CPA HANDBOOK

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SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA HANDBOOK

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SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA HANDBOOK

1.0 INTRODUCTION

1.1 This handbook provides clear guidance on the process of implementation of the Care Programme Approach (CPA) for South Essex Partnership University NHS Foundation Trust. The policy and handbook provides a framework for referral, assessment, risk management, review and discharge from CPA. It will reflect the standards of the National Service Framework, five years on (2004), Refocusing the Care Programme Approach, Department of Health 2008, and Person Centred Care Planning, alongside the Ten Essential Shared Capabilities and the Recovery Model and "The Care Standards Handbook" (Care Co-Ordination Association, CCA, formerly Care Programme Approach Association, CPAA) New Edition 2014.

1.2 The policy and Handbook must be applied together with other relevant legislation, (e.g. Mental Health Act, Capacity Act 2005, Section 117 Aftercare,)

1.3 CPA is the prescribed system for delivering care to patients with complex mental health needs. It is a national system which sets out how secondary mental health services help people with mental illnesses and complex needs. The approach is based on an holistic assessment of needs and risks and the development of a CPA care plan aimed at meeting those needs and dealing with the risks identified. This involves appointment of a care co-ordinator with specific responsibilities to co-ordinate care and review the care delivered and to maintain contact with patients.

1.4 Examples of secondary mental health services are;

- Community Mental Health Team/Recovery team
- Assertive Outreach Team
- Early Intervention Teams

1.5 As well as mental health needs it is important physical healthcare is also considered and addressed as part of the assessment and ongoing treatment.

1.6 In addition to the overarching CPA care plan (care programme) other plans of care may be made which will be components of the CPA plan. These may be for example, in response to a period of Hospital admission or a plan agreed by a particular therapist.

1.7 A sample of Good Practice Checklists from Co-Ordination Association, CCA, formerly Care Programme Approach Association, CPAA have been inclined in Appendix 1 as a resource for staff.

2.0 CONSENT, CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

Consent

2.1 Every time a patient sees a clinician or goes into hospital, a record is kept of the care received. Records include information about health, appointments, treatment and test results. This information may be stored on paper or electronically.

2.2 Patient information will automatically be shared and information used to ensure:

- Patients receive the care needed
- Doctors, nurses or other healthcare professionals involved in care have accurate up to date information for assessing health and future care needs
- Patient information is available should another doctor be involved or a patient is referred to a specialist or another part of the NHS
- Staff are able to review the care they provide and make sure it is of the highest standard

2.2 In most cases, a patient has the right to discuss information rights with the Trust including disclosure and withdrawal of consent.

2.3 To enable information is understood regarding consent an information leaflet is available from the Trust "**Your personal information** What you need to know".

2.4 If a patient does not understand or does not have the capacity to understand issues regarding consent this must be discussed with the MDT at the earliest opportunity and actioned.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLs)

2.5 The Mental capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves. It covers people from the age of 16 years old. The act provides for those people who have capacity and want to make plans for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how to go about it.

2.6 Deprivation of liberty only applies to those who have not got capacity to make a decision to consent to their care or treatment. It aims to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

2.7 To ensure every effort is made to enable patients to make decisions for themselves, please refer to Trust policies and procedures, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

3.0 CARE PROGRAMME APPROACH (CPA)

3.1 Values and principles

The Care Standards Handbook 2014 outlines the following principles that must be adhered to:

- The person is at the centre of planning
- The role of families and carers is actively supported
- There is good communication and active partnership
- Services are underpinned by recovery and social inclusion
- Good quality services are fair, open and easy to understand
- Information will be shared, but confidentiality respected
- People will be treated with dignity and respect

3.2 CPA Framework/Structure

CPA is a framework for effective mental health care. It has four main elements which are:-

- A systematic assessment of health and social care needs of people accepted in to specialist mental health services.
- The formulation of a person centred care plan. The care plan is the patients own record of who is supporting them with their recovery needs. The care plan must be person centred and focus on the patient's own strengths and aspirations. It is expected that care plans will address the principles of Social Inclusion, Recovery, dignity, respect, and be mindful of ethnicity and diversity.
- The allocation of a care coordinator.
- A regular review which will reconsider need of care under C.P.A and /or risk, and to adapt and change care plan as necessary.

CPA Structure consists of:

- Assessment
- Care Planning
- Risk
- Review
- Transitions
- Care Co-ordination

3.3 Who should CPA apply to?

The following are characteristics to consider when deciding if the support of CPA is needed.

- Severe mental disorder (including personality disorder) with a 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; adult/child protection eg

- Exploitation e.g. Financial/sexual
- Financial difficulties related to mental illness.
- Disinhibition
- 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, learning disability
- Multiple service provision from different agencies including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/recently detained under the Mental Health Act 1983 or in crisis.
- 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 unwell.
- Significant impairment of function due to mental illness
- Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues.

The following key groups will automatically be considered to require the support of CPA. Those

- Who have parenting responsibilities
- Who have caring responsibilities
- With a dual diagnosis (substance misuse)
- With a history of violence or self harm
- Who are unsettled in their accommodation
- Who are subject to Supervised Community Treatment. (S.C.T.)
- Who are subject to a Community Treatment order, (C.T.O.)
- Who are under a guardianship Order under the Mental Health Act 1983. (Section 7)

Section 7 of the Mental Health Act 1983 is a provision for Guardianship. All patients who are subject to this section should be treated as subject to CPA. This also applies to those patients who are currently liable to detention in hospital for treatment under a Section 3, 37, 47 or 48 of the Mental Health Act 1983, but who are not subject to any Home office restrictions, and who are assessed as presenting a substantial risk of serious harm to self or others, if not receiving suitable aftercare.

If patients within these key groups are not supported through CPA, the decision, which can be made by the MDT MUST be clearly documented in the case records with reasons given.

3.4 Do all parents need CPA?

Not all parents with mental health problems will need CPA. The assessment and thresholds for CPA should take account of the range of adversities experienced by the individual and their family and who require contact with a range of agencies and services e.g. maternity, children's services, young carer's services domestic violence, the criminal justice system etc.

The decision about whether a parent should become subject to CPA should include:

- Respecting people's wishes and needs as individuals including their roles and responsibilities as a parent and child in the family.
- Be built upon a thorough understanding of the developmental needs of children; taking into account the capacities of parents or caregivers to respond appropriately to these needs and the impact of wider family and environmental factors on parenting capacity and children including the impact on parental mental illness.
- Incorporate a public health perspective arising from the potential impact of mental health on parenting, on the child, over time and across generations.
- Be made by staff who are clear about and act upon their responsibilities to safeguard and promote the welfare of children in need, including the contribution of these objectives to strengthen and supplement parental capacities so that children may grow up with their families, wherever possible.

3.5 Common Assessment Framework

The Common Assessment Framework (CAF) is a framework used by all practitioners working with children and young people. It has been developed as a result of government documentation; Every Child Matters and The Children's Act 2004 and introduced as a way of understanding what help children and young people might need so they can do their best at school and in other areas. The aim is to provide the right support at an early stage to help identify those children with additional needs before these escalate into more serious concerns.

