Policy Document Control Page

Title

Title: Care Programme Approach Policy

Version: 12

Reference Number: CL3

Supersedes

Supersedes: Version 11

Description of Amendment(s):

- **Addition of the Role of the Consultant Psychiatrist**
- **Addition of the Inclusion of Personal Assistants within the Care Planning Process**

Originator

Originated By: Rachel Clayton

Designation: Project Director Service Line Management

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Rachel Clayton

ERA undertaken on: 4th March 2009

ERA approved by EIA Work group on: 23rd September 09 , reviewed 14th November 2012

Where policy deemed relevant to equality-

EIA undertaken by Rachel Clayton

EIA undertaken on 25th October 2012

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Approval and Ratification

Referred for approval by: Matt Walsh

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Approved by: Stan Boaler, Service Director Mental Health Services

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Executive Director Lead: Medical Director

Circulation

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Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 10th November 2019

Responsibility of: Stan Boaler

Designation: Service Director – North& South Division & CPA Service Lead

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 15th November 2016

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1. Introduction

The Care Programme Approach (CPA) is the framework that underpins mental health care for all service users in specialist mental health settings. It was introduced in 1990 as the approach for the care of people with mental health needs in England.

In 1999, the CPA was revised and integrated with local authority care management to form a single care coordination approach for adults of working age with mental health needs. This was to be used as the format for assessment, care planning and review of care by health and social care staff in all settings.

CPA has subsequently been reviewed to ensure that there is an improved focus on delivering a service with the individual at its heart.

Refocusing the Care Programme Approach was published by the Department of Health in March 2008. It is available on the Department of Health website and intranet for Pennine Care staff. The document sets out significant changes in the national policy and provides guidance on how the CPA should be operated. It is intended to supplement, and not replace or repeat, existing national policy. The document highlights that CPA has been reviewed to ensure that there is an improved focus on delivering a service where the individual using it, is at its heart, in which national policy is more consistently and clearly applied, and where bureaucracy does not get in the way of the relationship between the service users and practitioner. It is split into the following 7 sections:

Section 1 – Introduction: Consultation on the review of the CPA highlighted that there had been significant progress in national policy, particularly in being more responsive to need and greater empowerment of individuals to become more independent and improve their lives through more personalised care, more choice and their active engagement in service development. However it also found that there still remained variations around the country in applying these principles.

***Section 2 – Personalised Mental Health Care*:** It is challenging to provide services that people understand and own. However there should be open discussion on values and principles, to ensure that meaning and values underpinning service delivery can be understood, acknowledged and addressed. A draft statement has been produced, as well as a suggestion to focus on user/carer engagement and the equalities agenda.

***Section 3 – Refocusing the Care Programme Approach*:** From October 2008, CPA describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people who have 'complex characteristics'. This is defined in more detail later in this document. The document stresses that *CPA should not be used as an indicator of eligibility for service*. Where CPA is no longer needed, service users must still be provided with services for which they are still eligible for.

Section 4 – Assessment and Care Planning: This section refers to the assessment and re-assessment that occurs as part of the (new) CPA and relates it to the issues identified in the NSF, as part of multi-disciplinary assessment. It

highlights that Trust's should: *Aim to develop one assessment and care plan that will follow the service user through a variety of care settings, ensure that crisis and contingency planning and risk assessment are integral to the care planning process and routinely include arrangements for setting out measuring and reviewing specific outcomes.*

Section 5 – Whole Systems Approach: In order to be effective, CPA needs to be supported by organisational and system wide approaches that are able to support activity across a person's life domains and circumstances. Better communication, care pathways and effective protocols are seen as being particularly important.

Section 6 – Supporting The Workforce: The role of the CPA care co-ordinator will be taken by the person who is best placed to oversee care management and resource allocation, and can be of any discipline depending on capability and capacity. The ten essential capabilities (http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169) apply to all staff working in mental health. The national policy guidance builds upon these and identifies care co-ordinator principles of good practice, core functions and competencies.

Section 7 – Measuring and improving quality: The National Policy Guidance identifies a continuing need to maintain effective information systems that cover all service users of secondary mental health services, and the Mental Health Minimum Data Set will continue to be required for all service users. A range of tools are available for auditing the CPA

2. Policy Statement

The purpose of this policy is to:

Set out how the CPA should be implemented to ensure a consistent, efficient and effective system for managing the care and treatment of service users regardless of setting, in line with guidance contained in refocusing the Care Programme Approach March 2008.

