans must ensure that progress is communicated to the care coordinator/lead professional.

## 12 Contingency Plans

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

12.2 The contingency plan must include:

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

12.3 If a service user is a parent, the contingency plan must 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. Likewise if the service user is a child the contingency plans needs to be agreed with parents.

## 13 Crisis Plans

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

13.2 Crisis plans must 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

13.3 Crisis plans must ensure that all service users know how to contact the service out of hours. Carers, family members and significant others must know who to

contact when a crisis occurs at all times. Crisis cards are available for this purpose.

## 14 Care Reviews for those on CPA and Non-CPA

14.1 At the time the care plan is produced, the date of the review must be planned with the service user, which must be within the maximum timescale of the mental health care cluster review period.

14.2 The purpose of a 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.
- Whether on-going support from CPA is required
- The SDS social care plan and include information on progress made from proposed outcomes set out at the last review, on how the plan is working and whether a re-assessment for increased or decreased funding is required.

14.3 A 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/lead professional or when the service user is being discharged from the Trust's service.

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

14.5 The responsibility for arranging the review lies with the care co-ordinator/lead professional but can be delegated to the team administrative staff. The date, time and venue of the review must 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.

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

14.7 The consideration for review must include completion and recording of any required outcome measures that inform the plans for the service user's care, service development and Trust reporting requirements.

14.8 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.

14.9 A service user's personal details (e.g. 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 must 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).*

14.10 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 Trust & SEPT Section 117 Procedure for details on discharging from Section 117)* .

14.11 Any service users subject to a Supervised Community Treatment (SCT) under the Mental Health Act must have their SCT reviewed; this must 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).*

14.12 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).* Consideration of a person's mental capacity to manage their financial affairs, to make decisions regarding their health well-being and social care needs, particularly in relation to receiving and managing a personal budget (contact SDS Leads and ECC Essex Guardians for guidance). For children consent is dependent on whether the child is Gillick competent, if not their parent would be the one to seek consent from.

14.13 All attending the review (including the service user/carer) must have an opportunity to give their views. Changes in the care plan, crisis and contingency plan and risk assessment and management must be agreed and recorded, and a new 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.

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

## 15 Multi-Disciplinary Professionals Meeting

15.1 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.

15.2 All professionals meetings must be noted and form part of the service user's record. Decisions made at these meetings must 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.

## 16 Continuity of Care

*(Please refer to the Transfer of Care Policy)*

16.1 When a service user is removed from their normal place of residence (e.g. they go into a residential home, nursing home or hospital or children being placed into out of area foster/local authority care), it remains the responsibility of the care co-ordinator/lead professional to review the quality and appropriateness of their care in accordance with Trust policy and procedure.

16.2 The care co-ordinator/lead professional must 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.

## 17 Transfer between Community & Inpatient Care

*(Please refer to the Transfer of Care Policy)*

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

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

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

17.4 It is the responsibility of the care co-ordinator/lead professional, 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.

17.5 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.

17.6 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.

## 18 Disengagement from the Service

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

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

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

18.3 The action plan will be formulated following discussion within the team and where appropriate family members and/or carers must be involved. The action plan must 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.

18.4 It must 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.

## 19 Discharge from CPA /Non-CPA (Standard Care)

*(Please refer to the Discharge Policy)*

19.1 The decision to discharge a service user from the Trust's service must be made at a Review in partnership with the service user and where appropriate relative/carer.

19.2 The service user is discharged from the Trust's service when:

- The service user no longer requires specialist 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 the Trust's services and is not at risk of harming themselves or others or at risk of exploitation.

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

## 20 Transfer of Care Between Mental Health Organisations

*(Please refer to the Transfer of Service Users Policy)*

20.1 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.

**Appendix 1**

# Documentation & Information

**Documentation**
The current documentation to support CPA & Non-CPA (Standard Care) consists of:

- Personal Details
- Assessment Guidelines
- Referral
- CPA Care Plan
- Care Plan Letter for Non-CPA (Standard Care)
- Specialist Care Plan
- CPA Review
- Review Letter for Non-CPA (Standard Care)
- Carers Assessment
- Service User Self-Assessment

**CPA Forms for CAMHS**
Currently CAMHS have a modified CAMHS specific form for the Personal Details and the Referral.

**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 & Non-CPA (Standard Care) documentation corresponds with that recorded electronically on the Trust's Electronic Patient Record.

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

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

- Care Plan Folders
- CPA Information Leaflets
- Crisis Cards and Crisis Support Leaflets for the 3 localities of the Trust (Mid, North East, West)

**CPA Department**
The CPA Department can be contacted by email on[I/S] for supplies of the above and for further information on CPA.

**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**

## Role of the care coordinator outlining tasks that can be shared

| Clinical role | Case management/ Brokerage | Administration |
|---|---|---|
| Undertaking the following,<br>• Comprehensive needs assessment;<br>• Risk assessment and management;<br>• Crisis planning and management;<br>• Contingency planning<br>• Assessing and responding to carers' needs;<br>• Care planning and review;<br>• Transfer of care or discharge | Responsible for coordinating the care package of the service user by ensuring that the care plan is delivered and reviewed | Ensuring that the service user and all those involved have a copy and all involved understand their responsibilities and agree to them |
| Giving the service user the opportunity to **discuss/prepare** for their CPA review | 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**. | 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 | Monitoring the delivery of the services | Advising the service user that they may bring a friend/person of their choice to their **CPA review** |
| Provide support to the service user irrespective of setting (i.e. inpatient unit, residential care, prison etc.) by ensuring regular contact and monitoring their progress. | Taking responsibility for ensuring **continuity of care** | Identifying if a service user needs the services of an **interpreter** *(see the Translation and Interpreting Policy).* |
| Identifying any **unmet needs** | Ensuring that **carers** and other agencies are involved and consulted where appropriate | |

| Clinical role | Case management/ Brokerage | Administration |
|---|---|---|
| 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 | Communicate any unresolved issues to the appropriate managers | |
| Considering implications of the **Mental Capacity Act** and **Deprivation of Liberty** | Exploring **Self Directed Support,** with eligible persons and carers, with the aim of promoting their independence and **choice.** | |
| 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 must 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 | |
| Monitoring **physical health**. | Considering benefits, housing and employment implications. | |
| 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 | |

## 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 must take place in a CPA review meeting, unless exceptional circumstances prevent this. The service user must be encouraged to register with a GP in the new area as soon as possible.

**2.3** This Review must 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 must 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 must be drawn up.

**2.5** The transferring Care co-ordinator must 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 must document the information has been sent on the patient's file.

**2.7 Timescale**

The receiving district must 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 must 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 must be entered on both the transferring and receiving mental health services databases.

**2.9 Contingency Arrangements**

Arrangements must 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 must 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 must 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 must 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 must be sent immediately to the new district and discussion must take place between the teams at the earliest opportunity for an effective formal handover.

**3.3** The above must 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 must 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 must be clearly recorded.

**4.3** The care co-ordinator must 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 must 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 must 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 must 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 must 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 must 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 must seek advice in their service about making contact with the originating district to cancel the Missing Person's Alert, and must 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 must 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)

**Appendix 5**

## 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
- Care Clustering Policy
- Carers Strategy
- Clinical Risk Management Protocol
- Clinical Recording Systems Policy
- 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)
- Missing Person Procedure
- 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