The CAF is a tool that staff can use to obtain further information and understanding of the child's circumstances, following which, a multi-agency meeting will be called to plan on going support for the child and their family. The majority of CAF referrals will be undertaken by practitioners of universal services e.g. health visitors, school teachers etc. and a Lead professional will be appointed to co-ordinate the process.

Trust staff may identify children requiring a CAF either by direct contact with a child e.g. CAMHS, or from a patient who is a parent or parent to be. Examples of where a CAF may be used include a child acting as a carer for a parent with mental health problems or a child/young person identified as self harming etc.

For further information and CAF forms, please contact the local authority via the local authority website.

3.6 Children / Younger people and CPA

If children/young people have mental health needs then a referral would be made to Child & Adolescent Mental Health Services (CAMHS) who would conduct further assessment/s and provide necessary care. Many children and young people with straight forward mental health needs will continue to be supported under CAF arrangements with supplementary input from CAMHS. These children and young people will not be covered by the CPA framework.

CPA arrangements will be used for children and young people who are at high risk or who require admission to an inpatient adolescent mental health unit.

Lead Responsibility must always be clear. If the child/young person is outside the CPA framework, the children's service lead professional will be responsible for managing their care, with support from CAMHS workers and other agencies as appropriate.

However,

- If the child/young person is on CPA, the Care Co-ordinator will be from mental health services and will have responsibility for co-ordinating mental health care. They should work closely with the CAF lead professional.
- If young people are transferring from CAMHS to adult services the transition process should start at age 17. Services may agree a period of joint working to ease transition. A clear transition date should be agreed for transfer of lead responsibility, which should pass to adult services no later than the patient's 18th birthday, though joint working may continue beyond this date. The young person's care must be transferred from the CAMHS consultant psychiatrist to the adult consultant psychiatrist.

3.7 What the patient should expect under the care of CPA

The following will be provided to all patients under CPA.

- Support from an identified CPA care coordinator.
- A comprehensive multi disciplinary, multi agency assessment covering the full range of needs and risks.
- An assessment of social care needs against the Fair Access to Care (FACS) eligibility criteria to identify social care needs.
- An offer of Self Directed Support/Individual Budgets to meet identified social care needs.
- A comprehensive formal written personalised care plan: including risk and safety / contingency / crisis plan.
- Ongoing review, formal multi disciplinary, multi agency review of at least every six months but more regularly according to need.
- At review, consideration of an on-going need for CPA support.
- Access to advocacy support

- Carers, (if applicable), identified, listened to, and involved with the plan of care, and informed of their rights to their own assessment.

3.8 Patients who do not require the support of CPA

The following patients would not need CPA support:

- Those patients with more straightforward needs: with the involvement of one agency or no problems with access to other agencies / support.
- Those patients who have recovered from a complex episode, and who are in agreement with treatment and the need for care coordination support is minimised.
- Where assessments of need and risk have determined that the patient does not require the support of CPA, a Lead Professional should be allocated under Non CPA, or care discharged back to primary care.

Support of CPA must NOT be withdrawn without an appropriate review.

4.0 ASSESSMENT

4.1 All patients will have an initial holistic assessment which is periodically reviewed as required. The assessment is the starting point for all patient care.

4.2 A holistic assessment will consider patient needs and risks. To manage this SEPT provides assessment tools which must be used when assessing patients and are available on the intranet and within the electronic record.

4.3 The Care Standards Handbook 2014 outlines that the purpose of assessment is to:

- Provide an initial assessment of needs and where they may be met
- Evaluate the individuals strengths
- Identify the patients goals, aspirations and choices
- Assess the level of risk and safety
- Identify the need for specialist assessment, ie personality disorder, substance misuse and where appropriate refer to relevant service, agency or profession.
- Determine whether intervention from services is appropriate
- Identify the persons need for CPA or other care process can support them
- Establish an information base

4.4 Initial Assessment

The purpose of undertaking a first assessment of a patient's circumstance is to determine what interventions are considered appropriate.

Whichever route a person is referred through, an initial assessment will be completed which will start to determine the need for further treatment and may trigger a referral for allocation of a care coordinator to enable services to be provided under CPA.

Appropriate arrangements must be made at the earliest opportunity to enable communication for example:

- an interpreter to be made available for people whose first language is not English and who have difficulty expressing themselves and communicating their needs clearly.
- support for anyone with a hearing impairment to access services through BSL(British Sign Language) interpreters or hearing loops.

Persons accepted in to the secondary mental health service must receive an assessment of their presenting mental health issues, social care and physical health needs. This assessment must also include a risk assessment. The assessment must take a person centred approach and identify the person's choices and needs.

The purpose of the assessment is to gather information about the referred person; their situation and management of their current mental and physical health needs. This allows a plan to be made for further care and/or where appropriate to refer onwards.

The assessment will also provide the opportunity to identify and record any carer involved.

All of the initial assessments will enable the clinician to decide *whether the patient should be considered for CPA, Non CPA or to refer* back to the original referrer. Patients with complex multiple needs, who require more frequent and intensive interventions and have identified risks must be considered for care under CPA. However, patients who have straightforward needs, are in agreement with treatment regimes and have manageable risks identified will not be subject to CPA. However, all assessments should be discussed within the team's Multi Disciplinary Team Meeting for a final decision to be made.

Where CPA is not deemed necessary, the patient and carer must be given advice, information or be referred to a more appropriate agency for help. It is important to ensure that the referrer and the referred person understand that re-referral to the secondary mental health service is possible if circumstances change or the difficulties cannot be resolved in any other way.

For those patients whose needs fall within CPA, the referral, assessments and any other relevant documentation will be forwarded to the relevant community team for the allocation of a named care co-ordinator.

Upon the appointment of a named care co-ordinator, the practitioner will continue with the assessment including any identified risk. The full assessment where possible should cover the following:-

- Psychiatric/Psychological functioning and mental health needs
- Any needs arising from co-morbidity and co-existing problems
- Physical needs and disability
- Social functioning, social needs and social circumstances
- Personal circumstances including family or other carers

- Child care issues and caring responsibilities
- Experience of violence and abuse
- Housing status and needs
- Financial status and needs
- Leisure, employment, training and education
- Risks to the individual or others
- Current medication
- Informal support network
- Patients views on own strengths and aims
- Carer and family involvement
- Religious and spiritual needs
- Communication, cultural and access needs
- Gender, sexuality and sexual orientation
- Advocacy needs

It is essential that the assessment and subsequent care plan makes use of a Direct Payment/ Self Directed Support, where appropriate, in order to meet the identified social care needs of the patient.

An assessment of carers' needs must be offered to carers where a carer has been identified. A carer will be entitled to an assessment regardless of the amount or type of care they provide. Carers must be informed of their rights and offered an assessment of their own needs within four weeks of allocation.

The assessment process must be on going and will need to be revisited often for review. It must continue to include the thoughts and needs of the patient, and the carer/ significant other, where appropriate.

It is important to involve patients and carers in all areas of CPA to enable a full comprehensive assessment that includes the person's views and where appropriate carers views.