This policy replaces the previous Trust CPA policy and underpins any locally agreed protocols.

The Trust will ensure that the application of any part of this policy does not have an effect of discriminating, directly or indirectly, on grounds of age, disability, gender, gender reassignment, pregnancy and maternity, marriage or civil partnership, ethnicity / race, religion / belief or no religion / belief or sexuality.

3. Scope of the Policy

This policy applies to:

3.1. Staff

- All staff employed by the Trust.
- All staff working in the specialist mental health service employed by other agencies (e.g. social services)

3.2. Adults of working age

The CPA policy is applicable to all adults of working age in contact with the secondary mental health system (health and social care).

3.3. Children and young people

Where a child/young person has a *serious mental health problem* they will be subject to the Care Programme Approach. This applies to those diagnosed with, and being treated for:

- Severe depression/ Affective disorders/ OCD leading to serious functional impairment or risk
- Psychosis, schizophrenia, bi-polar affective disorder
- Severe self-harming behaviour
- Behaviour that leads to a high risk of injury to self or others
- Severe eating disorders
- Severe somatisation / pervasive refusal syndromes

The interfaces between CPA and other children's' assessment frameworks e.g. CAF (Common Assessment Framework), Looked After Children Reviews etc. are described further in section 7.9.2 of this guidance.

All young people discharged from Tier 4 inpatient services will be discharged on CPA until the initial follow up review. In addition any young person who meets the threshold for involvement of the Trust wide Inreach Outreach service should also meet the criteria and be subject to CPA.

3.4. Older People

The CPA should be applied to older people with severe mental illnesses, including schizophrenia and or other psychoses, in accordance with the National Service Framework for Mental Health, and the National Service Framework for Older People.

The assessment of their needs will be based on the mental health assessment and care planning system and a decision regarding whether they require CPA made based on this assessment.

CPA should be applied to older people with severe functional or organic mental health problems where they meet the characteristics for CPA outlined in this guidance.

3.5. People with a Learning Disability

The CPA should be applied to all individuals with a learning disability who are experiencing mental health problems of a severity warranting care and treatment by the specialist mental health service.

Where an individual with a learning disability does not have an identified mental health problem, CPA does not apply.

3.6. Drugs and Alcohol services

It is acknowledged that Drug and Alcohol services deal with a range of service users not all of who will have an identified mental health problem.

However, the CPA should be applied to all those who present to drug and alcohol services with a co-morbid mental health problem of a severity that warrants care and treatment from the specialist mental health service. Care Co-ordination of these clients will be managed within the specialist mental health service and not Drug and Alcohol services.

3.7. Psychological services for those with physical illness

Once accepted by specialist mental health services, those being treated for a mental health problem associated with physical illness (e.g. cancer) or unexplained physical symptoms (e.g. chronic fatigue) requiring *specialist psychological interventions* **are** subject to CPA if the mental health problem is of sufficient severity to warrant the intervention of specialist mental health services, when assessed *in isolation* from the physical problem.

Examples of this would include those presenting with:

- Agitated depression/high suicide risk (linked to a life threatening condition)
- Transient psychosis (occurring post-transplant)

While there might be a significant level of complexity associated with the physical care provided by outside trusts/agencies, the level of CPA will be determined by a consideration of the extent of service intervention required, and any risks *specifically* associated with the person's mental health difficulties.

The involved mental health professional will act as Care Coordinator in relation to the person's mental health needs, and in this capacity liaise closely with other care providers as required.

However this worker is unlikely to be *best placed* to coordinate wider aspects of care i.e. physical treatments, and so is not required to assume overall responsibility for these.
In such circumstances the mental health professional must ensure that the care plan is specific about the nature and extent of the intervention being provided by specialist mental health services, clarifying the limits to this.

3.8. Primary Care

People with mental health problems, who are receiving their care package from within Primary Care services (i.e. via their GP practice), will **not** be subject to CPA, whether or not an element of this care is being provided by Pennine Care staff.

3.9. Inpatients

Service users on CPA who are referred to inpatient Services will continue to be supported under the CPA policy. All admissions will continue to be decided using the Acute Care Gate keeping policy or the NHS England gatekeeping policy for CAMHS inpatient services.

3.10. Rehabilitation and High Support Services

Service users on new CPA who are referred to RHSD Services will continue to be supported under the new CPA policy.