4.5 Assessment of Impact on Children

The impact of an adult's mental health on their children must be identified and recorded. Any concerns, please refer to Safeguarding Children Policy.

5.0 THE CPA CARE COORDINATOR

5.1 The role of the CPA care coordinator 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. If the care co-ordinator is not available through absence a named buddy will continue the role. Care coordinators will be an appropriately qualified mental health professional who is either employed by or seconded to South Essex Partnership University NHS Foundation Trust.

5.2 The Care Standards Handbook 2014 outlined the general responsibilities for care coordinators as:

- Involvement of patients, family and carers, and other partners in the care planning process
- Record and provide information in line with legal and operational requirements
- Take appropriate action to challenge discriminatory information and practice
- Clarify how and when information will be shared, and with whom

5.3 The patient must be allowed a choice of sex of the care co-ordinator, and the service must make all efforts to meet that choice.

5.4 The Care Co-ordinator's role would likely fall to a member of a community team, e.g. Social Worker or Community Psychiatric Nurse.

5.5 The care co-ordinator will ensure that identified mental health care needs are fully met. They are responsible for ensuring all involved professionals, including the patient, carer, and/or significant other, take part in the discussion and decision-making on the following issues:

- The assessment and management of risk
- The provision of identified services
- Discharge of the patient from secondary mental health services back to the care of his/her GP

5.6 The Care Coordinator is responsible for ensuring that patients on their caseload within the community are offered an annual health check and are supported in achieving this. It is important to record how the patient chooses to manage their own ongoing physical health. Please see Trust Policy 'Physical Healthcare' (CLP55).

5.7 All correspondence written about an individual patient must be made available to the named care co-ordinator.

5.8 The care co-ordinator's core functions are to carry out the following:-

- To complete an initial comprehensive needs and risk assessment.
- To develop a crisis management plan.
- To undertake appropriate carer's assessment.
- To ensure personalised care planning in partnership with the patient.
- To ensure ongoing review of needs and risks
- To ensure ongoing monitoring and review of care plan(s).
- Transfer of care, review of CPA need and discharge.

5.9 The role is essentially one of establishing and sustaining a professional relationship with the patient and significant others, co-ordination and communication; assessment; risk management, care planning, review and discharge planning.

5.10 The responsibilities of the care co-ordinator remain in place whatever the setting, especially during the period of in-patient treatment or when the patient

is receiving intensive support from specialist services such as Community teams or residing in a residential/nursing home.

5.11 In meeting the above, the care co-ordinator will be required to undertake the following main duties:-

- A thorough comprehensive assessment of the person's health and social care needs, including an assessment of risk. The assessment must include the needs of any children or vulnerable adults whom are affected by the patients mental illness, and any carer on whom the patient depends in the assessment process.

- Co-ordinating further specialist assessments where necessary and to Co-ordinate the formulation and updating of the personalised care plan, ensuring that the patient and all those involved understand their responsibilities and agree to them. The care plan must be made available to all concerned in the care.

- The CPA Care coordinator together with the patient must formulate a crisis and contingency plan, regularly updating this and circulating as appropriate.

- Care coordinators must maintain regular contact with the patient and monitor their progress, whether at home and / or in hospital and / or in receipt of specialist services. They must make sure that the right services are in place in the right quantities at the right time.

5.12 If a patient, who remains vulnerable, refuses to take part in the CPA process, all steps should be undertaken to find out why, and continued attempts must be made to engage with them.

5.13 Care coordinators must encourage the person to register with a GP and that s/he is involved and informed as necessary. They must organise and ensure that reviews of care take place, and that all those involved in the patients care are told about them, consulted, and informed of any outcomes.

5.14 Those patients who are outside of their catchment area will be supported by a Consultant Psychiatrist as agreed by the Clinical Director for Community Mental Health Services and where appropriate care co-ordination from a Community Mental Health Team (CMHT).

5.15 The care coordinator must ensure that the patient understands the care co-ordinator role, knows how to make contact and who to contact in the care co-ordinator's absence.

5.16 The carer/ significant other, if applicable, must be identified, informed of his/her rights to a Carer's Needs Assessment, and where relevant, the care coordinator must ensure that a needs assessment is undertaken and a Carer Support Plan formulated. If the carer declines a carer's assessment, they

must be given general information and advice, or signposting to services they may require.

5.17 In line with the principles of social inclusion, the care coordinator must provide support and assistance with housing; education; employment and leisure. They must access resources as necessary to help the patient, including the purchase of social care services where appropriate via a Direct Payment.

5.18 The care coordinator must ensure that care plans for patients who are at high risk of suicide include more intensive provision for the first three months after discharge from in-patient care, and 7 day follow up (Policy CLP49) after discharge.

5.19 The care coordinator should encourage the patient to write an Advanced Statement/ Decision when their mental health is considered stable.

5.20 Guardian or Supervisor under the Mental Health Act 1983

The care co-ordinator may also be required take on other roles such as a Guardian or supervisor under the Mental Health Act 1983. This will take place:

- Where there is deterioration in the patients mental health or where problems are arising in the delivery of the care plan, then an urgent review will need to be arranged.
- If significant new risk factors are identified in the course of delivering the care plan the care co-ordinator must consider calling a review meeting as soon as possible so that this can be discussed with everyone concerned.

5.21 CPA Standards

The following standards are expected of all care co-ordinators in relation to those patients on CPA, and individual cases will be audited to ensure standards are being consistently met in practice.

5.21.1 ALL

The care plan must have a record of where and by whom services will be delivered, intended outcomes and timescales.

The care plan must indicate the patients involvement and patient's must be offered the opportunity to sign their Care plans to indicate agreement and offered a copy.

All care plans must have a review date.

A Crisis & Contingency Plan must be completed that clearly sets out what action is required if the patient becomes unwell or their mental health is deteriorating. An individualised record must be made in each of these areas:

- Things that are likely to trigger a crisis
- Signs that the patient is becoming unwell
- Particular difficulties that have arisen in the past
- Who the patient is most responsive to

- How to contact that person
- Previous strategies which have been successful in overcoming crisis

All care plans must be revised and re-issued after their CPA review.

A carers assessment must be offered to anyone caring for, a patient on CPA.

5.21.1 COMMUNITY (including after inpatient discharge)
The care co-ordinator must ensure specific face-to-face follow up takes place within 7 days of a patients discharge from hospital. Please refer to the 7 Day Follow-Up policy (CLP49) for detailed guidance. The community team manager is responsible for ensuring adherence to this policy.

Following discharge from hospital, a review of the care plan must be held within 4 weeks.

6.0 CPA FOR MENTAL HEALTH SERVICES AND OLDER PEOPLE

6.1 Assessment of older people must attend to the broader range of health and social care needs in addition to mental health presenting problems. An older person's health and mental health issues may be highly complex and involve several assessments and be coordinated by several disciplines.

6.2 Good communication between agencies and specialist services is needed as it may be likely that the person is known to more than one service.

6.3 Single Assessment process (SAP) and CPA
Single Assessment Process is the first assessment that is used for older people. Therefore, some older people would have already been assessed under (SAP) and may even have care planned using it before they are assessed for their mental health. Where the person's mental health is not complex and causes no significant risk, their plan of care can be coordinated through their SAP within primary and social care and there may be no need for CPA. However, if the person's mental health and social care package is predominantly related to their mental health, then there will be a requirement of a care coordinator and care should be provided under CPA.

7.0 INPATIENT STAFF

7.1 All patients who are admitted into an acute or older people's inpatient area will be allocated a Named Nurse within 24 hours of admission. He/she must be a registered nurse. For further information regarding responsibilities of the named nurse please see Trust Clinical Guidelines CG10, (Named Nurse Clinical Guidelines).

7.2 The named nurse will inform the relevant Community Mental Health team within 24hours (whether or not the patient admitted is previously known to them). Where the patient is unknown to the Community Mental Health Team,

information will be sent to the relevant team within 3 days for allocation of a Care Coordinator.

7.3 The named nurse is responsible for assessing patient needs and presenting issues and for planning, implementing and evaluating care to meet the needs and presenting issues, in collaboration with the patient, carer and/or significant others, and care coordinator, if one is appointed.

7.4 The named nurse is responsible for ensuring the Care plan is formulated, understood and agreed by the patient, carer and/or significant others with discharge criteria and discharge needs identified. Risk management plan completed and discussed with care coordinator if appointed.

7.5 The named nurse is responsible for coordinating care during the inpatient stay and ensuring that any welfare benefits issues are addressed.

7.6 The named nurse is responsible for arranging the pre discharge meeting, ensuring that all relevant people are invited

7.7 The named nurse is responsible for informing the care co-ordinator of significant changes that may affect either the discharge plan or discharge date

7.8 The care co-ordinator from the community team will retain his/her responsibility for actively overseeing the patients CPA care plan, in close liaison with the named nurse throughout the period of the inpatient stay.

7.9 The named nurse will discuss the patient's in-patient treatment plan with the care co-ordinator within 3 days of admission.

7.10 If the existence of a carer has not previously been identified, the named nurse will identify if there is a carer within 3 days of admission, and record this. Carers will be offered a meeting within 5 days of admission.

7.11 All patients will be offered the opportunity to talk on a 1:1 basis with an identified nurse at least weekly.

7.12 A review meeting will take place as soon after admission as appropriate, within a maximum of 3 weeks.

7.13 Treatment plans will be personalised and based on individual needs and all in-patient treatment plans must have a review date.

7.14 All patients will have a risk management plan in place following the risk assessment.

7.15 A review meeting must be held prior to discharge with the named care co-ordinator.

7.16 Unless the patient objects, carers and relatives must be involved in the planning, decision-making and review of the patients treatment and care.

7.17 All carers must be informed of their right to a carer's assessment prior to the patient's discharge.

7.18 All correspondence to all parties must be copied to the care co-ordinator.

8.0 RISK MANAGEMENT (CPA)

8.1 Risk assessment is an essential and on going part of the Care Programme Approach process. Risk must be clearly documented and reviewed regularly.

8.2 The assessment of risk and the management of risk provides ~~the~~ services the structure to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others.

8.3 Risk is also dynamic, risks are constantly changing in response to circumstances, in particular treatment and management decisions are likely to influence the risks.

8.4 Please refer to the Trust policy on Clinical Risk Assessment for detailed guidance, and for risk assessment tools ratified for use within the trust.

8.5 Where significant risk factors have been identified it would be expected the patient would be placed on CPA and a Risk Profile; a Crisis & Contingency Plan will be completed.

8.6 Risk assessment will include where appropriate (core standards handbook):-

- Self harm, including accidental harm, alcohol, drug or substance misuse issues including any likely interaction between medication and substances, degree of dependence/withdrawal problems, deliberate self harm.
- Suicide, including previous attempts, threats, opportunity, means
- Violence to others, including domestic violence, access to potential victims, specific threats made, history of violence to potential victims, specific threats made, history of violence to family, staff, to other people, degree of harm caused, and any history of sexual assault.
- Other types of risk to other people, including risk to children (accidental), arson, risk to staff other than violence, destruction of property, environmental risks, moving and handling, infection control
- Self neglect including inability to care for self, lack of carer support, falls
- Exploitation by others/vulnerability to abuse such as financial, sexual, physical, bullying and harassment

8.7 In assessing risk the following factors should be considered:

- Detention under the Mental Health Act
- Previous admissions into hospital

- Incidents involving the Criminal Justice system
- Non-compliance with medication
- Reluctance to engage with services
- Failure to attend appointments
- Previous risk taking behaviour
- Substance misuse
- Age
- Gender
- Social Situation ie. Redundancy, Divorce

8.8 In the identification of risk and the management of risk, it is essential to seek information on the patients past behaviour and any previous potential triggers for dangerous behaviour and to consider the information in the context of the patients present circumstances as well as considering what previous strategies have worked. Information from the patient should be supplemented where possible from other sources, e.g. voluntary agencies, other mental health units etc. Where there are carers they should be consulted, involved and kept informed wherever possible.

8.9 Details of the risk assessment and on going risk must be clearly evidenced in the case notes.

9.0 SAFEGUARDING OF ADULTS AND CHILDREN

9.1 Instigation of safeguarding procedures or suspicion of abuse / exploitation in the case of a patient will automatically result in an increase to CPA, regardless of previous CPA status or location of the patient.

9.2 Exploitation and/or abuse suspected or carried out by carers, relatives, staff, members of the public or other patients should all be dealt with under safeguarding procedures. See Trust Policy on Safeguarding Adults.

9.3 All staff have a duty to protect vulnerable adults and a responsibility to inform the Safeguarding lead and Team manager if abuse is disclosed or suspected. Please refer to Safeguarding Adults Policy.

9.4 If a staff member has concerns for a child, please refer to Trust Policy on Safeguarding Children.

9.5 Mental Health Professionals should routinely record the names and dates of birth of any children within the household of a patient, or any children the patient has parental responsibility for or regular contact with and clarify whether the child/ren are a carer for their parent or other siblings due to their parents health issues. If possible, they should also record the names of the children's schools, their GP and any other health or social care involvement within the family.

9.10 At assessment, review or discharge planning, staff should consider if the patient is likely to resume contact with their own child or other children in their network of family and friends.

9.11 If the patient has or may resume contact with children , this should trigger an assessment of whether they are any actual or potential risks to the children , including delusional beliefs involving them and drawing on as many sources of information as possible including concordance to prescribed treatment.

9.12 For further guidance, please refer to Safeguarding Policies found on the Trust Intranet.

9.13 The welfare of the child is paramount and overrides any apparently conflicting needs of the parent.

10.0 PERSON CENTRED CARE PLANNING

10.1 Principles

Person centred care planning is about listening to the patient and finding out what he/she wants and needs. It is about helping patients to think and plan what they want from their life now and in the future, and to enable friends, family and professionals to work together with the person to achieve these goals.

10.1.1 A care plan is unlikely to succeed unless the patient can fully relate it to their own wants, needs, aspirations and goals.