4. Roles and Responsibilities

It will be the responsibility of the Chief Executive to ensure arrangements and resources are in place to ensure the provision of CPA within the Trust as outlined within the policy. Overall management of CPA will be the responsibility of the Director of Operations, including implementation of the policy, appropriate training and performance management.

The Director of Operations will in addition be responsible for ensuring the policy is reviewed within agreed timescales.

The Service Director with the lead for CPA will be responsible for reviewing the policy in liaison with the Director of Operations.

The patient safety and clinical risk manager is responsible for coordinating risk management activity (clinical) within the Trust.

Lead managers, team supervisors, health and social care staff are responsible for the implementation of the policy and in particular, for the recognition and management of a potential service user clinical risk. In addition, lead managers are responsible for

- Ensuring that appropriate training is made available to all professional groups as outlined within the Policy
- Ensuring that all appropriate health and social care staff in all community and inpatient services attend CPA training relevant to their role (see section 8.2)

It is the responsibility of CPA care coordinators and key workers to ensure they undertake assessment and care planning in line with the CPA policy and to ensure that they have attended the approved training to do so.

It is the role of the Consultant Psychiatrist named as the patient/service user's doctor under CPA to bring medical knowledge and expertise when directly involved in the care of the patient. It may also be necessary to bring clinical leadership and expertise where appropriate (e.g. the relapsing patient).

The scope of responsibility for the individual practitioner is summarised as:

- *Each individual is responsible for their own actions within the sphere of their professional competence*

- *Training and qualifications attaches a certain reasonable expectation of competence to practicing professionals*

- *Individuals cannot be held accountable for factors over which they have no control and for information they cannot access. However practitioners must*

be able to demonstrate reasonable attempts to gain relevant information take action or challenge the actions and decisions of others.

In order to support practitioners in exercising their individual and professional accountability the Trust (through managers) is responsible for providing:

- Systems that effectively trigger multi disciplinary discussions and decisions regarding whether a person is eligible for CPA.

- Regular opportunities for practitioners to discuss assessment and care planning within a multi-disciplinary team and with their line manager via supervision. Ensuring that high risk service users are discussed at least monthly.

- Opportunities for staff to attend required training as identified within the training needs analysis.

- Relevant interagency agreement to ensure high quality communication and coordination across services.

5. Statement of Values and Principles

"Seeing your future together"

Pennine Care's vision is to provide high quality health and social care that improves an individual's opportunity for social inclusion and recovery. In partnership with the wider community, our care will improve mental wellbeing and drive out health inequalities.

Recovery is a process that is different for each person. A service cannot 'provide' recovery but we will aim to provide services in ways that will promote recovery and can lead to social inclusion. Promoting recovery is a principle that underpins all mental health services offered by Pennine Care and its local authority partners.

Pennine Care recognises that stigma is a reality and the consequences of mental health problems can be social exclusion and prevention from living an ordinary life. We believe that people can, and do, live full and rewarding lives, with or without continuing problems.

In achieving this:

- We will encourage hope and hopefulness
- We believe that people have the right to develop, learn from experience and manage their own lives
- We welcome people, their families and carers to be involved in various ways
- We aim to provide the help to get individuals where they want to be
- We recognise that everyone has their own values and that these determine what is important. Difference will be acknowledged through working in partnership, we will seek to understand and provide services that respond to

an individual's needs and leave them in control as much as possible (put them in the driving seat)'
- We will ensure that there is prompt effective treatment including access to medication where appropriate
- We will ensure care is co-ordinated in a way which embraces the above principles

The CPA in Pennine Care will adopt the above values and principles.

5.1. Recovery Principles

- We want to prevent loss of what is important e.g. identity, ambitions, plans, relationships, employment, education, recreational opportunities. We want to help people regain these things if they have lost them.
- We want to help people to achieve mental and physical wellbeing.
- We want people to maintain or regain control of their life and the support he or she needs and be independent.
- We will encourage people to use 'self directed support', individual budgets, and direct payments.
- People need good information about options, treatments and what support is available in order to make informed choices.
- We want to ensure good outcomes
- A shared broad understanding of problems, needs, goals and ways of achieving them.
- Carers' needs are understood and addressed.
- A care plan that is centred on what the person wants to achieve.
- A personal support plan – if the person wants to develop this.
- The person and their family are hopeful that life can be satisfying and rewarding.
- The person is able to manage their own life and live it in the mainstream.
- Children and young people – Care planning for young people with serious mental health disorders should assist in helping them towards their potential in the key outcomes highlighted in "Every Child Matters**".**

6. Characteristics of CPA

The policy separates the requirements under the approach according to those who require CPA and those who do not require CPA.