10.1.2 Recovery tools or other assessment or planning tools approved by the Trust are used at the point of planning care and identifying priority areas. Wellness Recovery Plan (WRAP), Advanced Decisions/ Statements, can become a feature of the care plan if agreed.

10.1.3 The care plan is a written record of who is doing what, when, where, how and why, and written using language and terminology that the patient and their family or carer (where appropriate) is able to understand and is comfortable with.

10.1.4 Care plans will only be shared appropriately; this particularly applies to those who have a part in delivering the agreed care. On occasion, it may be necessary to share information without the patient's permission in order to manage risk. This issue should ideally be taken to the Multi Disciplinary team for agreeing this decision first.

10.2 Developing the Care Plan

10.2.1 The care plan must be developed in partnership with the patient and/or their carers, and focus on wellbeing and recovery.

10.2.2 The care plan will identify social care needs that are to be met through social care funding and FACS criteria.

10.2.3 If the patient is subject to Section 117 of the Mental Health Act 1983, then aftercare needs must be noted within the care plan.

10.2.4 The care plan must reflect the needs evidenced at assessment and include any risks identified. It should focus on the patient's strengths and promote their recovery, recognise their diverse needs and preferences. Its purpose is to identify interventions and anticipated outcomes, as well as all actions necessary to achieve the agreed goals. There should be an estimated timescale by which these goals may be achieved or reviewed.

10.2.5 The care plan must be based on the views of all involved in the care of the patient, the patient themselves and their family. If the patient has an Advanced Statement/ decision in place, then copies if the patient agrees must be included within the case file and be identified within the care plan. See Trust Policy 'Advance Decisions and Advanced Statements in Mental Health' CLPG6.

10.2.6 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. The patient will be invited to sign the care plan to indicate that they were involved in its development. However, there is no obligation to sign if they do not wish to and this must not influence how the plan is delivered. If someone does not wish to sign this must be clearly recorded as such.

10.2.7 If the patient disagrees with any part of their care plan this must be acknowledged and included within the plan.

10.2.8 A review date of the Care Plan should be negotiated and agreed with the patient and recorded on the care plan.

10.3 Review

10.3.1 Review is an ongoing process and has the purpose of considering and sharing the following:

- Any progress the patient has made
- Views of the patient, care and professional
- Ways in which the patient's needs may have changed
- Whether the patient continues to or now requires the support of CPA
- Extent to which the care plan, including crisis and contingency plan, requires amending
- Any user led document, such as Advance Statement WRAP, and or the impact it has/could have on the care plan and/or crisis plan
- The need to transfer to another system of care.

10.3.2 The review should be planned in well in advance and the regularity of the review will depend on the needs of the individual. The format of the review will also depend on the amount of support being offered.

10.3.3 Any person involved in the care plan, including the patient or carer can ask for a review to be held at any time and if this is refused the reason must be recorded in the case file.

10.3.4 For those discharged from hospital it is particularly important to review the implementation of the care plan within the first month of discharge from hospital.

10.3.5 All patients on CPA must have their care reviewed no less than once every six months. Any change of circumstances can trigger the need for a review, especially if there is a change to social services funding, a change of care coordinator, a change of care setting or if any risk level changes.

10.3.6 The level of complexity of each case will determine who needs to be present at the CPA review. It may not be practical to have all those individuals involved in the care plan attending a meeting. It is essential that the patients feelings and views are taken into account, as large meetings can be intimidating. However the care co-ordinator should ensure the views of others are represented, e.g., the GP could be contacted by either letter or telephone to be asked for their contribution. The care co-ordinator must be clear about who needs to be involved and who the patient would like to be involved. The patient's wishes about the location and timing of the meeting and the number of people attending should be respected wherever possible.

10.3.7 Where appropriate, carers should also be involved in the review. If they are unable to attend in person they will be invited to contribute in some other way.

10.3.8 It is essential that the care co-ordinator prepares and plans for the review by seeking prior to the review the views of all those involved in the care plan. The individual patient where possible must be involved in forthcoming reviews and helped to prepare for them.

10.3.9 The patient and their carer (as appropriate) should be informed if there is a change in their diagnosis and in the treatment they need to receive. All other changes in the care plan must be communicated to all parties as appropriate.

10.3.10 At each review the date of the next care plan review must be set and the patient informed, including all parties involved in the care plan.

10.3.11 Section 117 of the mental Health Act 1983 status should be discussed, considered and documented at each C.P.A. review. Further

information and guidance regarding Section 117 is available in a separate publication from local Social Care Services.

10.3.12 Copies of the review documentation must be circulated to all those involved in the care plan, including the patient and where appropriate the carer(s). At each review the care plan must be revised and copies issued if regardless of whether changes have been made or not.

10.3.13 Where transfer of care co-ordination responsibilities is required, the care coordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team / service.

11.0 HOSPITAL ADMISSION AND DISCHARGE

CPA for Inpatients

11.1 Admission to hospital is a significant characteristic for CPA. Therefore, all inpatients will be subject to CPA and will require a CPA identified care coordinator regardless of their CPA status before admission.

11.2 To ensure continuity of care and the provision of a full and comprehensive assessment of needs the following must take place within the in-patient area for all patients:

- Allocation of a named nurse as per Trust Named Nurse Policy.
- Documentation for In-patient purposes completed upon admission and continually updated and regularly reviewed as per Named Nurse Policy.
- In-patient documentation must include continually updated ward based risk assessments and in-patient treatment plans. All appropriate service specific records must be maintained as agreed.
- Initial assessment and treatment plans must be completed within 72 hours of admission.
- The existence of a carer must be identified within 3 days of the patient's admission.

11.3 The named nurse will make available the opportunity for regular meetings between themselves and the patient to discuss and consider where possible, collaborative treatment plans treatment plans and options in accordance with the named Nurse Policy.

11.4 The named nurse will ensure that the patient and if appropriate their relatives and / or carers are involved in all aspects of care from admission to discharge.

11.5 The named nurse and care co-ordinators will maintain open communication to facilitate full assessments of need and appropriate treatment plans.

11.6 If it becomes necessary for a patient to have a period of in-patient care the relevant community team and care co-ordinator will maintain contact with the

patient throughout. Care Services Improvement partnership (CSIP) *'A Positive Outlook : A good practice guide to improve discharge from in-patient health care' 2007* emphasises a whole systems approach to care planning and the need for liaison between inpatient and community team.

11.7 The named nurse will jointly work with the named care coordinator during the patient's stay in hospital.

11.8 All persons discharged from hospital must be seen and spoken to as below within one week following discharge by the care co-ordinator or, if necessary, by their representative. A follow up telephone call to carer within 7 days of discharge will also be made.

11.9 The points to be raised in the '7 day follow-up' discussion are as follows:

1. How are you feeling?
2. Have you got your medication?
3. Have you got a copy of your care plan?
4. Your care co-ordinator is due to see you on --/--
5. Do you know when your next appointment to see your
6. Consultant is for?
7. Is there anything else we can do for you?
8. Does your carer need any support (if applicable)

11.10 After discharge from hospital the implementation of the care plan must be reviewed to consider whether the person needs to remain on CPA.