<u>CPA</u>
CPA is designed for people identified as suffering with a severe and enduring mental illness with complex mental health needs, posing a significant level of risk and requiring multi-disciplinary input and inter-agency involvement.

All service users subject to Supervised Community Treatment (SCT) must also be supported by CPA.

<u>Non CPA</u>

Non CPA is designed for people with a severe and enduring mental illness with on-going maintenance & monitoring needs; they would be identified as having a low to

moderate risk of harm to themselves or others as a result of their mental illness and would expect to require limited interventions from secondary mental health services such as annual review, time-limited recovery based interventions or low level maintenance interventions e.g. depot administration.

A small minority of service users who are primarily managed in the community and are defined as dangerous and high risk to others will require augmented arrangements for information gathering and sharing, multi-agency working and enhanced risk management plans which will be managed through CPA Plus. Their clinical information will be gathered and recorded with the same documentation; however there will be internal governance arrangements to effectively manage this group of service users.

CPA Plus

CPA plus is designed for those patients who are primarily managed in the community who are identified as having severe and enduring mental illness with complex and serious needs and identified as dangerous and high risk to others as a result of their mental disorder (individuals who may pose a risk to public protection). The CPA plus framework will provide an enhanced process for managing the presenting risk in the community setting.

Changes in a person's condition or circumstances may result in a change in their CPA status.

The national policy guidance emphasises that being on CPA must not be seen as an eligibility criteria for receipt of services. CPA is a process for managing complex and serious cases, not an eligibility tool.

6.1 ***Children/ Young people – key determining factors will be:***

- severe mental health disorder with either significant risk and/ or functional impairment
- plus need to ensure close communication/ coordination with young person, carers, other professionals and agencies

By necessity, CPA is required for young people with complex mental health difficulties who require intensive support from CAMHS Inreach/ Outreach and EIT.

The differences between CPA plus, CPA and the process for other service users is summarised as follows:

Area	Service users needing CPA Plus	Service users needing CPA	Service Users not requiring CPA
An individual's characteristics	• Severe mental disorder with a high degree of clinical complexity • High level of historical/current risk to others • Multi agency concern regarding risk behaviours • Difficult to engage • Substance misuse • Chaotic lifestyle • Current care plan is insufficient to manage risk and meet needs • Non concordance with support and treatment • Primarily managed in a community setting	• Complex mental health needs; • Severe and enduring mental illness • Multi-agency input; • Significant levels of risk. • Moderate degree of clinical complexity. • Potentially difficult to engage.	• Lower level of need (maintenance and monitoring) • Severe and enduring mental illness. • Single statutory agency input in addition to GP. • Low degree of clinical complexity. • Low to moderate level of risk. • Actively engages with services and treatment.
What the service users can expect	• Support from CPA care co-ordinator with appropriate skills to meet range of complex needs • Comprehensive formal written multi agency care plan: including risk and contingency/crisis plan. • Monitoring of care plan by relevant team manager • A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks. • An assessment of social care needs against Care Act eligibility criteria. • Assertive engagement approach from the care team • On-going review, formal multi-disciplinary, multi-agency review at least once a month • On-going consideration of need to remain on PA plus or potential step down to CPA if risk or circumstances change • Increased need for advocacy support. • Carers identified and informed of rights to own assessment.	• Support from CPA care co-ordinator (trained & part of job description) • A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks. • An assessment of social care needs against Care Act eligibility criteria. • Comprehensive formal written care plan: including risk and contingency/crisis plan. • On-going review, formal multi-disciplinary, multi-agency review at least once a year. • At review, consideration of on-going need for CPA support (including need for CPA plus or removal from CPA) • Increased need for advocacy support. • Carers identified and informed of rights to own assessment.	• Support from professional(s) • A full assessment of need for care and treatment, including risk assessment. • An assessment of social care needs against Care Act eligibility criteria. • Clear understanding of how care and treatment will be carried out, by whom, and when (can be in the form of a letter) • On-going review as required • At review, consideration of on-going need for support from the service. • Potential need for advocacy support • Self-directed care, with some support if necessary • Carers identified and informed of rights of own assessment

7. Local Policy and Procedures

7.1. Overview

Following on from the National Policy Guidance, this section sets out the approach to CPA to be followed within Pennine Care, and all the Local Authority services managed by the Trust.