11.11 Care plans for patients with severe mental illness who are at high risk of suicide must include more intensive provision after discharge from inpatient care for the first three months.

11.12 For further information regarding the transfer of care of an inpatient to the Community Mental health Team, please see trust policy 'Transfer Procedure For Patients Within and From Mental Health, Learning Disability and Community Health Care Services (CLPG24a).

Out of Area Patients

11.13 When a patient is admitted to an inpatient setting from outside of the catchment area the same principles of CPA will be applied as outlined in this handbook.

11.14 Those patients who are outside of their catchment area will be supported by a Consultant Psychiatrist and where appropriate care co-ordination from a Community Mental Health Team (CMHT).

12.0 PATIENT INVOLVEMENT

Advocacy

12.1 Advocacy is communicating on behalf of another person to secure rights, meet needs or support people to make informed choices. Advocacy makes sure that a person's voice is heard and that their needs are met with available services. They ensure that a patient knows their rights and have the correct information to make informed choices.

12.2 Information should be given to the patient soon after referral / admission into hospital or on inclusion onto CPA.

12.3 Advocates, whether paid or unpaid have a role in representing patients or helping them to represent themselves. They should be encouraged to be involved in CPA if the patient requests this.

Direct payments for Patient's

12.4 Direct payments and personal budgets are central to the Government's Agenda upon personalising the health and social care fund. (Putting People First 2007, Draft Social care Bill 2012). Their aim is to give patients and carers greater choice and control over the care and support they receive. All local authorities now offer personal budgets in lieu of community care services based on an agreed needs led assessment to meet eligible needs.

12.5 Direct payments for patient's can be used to purchase personal assistants in order to meet the social care needs, but there are many other uses as long as the identified needs are of a social care nature and that they meet the criteria according the Local Authority Fair Access to Care Services (FACS).

12.6 Everyone to whom Direct payments are made, has by law, to be considered 'willing and able' to manage them, with assistance if necessary. This means that they must be able to direct both the services they receive and the administration of them. People who receive a Direct Payment are accountable for the way the money is spent.

12.7 In common with other services offered by the Local Authority, councils ask recipients of direct payments /personal budgets to make an assessed financial contribution to the cost of their care package. However, charging restrictions apply for after care services provided under Section 117 of the Mental Health Act 1983.

12.8 The Government is currently exploring the feasibility of Personal Health Budgets. A personal Health Budget is an allocation of NHS funding given to a patient after an assessment. The individual then personally controls that sum of money and uses it to buy services to meet their health needs. Pilots have

been completed and it is expected that this funding stream will be rolled out initially to services subject to Continuing Health care funding in 2013.

12.9 For further details please refer to your Local Authority guidelines for Direct Payments. Further information is available on the Department of Health website. www.dh.gov.uk

13.0 DISENGAGEMENT FROM SERVICES

Disengagement

13.1 All incidents where patients disengage from services must automatically trigger a review of care including a review of the contingency plan. If the patient has disengaged and it has not been possible to re establish contact, this must be discussed in the MDT meeting. The MDT should decide if/where it is appropriate to refer onto depending on the current circumstances.

13.2 After efforts have been made to find out why the patient has failed to attend an arranged appointment and the care coordinator still cannot contact the patient, then they must inform the persons involved in the care plan and risk management plan which includes the family/carer, G.P. and the Consultant Psychiatrist.
Where risks are identified and all efforts to trace the patient have been attempted, then the police should be called to obtain a welfare check.

13.3 For further information, please refer to Disengaging or Non Concordant with Current Prescribed Treatment Policy.

Patient Declining Care.

13.4 If at any point the patient declines care under CPA, which was initially agreed in the care plan, the Care Coordinator /key Worker must give this matter their urgent attention.

13.5 If the patient is refusing a certain aspect of their care, then this must be discussed with them and assessed as to whether their refusal presents any further risk management within their care. The outcome of this must be discussed with the MDT. This should be read in conjunction with Procedure for Community Mental Health Patient Disengaging or Non Concordant with Current Prescribed Treatment.

Self-discharge from an Acute Treatment / Inpatient Unit for patients not detained under the Mental Health Act 1983.

13.6 If a patient decides to discharge themselves from an Acute Treatment / Inpatient setting, a clinical risk assessment should be completed based on the most up to date information. See Clinical Risk and Management Policy.

13.7 Where a patient has refused to engage with his/her treatment plan and thus chooses to leave the ward/unit, the staff member must inform the Duty doctor and the nurse in charge immediately. Senior staff then will decide whether the patient's refusal to comply with their treatment plan or desire to leave the

ward/unit will result in the deterioration of the patient or a risk to themselves or others. They will then decide as to whether it is appropriate to assess the patient under the Mental Health Act 1983.

13.8 If it is decided that the patient is not detainable under the Mental Health Act 1983, and the patient decides to discharge themselves against medical advice, then the relevant Community Mental Health team must be informed, and a copy of the risk assessment faxed to them.

13.9 A 'Release from Responsibility Letter' must be completed by ward staff and copied to the patient's notes.

13.10 With consent from the patient, family members/carers must be informed of the self discharge.

13.11 If the patient may pose a risk to family members, and or carers, then staff have a duty to inform them irrespective of consent obtained from the patient.

14.0 CARERS

Supporting Carers under CPA and Non CPA

14.1 Health and social care is provided in partnership with patients, their carers and relatives. Carers can form a vital part of the support required to aid a persons recovery and wellbeing. However, caring for another can have an impact on the health, wellbeing, finance, leisure and employment opportunities of the carer.

14.2 It is important that all staff recognises the value of carers and see them as partners in care.

14.3 Evidence suggests that carers themselves are a high risk group in terms of their health, as accumulative stress associated with the caring role, can impact on their physical and mental health.

14.4 It is therefore important that staff identify carers as early as possible within the patients care pathway, as early identification provides carers with an early opportunity to access support, and minimise the impact on their own health and relationships.

14.5 A revised and expanded National Carers Strategy was published on 10th June 2008. This cross-governmental Strategy updates the previous Prime Minister's Carers Strategy (1999) and highlights the importance of all agencies working together to improve the lives of Carers.

Who is a Carer?

14.6 The Care Act 2014 states:
A carer is someone who helps another person, usually a relative or friend, in their day to day life. This is not the same as someone who provides care

professionally or through a voluntary organisation.

14.7 A carer may be a sole carer or part of a wider caring network and there may be more than one carer within the social network.

14.8 Carers come from all walks of life – all cultures and religions. It is important to recognise that carers can be of any age. Some are only 9 years of age, while others are nearing 90. Most carers live with the cared for person, although some may live nearby or a distance away.

14.9 Some carers provide full time care, while others try and juggle both a job and the caring role.

Young Carers

14.10 A young carer is a child or young person whose life is affected by caring for someone with a physical or learning disability, or who has mental health problems, or/and has drugs alcohol problems, over and above “just helping out”. Young carers have caring responsibilities that would normally be expected only of an adult.