In addition to the National Policy Guidance on CPA, those seeking to apply this policy should be familiar with:

- The Mental Health Act (1983 as amended 2007)
- The Mental Capacity Act (2005)
- National Guidance on Continuing Care
- The Care Act (2014)
- Every Child Matters
- Relevant Local Authority Assessment and Care Management Policies
- All Relevant Trust Equalities and Diversity Policies.

They should also be familiar with Pennine Care policies and procedures, including the Physical Health Policy, Risk Assessment Policy, and Safeguarding Policy.

Although identified as the 'CPA Policy' this policy covers all secondary care mental health service users, including those identified as not needing CPA.

In line with the National Policy, this policy sets out a more comprehensive process for those people on CPA whilst also ensuring that those service users not under CPA receive appropriate and effective assessment (including risk assessment) and review.

Key Performance Indicators and general principles of good practice continue to apply to all service users whether dealt with under CPA or not.

The following section provides a step by step overview of the assessment and care management process of the secondary care mental health service care pathway.

7.2. Access To Secondary Care Mental Health Services

7.2.1. Single Point of Access

Access through a single referral process, to the support and resources of both health and social care, is one of the hallmarks of a truly integrated CPA/Care Management service.

Single points of access for Adult and Older Peoples mental health services are now established in all boroughs in the Trust and assessment of eligibility for secondary mental health services will be undertaken through this process.

7.3. Eligibility for Secondary Care Mental Health Services

Individuals who meet the eligibility criteria for secondary care mental health services will be directed to the relevant service to meet their needs by the Single Point of Entry.

Further guidance regarding the eligibility criteria for each service area will be available locally.

Consideration must also to be given to assessing presenting problems against the Care Act (2014) eligibility criteria.

When a person is assessed as having needs which meet Care Act (2014) eligibility criteria for social care services, but are not appropriate for specialist mental health services, the team will negotiate with other appropriate service providers to ensure that the needs are addressed.

7.3.1 Eligibility under the Care Act (2014)

Each Local Authority has to provide services on the basis of eligibility criteria set out in the Care Act (2014)

The Care Act (2014) defines the primary responsibility of local authorities as the promotion of individual wellbeing and requires them to promote integration with the NHS and other key partners with the aim of putting people at the centre of their care and support and maximising their involvement in order to meet their individual needs.

Each Local Authority has developed an assessment process to determine the eligibility of individuals for Local Authority funded services in line with the national eligibility criteria as detailed in the Care Act (2014) which will be available locally.

7.4 Contact and Assessment

7.4.1 Core Information Requirements

For all people who come into contact with the Trust, there is a need to record (and maintain accurately) a core data set of information. Held on NCRS/PARIS this is comprised of:

- Information about the service user, carer(s) and any children in their care/household and equalities monitoring data
- Information required by the Mental Health Minimum Dataset

7.4.2 Contact and Initial Assessment

Assessment begins at the first point of contact with a service user, and may incorporate information provided by other professionals. It will also determine whether or not there is a need for further contact with the service user, and may determine whether or not they will need support under CPA.

In any event, it requires the collection of the core information requirements as identified above.

The process of initial assessment may also incorporate a brief intervention by the service, and should not just be seen as determining whether further services are needed.

Assessment must be thorough, but appropriate to the identified nature and complexity of need. As with all assessment and care planning activity, it needs to be led by the service user, who should be encouraged to develop and express their own views and wishes and to use whatever tools and processes are available to them (e.g. WRAPs, advance statements).

The Assessment process will draw upon the core information dataset that will help, for example, to identify whether or not there may be childcare issues to consider.

It may also draw upon information from other assessments carried out previously (as long as that information remains relevant).

Consideration must be given to the following areas throughout the assessment process:

- *Service user perspective, wishes and aspirations*
- *Presenting issues/ problems*
- *Mental state and symptoms*
- *Medication and medical history*
- *Physical health needs*
- *Dual diagnosis and Co morbidity issues*
- *Personal/family circumstances*
- *Social functioning and development*
- *Parental mental health*
- *Safeguarding issues adults and children*
- *Accommodation issues*
- *Daytime Activities, Employment and Education*
- *Finances/welfare benefits*
- *Religious and spiritual needs*
- *Communication and Language*
- *Culture and Ethnicity*
- *Gender / Age / sexual orientation*
- *Support and advocacy needs*
- *Risk*
- *Carers views and needs*

Not all of these will be relevant for every person, but it is important that any assessment takes account of them and their relevance at that time.