14.11 Staff must consider the use of the Common Assessment Framework and Children Act, 2004 where appropriate.

Black and Ethnic Minority Carers

14.12 Practitioners must at all times be sensitive to working with carers from different cultures; in particular circumstances the idea of ‘carers’ is sometimes better replaced with an appreciation of the role of kinship networks and extended families (DOH, 2002:19).

14.13 Interpretation and translation service should be accessible for carers where the "first language” is not English.

Early Identification of Carers

14.14 Carers should be identified as early on in the care pathway to ensure that carers are provided with appropriate information and support to help them sustain their caring role.

Carers Needs Assessments:

14.15 The Care Act 2014 gives carer’s a right to assessment for support, where the carer appears to have needs. This means carers are able to have an assessment, comparable to the right of the people they care for. The Carers (Equal Opportunities) Act 2004; The Carers (Recognition and Services) Act 1995; The Carers and Disabled Children Act 2000, including the National Service Framework for Mental Health advises carers to have an assessment of their caring, physical and mental health needs and their ability to continue to care.

14.16 The term ‘substantial and regular’ is not defined in statutory guidance. The guideline that the practitioner should apply will relate to the impact of the

caring role on the individual carer. Questions to be addressed will relate to the sustainability of the caring role, risk of caring role or significant relationships breaking down and the carer's capacity/ ability to have a life alongside caring.

14.17 An assessment of the carer's needs can be done either separately, if preferred, or jointly with the patient assessment. The care coordinator has overall responsibility to ensure that carers assessments are offered, and will be responsible for undertaking the assessment. In situation where there are clear tensions between the carer and the patient, it may be appropriate to use different assessors to ensure impartiality and to ensure that each person's needs are equally understood and addressed.

14.18 Any carer providing care to a patient who is subject to the Care Programme Approach must be offered an assessment of their needs in relation to their role as a carer.

14.19 A carer's assessment should include

- Current support provided by the carer or others for the patient
- Current support for the carer
- Carer's views

14.20 When identifying a carer's needs the following must be considered: financial / benefits advice; domestic or personal assistance; respite; the need for a break from the caring role; emotional support; accommodation; social and recreational; employment; life long learning; leisure; health; advocacy; transport and information about the mental health needs of the patient.

Role of Carer Support Workers:

14.21 Where carers support workers posts are funded, they will assist the care co-ordinators in supporting carers. Support Workers provide focussed short term intervention and assist with the following:

- Assisting carers to complete a carer Self-assessment
- Compiling Carer Support plans
- Provide carers with information, advice, education and signposting to relevant services
- Assist care coordinators to access Carer Direct Payments
- Review Carer Support Plans
- Short-term emotional support
- Development carer support networks.

Carer Support Plans

14.22 The Carer's Support Plan should include:

- Information about the mental health needs of the patient for whom they are caring, including information about medication and any side effects.
- Provision of advice on how to cope at critical times.
- How to recognise signs of a relapse and information on what to do and who to contact in a crisis.

- Information on services to meet their own mental and physical health needs, and how it will be provided.
- How to get information and advice on income, housing, educational and employment matters.
- Arrangements for social support, including access to carer's support groups
- Interventions to develop or build on carers own coping strategies, and enable them to self-manage
- Arrangements to enable a break from caring.

Review of Carer Support:
The Carers Support Plan must be reviewed on an annual basis or if there is a change in circumstances. The relevant CPA Carers Review Form must be completed.

Involving Carers
Wherever possible, carers should be consulted during the assessment process of the patient, care planning and at reviews. Generally such consultation will take place with the consent of the patient. However, if there is a significant risk to the patient or to the carer then contact may be made without the patient's agreement.

Carers should also be given information about medication and other treatments; support arrangements; risk management strategies and crisis and contingency plans. Even if the patient does not want their carer(s) to be actively involved in their care programme, it is important for them to know who the care co-ordinator is, where he or she is based and how to access services in a crisis or outside office hours.

15.0 TRANSFER OF CARE COORDINATION RESPONSIBILITES UNDER CPA.

15.1 **From one Community Mental Health team to another**
Any decision to transfer the care of a patient between workers/services within the Trust will occur as part of a review and in line with any agreed transfer protocols.

The Care Coordinator must contact the receiving team/service and after ~~the~~ transfer has been agreed, pass on all relevant CPA documentation to the new team/service. There must be a formal handover between teams.

The transferring Care Coordinator remains responsible for the care of the patient until the transfer has been formally accepted.

The receiving team/service are responsible for ensuring that allocation to a new care Coordinator takes place no later than one month after the transfer has been agreed.

15.2 **From CMHT to Home Treatment Team**

When referring a patient from the CMHT to Home Treatment Team, the Care Coordinator must firstly speak with a member of the Home Treatment Team, who must verbally accept the patient in principle. The Care Coordinator then needs to send the patients updated Core and Risk assessment to the team.

For Further information, please see 'Discharge Procedure'.

16.0 SECTION 117 OF THE MENTAL HEALTH ACT 1983 STATUTORY AFTERCARE

16.1 The Care Programme Approach is applicable to all patients who have been discharged from hospital subject to Section 117 of the Mental health Act aftercare.

16.2 Patients subject to Section 117 cannot be charged for services which are provided for the purpose of statutory aftercare.

16.3 All patients who are detained in hospital under Section 3, 37, 47 and 48 of the Mental Health Act 1983 are subject to Section 117. This includes patients who have been formally detained and become informal for the remainder of their admission. The care arrangements for patients who are subject to Section 117 aftercare will come under CPA.

16.4 Further guidance and the procedure to be followed is available in a separate publication from local Social Care Services.

17.0 CHANGE IN CPA STATUS

17.1 Patients who are accepted under the Community Mental Health teams following their initial assessment are either placed on CPA or non CPA. However, this status may be changed at any time during the patients involvement within the team or at CPA review. This is dependent on any changes to their mental health or identified needs.

17.2 Where there is evidence of a change in mental health or need is identified, a CPA review should be arranged, and in consultation with the patient care and/or significant other, a decision should be reached as to the CPA status. All decisions regarding CPA status must be fully documented and explained to the patient, carer and/or significant other.

18.0 DISCHARGE FROM CPA

18.1 At every formal review, there will be consideration as to whether the patient still needs the support provided by CPA. It is important that when it is deemed appropriate to discharge the patient from CPA that everyone involved in the care will be informed of this decision. All relevant parties such as the patient, carers, significant others, GP's and any others involved will be sent a

discharge notification letter within 3 days by the care coordinator of confirmation that the discharge has taken place.

18.2 Prior to discharge, a thorough risk assessment with full patient and carer involvement must be undertaken. A written record of the discussion and decision will be documented in the patients records.

18.3 The support of CPA will not be withdrawn without:-

- An appropriate handover (To lead professional or GP)
- Exchange of information with all concerned including carers.
- Plans for review, support and follow up as appropriate.
- A clear statement about the action to take and who to contact in the event of relapse or change.
- Patients will be encouraged to write an Advanced Statement/ Decision; giving guidance on how they would prefer to be helped should they need specialist mental health services in the future.