Initial assessment should be completed using the Trust Approved Documentation. Following initial assessment eligibility for CPA may be determined. Until, and unless that is the case, service users will continue to be managed through the mental health assessment and care planning processes.

A single designated worker can undertake the assessment, but other staff and specialists may be called upon to contribute to it.

As with all assessments, where there is a likelihood of a need to provide Local Authority (funded) services, the assessment needs to take account of the eligibility criteria set out in the Care Act (2014).

Once it has been determined that a person is eligible for secondary care mental health services further assessment may be required within specific teams (e.g. EIT). These assessments will review and build on the existing information gathered during the initial assessment; however they should not repeat the full process.

The information gathered during the assessment process will be used to help determine if someone requires CPA therefore a separate CPA assessment is not required. However following assessment or review the decision regarding whether or not the person requires CPA must be recorded on NCRS/PARIS. The assessment/review documentation should outline details of all those involved in the decision (including name and designation) the outcome, reasoning and subsequent actions, it should also include the views of the person themselves and their carer / family.

All services users will be given Information outlining how to contact services and detailed crisis, risk management and contingency plans must be written in the care plan / management plan which all service users will receive a copy of.

Minimum expected frequency of contact and zoning allocation for individuals is outlined below according to their CPA status

	CPA +	CPA	Non CPA
Contact frequency	To be dictated by the MDT. As a minimum contact should be attempted on a 2 weekly basis.	As a minimum 4-6 weekly by community mental health practitioner. If the patient has a psychiatrist they will be seen as by them as clinically indicated with a minimum of once every 12 months.	As a minimum 2-4 monthly, if moving to 4-6 monthly consider discharge (individuals only receiving annual care management review to be seen as a minimum 12 monthly)
Zoning	Red Discussed at each zoning meeting and supervision session	Red, Amber or Green	Green or None depending upon team allocation.
Minimal formal review period	Monthly – see minimum requirements for review on page 21	Minimum annually but more frequently if required e.g. following significant change in presentation.	Annually
To be discussed at management supervision	At every Supervision	Minimum quarterly or if needs change	Minimum six monthly or if needs change

7.5 Care Planning and Review

7.5.1 Service users assessed as not requiring CPA

Service users who do not require the support of CPA but meet the eligibility criteria for secondary care mental health services will still be assessed and supported to ensure that their needs are met, and that services are delivered efficiently and effectively.

The key components associated with this are:

- The Key Worker
- The Care Plan/Management Plan
- The Review

7.5.1.1 The Key Worker

The Key worker is the designated worker with responsibility for ensuring that the assessment and care planning requirements are met for that individual.

Those requirements are that:

- The core dataset is kept accurate and up-to-date on NCRS/PARIS.
- A care plan/ management plan and a documented assessment of risk are in place, up-to-date and implemented.
- A review is carried out when circumstances require it and at least annually.

Ordinarily, key workers will be members of Community Mental Health Services or will be Psychiatrists and should be competent to undertake the functions set out below.

All services users that do not come under CPA must be reviewed at least annually. Cases should be reviewed more frequently when there are significant changes to be taken account of.

The minimum standards for review for those clients who are not on CPA are as follows:

- Annually or when there has been a substantial change.
- The review should be co-ordinated by the key worker and involve service users (including a face-to-face meeting), carers and relevant service providers.
- The review will result in update to the care plan/ management plan (including crisis, risk management and contingency plans). This will consist of a clear understanding of how care and treatment will be carried out, by whom and when.
- A copy of the care plan/management plan should be provided to the Service User / Carer and relevant agencies involved in the delivery of care.
- The format of the review record and care plan/management plan is flexible dependant on the circumstances and can be in a letter format.

It is the responsibility of the key worker to ensure these requirements are met and properly recorded.

It is the responsibility of the Team Managers using information from NCRS/PARIS that reviews are carried out in a timely and effective manner. They should be aware of how many reviews are due on a monthly basis, and how many are overdue. They need to ensure that assessments and care plans are appropriately compiled and up-to-date, and shared with service users.

7.5.2 Service users who do require CPA

CPA has 3 main components:

- The Care Co-ordinator
- The Care Plan
- The CPA Review

7.5.2.1 The Care Co-ordinator

As with key workers, care co-coordinators will generally be drawn from community based teams and will be professionally qualified nurses, Social Workers and OT's. Psychiatrists may also take on the role. Again, as with key workers, their responsibilities include ensuring that:

- The core data set is kept accurate and up-to-date on NCRS/PARIS
- A care plan and risk assessment/ risk management plan are in place, up-to-date and implemented.
- Review within 3 months of the initial care plan
- A CPA review is carried out at least annually and when circumstances require it.

The national guidance is accompanied by a paper that outlines the core competencies of care co-ordinators and relates them to the National Occupational Standards (Care Co-ordinators Core Functions & Competencies - PSE consulting 2008).

The key care co-ordination functions are identified as:

- Comprehensive Needs Assessment
- Risk Assessment & Management
- Crisis Planning & Management
- Assessing & Responding to Carers Needs
- Care Planning & Review
- Transfer of Care or Discharge

Further details about these functions are set out in 'A practice guide to CPA' copies of which can be accessed on the CPA intranet page.

7.5.2.2 Care Planning

Central to CPA is the care plan which aims to ensure a transparent, accountable and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs which are associated with a person's mental health needs. The care plan should include the following:

- a treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration.
- details regarding any prescribed medications
- details of any actions to address physical health problems or reduce the likelihood of health inequalities
- details of how the person will be supported to achieve their personal goals
- support provided in relation to social needs such as housing, occupation, finances etc.
- support provided to carers
- actions to be taken in the event of a deterioration of a person's presentation, and
- guidance on actions to be taken in the event of a crisis.

The care plan should set out the practicalities of how the service user will receive treatment, care and support from day-to-day, and should not place undue reliance on the patient's carers.

The care coordinator has responsibility for co-ordinating the preparation, implementation and evaluation of the care plan.

The care plan should be prepared in close partnership with the service user from the outset. If the service user wishes help should be given to access independent advocacy or other support where this is available. In order to ensure that the care plan reflects the needs of the individual service user, it is important to consider who needs to be involved, in addition to the service user themselves. Subject to the service user's views, this may include:

- the patient's responsible clinician
- community mental health practitioners and other members of the community team (e.g. psychological therapy practitioners)
- nurses and other professionals involved in caring for the patient in hospital (for inpatients only)
- the patient's general practitioner (GP) and primary care team (if there is one). It is particularly important that the patient's GP should be aware if the patient is to go onto a community treatment order (CTO)
- any carer who will be involved in looking after them
- the patient's nearest relative (if there is one) or other family members
- a representative of any relevant voluntary organisations
- the clinical commissioning group's appointed clinical representative (if appropriate)
- an independent mental health advocate, if the individual has one
- an independent mental capacity advocate, if the individual has one
- the patient's attorney or deputy, if the patient has one
- any another representative nominated by the patient

Where the service user is under the age of 18 it may also be necessary to involve their parent, or whoever will be responsible for looking after the service user, to ensure that they will be ready and able to provide the assistance and support which the individual may need.

Particular care should also be taken to ensure that the concepts of participation and proportionality are applied to older patients.

People who are supported under CPA will also have a more detailed Risk Assessment and Action Plan, in line with the separate risk management policy. Depending upon their circumstances and physical health needs, they will also have a more detailed physical health assessment with actions arising incorporated into the care plan.

7.5.2.2.1 Inclusion of Personal Assistants within Care planning processes:

Where a patient has a personal assistant (PA) within their employ (by any means) for support in relation to their mental illness every effort must be made and documented to seek the consent of the patient to include the PA in both risk assessment awareness and care planning. It is vital that care coordinators understand the role of the PA with the service user and incorporate this role within the context of risk formulation and through the care planning. If a service user does not give consent for information about their illness to be shared with their PA then this must be discussed in supervision with the care coordinator's line manager and a decision reached about the necessity to override consent if the risk of harm to the PA outweighs the principle of consent. If it is agreed that the principle of consent outweighs that of disclosure then this must be documented fully at supervision, in the service user's records and on their risk assessment. It is good practice to revisit this question at each review of the service user's care (CPA meeting) or after each significant or untoward incident. For any service user on CPA+ a wider multi-disciplinary meeting must be convened to discuss the issue of a refusal to give consent.