N.B. Should a crisis or relapse occur for the patient within six months of closure, the receiving team should make arrangements for supporting the patient. If the patient returns to secondary mental health services for assistance within six months then they will be accepted back immediately for assessment, care planning and review to the community team's caseload.

Please read in conjunction with 'Discharge Procedure for Mental Health, learning disability and Community Health care Services.

19.0 NON CPA

19.1 Principles of Non CPA

In accordance with new guidance from Department of Health 'Refocusing the Care Programme Approach 2008, here is only one level of CPA within the Trust. Those people who do not have the characteristics of CPA will be considered Non – CPA.

Therefore, SEPT adopts a Non CPA approach for caring and treatment for patients who have straightforward support needs and do not have higher risks and complex clinical symptoms or care management requiring multi agency intervention with care coordination.

For patients who only have contact with a Consultant Psychiatrist, then their care plan of care and risk management will be contained within their outpatient letter.

19.2 Who Should Non CPA Apply To?

Please see section 4.0.

19.3 What patients should expect under Non CPA

For those patients who do not require the support of CPA, they will be allocated a key worker and be covered under non CPA.

The patient will have a full assessment of their needs, including a risk assessment.

The key worker, in collaboration with the patient, care and/or significant other will formulate a plan of care which is recovery focused. This will be conveyed in a written letter.

The key worker will act as a point of contact to the patient and their carer, and signpost them to other relevant services which may be applicable.

The option of Self Directed Support should be offered as a way of meeting care needs at every assessment and review.

Care plans should be reviewed as necessary, but no longer than annually. On going consideration for need of CPA if risk or need increases.

19.4 The Key Worker

The lead professional, (key worker) will take the lead responsibility for the patients treatment and care when the person has been assessed as not needing the support of CPA.

The Key Worker will ensure that the assessment of needs and risk is ongoing and making sure that all care prescribed is delivered. They will be the point of contact for the patient, carer and/or significant other and review the patient's progress on a regular basis. They will encourage the patient to consider Self Directed Support packages, personal budgets and Advanced Decision/Statement.

The Key Worker will maintain liaison with others involved in the patient's care and continue to complete records in line with trust and professional standards.

The Key Worker is responsible for ensuring that patients on their caseload within the community are offered an annual health check and are supported in achieving this. Please see Trust Policy 'Physical Healthcare' (CLP55).

19.5 Assessment

Every person referred to secondary mental health services will receive an assessment of their physical, social and mental health needs. Please see section 4.0.

19.6 Risk assessment

Risk assessments must be an integral part of all assessments and will be a continuous process as with all other forms of assessment. The risk management plan must be completed and form part of the care plan.

For patients who only have contact with a Consultant Psychiatrist, their risk management plan will be contained within their outpatient letter.

Any concerns regarding risk for a patient on Non CPA should be discussed at the Multi Disciplinary Meeting for further advice, possible outpatient appointment and review of CPA status.

19.7 Care Planning including review.

The Non CPA Care Plan will be developed by the key Worker, patient and any carers and/or significant other. It will focus on the patient's strengths, aspirations, promote recovery and recognise diverse needs arising from cultural and ethnic background, gender, sexuality and any physical disability or health problem.

Care plans will be recorded in the form of a letter stating the care to be provided.

The Care Plan will be reviewed at least annually with the patient and carer and/or significant other. The review should include consideration of whether the needs of the patient have changed, what service has been beneficial or inappropriate. The review will continue by considering whether any service should be changed, any relapse has occurred or whether the patient needs to be discharged from services or needs to be placed on CPA. These decisions must be discussed with the Multi Disciplinary team. The patient, carer, and/or significant other and the GP should be informed of the outcome of the review.

19.8 Discharge

Discharge will normally be agreed at the appropriate time such as at the end of a course of treatment or when treatment is no longer required. When discharge occurs following a final review, this will be recorded in the form of a letter to the patient and to the GP.

Discharge from the services can also occur when a person decides that they no longer require the service offered. The clinician/ Multi Disciplinary Team will consider the circumstances, and where necessary consider taking other actions. If no action is required, then the patient will be discharged and the clinician will write to the patient and the GP. The patient will be given information regarding how to access services in the future if their needs change and the GP will be given advice on referring the patient if needed.

Please read in conjunction with 'Discharge Procedure for Mental Health, learning disability and Community Health care Services.

19.9 Change in Status

Please see Section 13

20.0 DOCUMENTATION

20.1 Records Management

Department of Health Records Management Codes of Practice 2006 provides guidance as to the required standards of practice in the management of

records, and is based on current legal requirements and professional best practice.

Risk Management Standards, (RMS) require the trust to have a comprehensive system for the completion, use, storage and retrieval of health records.

For further information, please see Records Management Policy.

20.2 Electronic Records

The use of Information Technology is ever growing within the NHS and CPA paperwork is now available electronically on the Trust's electronic records system.

For management, standards, security and maintenance of electronic records, please see Records Management Policy.

20.3 Electronic CPA. (ECPA)

ECPA paperwork includes the following documents:-

- Assessment.
- Care Plan
- Risk Profile
- Pre Review
- Review
- Continuation Sheet
- Patient Information Form (PiF)
- FACS form

Staff must use the electronic documents, they should be completed electronically and should not be printed and completed by hand. Currently there are two types of patient record in the Trust "electronic record" and "paper record".

Where a patient has a paper record the electronic documents must be printed before the 'Complete' button is pressed. The printed documents must be kept within the patient's case file.

Where a patient has an electronic record the electronic documents must be printed before the 'Complete' button is pressed and then scanned into the patients electronic health record.

The only paper documents that are still required are the 'Discharge Form' and the Non CPA Care Plan.

All documentation must be accurate and timely and adhere to confidentiality requirements and records management guidelines.

For further information please see Trust Policy 'Records Management' CP9. Please see Appendix 1 for Flowchart of Electronic Documents.

21.0 CPA AND EQUALITY AND DIVERSITY

21.1 The Trust intends that CPA be a means of coordinating patient care in a non-discriminatory way and to promote diversity. It also recognises the equality of opportunity with the objective of recovery. It is the responsibility of clinicians who are care coordinating patients on CPA and Non CPA to ensure that they take into account the diversity of the population, thus fully meeting the assessed needs of patients and their carers.

21.2 Prior to assessing, reviewing or planning the patient's care, arrangements must be made for all venues to be accessible regardless of disability.

21.3 Communication needs must be met at all times. Where English is not spoken, arrangements for an interpreter must be organised.

21.4 Written materials should be provided in appropriate formats and wherever possible, CPA documentation should be available in either Easy Read format or the appropriate language. Large print versions may be provided via photocopier facility. (A4 – A3).

21.5 Care plans must consider the assessed needs of both patients and their carers regarding any evidence gathered with demographic issues, i.e race, ethnicity, culture, religion and spirituality, gender and sexual orientation.

21.6 For further guidance, please refer to Trust policy, 'Equality, Diversity and Human Rights Policy'.

22.0 MONITORING

22.1 The review of this Handbook will take place on a three yearly basis, unless national guidelines dictate otherwise.

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