7.5.2.3 CPA Review

The CPA review system needs to meet the more complex needs of the service user group. The frequency of review should be determined by the care coordinator but as a minimum must be reviewed within 3 months of the initial care plan, and at least 12 monthly thereafter. Service users should be reviewed more frequently when there are significant changes to be taken account of.

Reviews needn't always comprise of a formal meeting (though this might be the most appropriate format) in all cases the users wishes / preferences should be considered. It may not be necessary for all care providers to be present and on some occasions the service user may choose not to attend however in these circumstances the review should still be completed.

Reviews should consider

- If needs have changed and /or the care plan requires amending in relation to :
    - Mental health
    - Physical health
    - Social / personal circumstances

    - Risk assessment
    - Safeguarding children / adults
- How far the anticipated outcomes have been achieved
- If the service user continues to meet eligibility for support
- A reassessment of un-met needs
- If the CPA status has changed
- If the Mental Health Cluster has changed
- Discharge planning arrangements (where appropriate)

The minimum standards for reviews for service users on CPA are as follows:

- 3 months after services begin, or if there has been a substantial change
- Annually thereafter
- Co-ordinated and chaired by the Care Co-coordinator* and involve service users (including a face-to-face meeting), carers and service providers
  *(*NB When individuals are admitted to non-acute hospital settings the inpatient team will usually coordinate and chair CPA reviews.)*
- Result in a care plan being developed or updated. (including detailed crisis, risk management and contingency plans)
- A copy of the care plan should be provided to the Service User / Carer and relevant agencies involved in the delivery of care
- If discharged, service users should be provided with a discharge plan outlining how and when to access the service in future should their situation change. This can be provided in the most appropriate format for the service user.

It is the responsibility of the care coordinator to ensure these requirements are met and properly recorded.

It is the responsibility of the Team Managers using information from NCRS/PARIS that reviews are carried out in a timely and effective manner. They should be aware of how many reviews are due on a monthly basis, and how many are overdue. They need to ensure that assessments and care plans are appropriately compiled and up-to-date, and shared with service users.

7.5.3 Service Users who require CPA Plus

In addition to the requirements outlined above for individuals who require CPA service users who are identified as meeting the criteria for CPA plus will also be subject to the following requirements:

Individuals who are deemed to require CPA plus should be screened by the MDT to agree allocation to CPA plus.

The minimum membership of the MDT for individuals who require CPA plus will include a named Care Coordinator, Team Manager, Psychiatrist and where appropriate a Psychological therapist.

The Team Manager for the team that the service user is allocated to will be the identified guardian of the case whilst the individual is subject to CPA plus. The guardian has the responsibility to inform the community services manager and the governance team of the decision to move an individual to CPA plus.

When an MDT decision is made to move a service user to CPA plus the Team Manager will review current resources allocated to the case and care coordination allocation to consider suitability and arrange reallocation or additional resources if necessary.

The care coordinator is responsible for reporting any concerns or issues regarding individuals subject to CPA plus to their team manager and reporting incidents as per Trust policy.

The care coordinator is responsible for highlighting increased risks to others and sharing all relevant information regarding individuals subject to CPA plus with their team and any relevant multiagency partners.

The team manager is responsible for ensuring that an alert is placed on NCRS/PARIS to identify all individuals who are subject to CPA plus.

The governance team will support the team manager with decision making regarding service users subject to CPA plus and will be responsible for providing an overview for the Trust and Local Authority partners of the cases subject to CPA plus. The governance team will be responsible for escalating information within the organisation regarding individuals subject to CPA plus as required.

The minimum standards for reviews for service users on CPA plus are as follows:

- To be formally reviewed by the MDT on a monthly basis.
- Co-ordinated and chaired by the Care Coordinator and Team Manager and involve all relevant agencies as required e.g. Police, CJMHT, Housing, Probation, Drug and Alcohol Services, GP, PCFT Governance
- Result in a detailed care plan being developed or updated that specifies interventions to manage identified risks (including detailed crisis and contingency plans) and agencies responsible for delivering the interventions.
- A copy of the care plan should be provided to the Service User / Carer and all agencies involved in the delivery of care including the service users GP.
- Decision made regarding requirement for individual to remain on CPA plus or be stepped down to CPA.

When individuals who are subject to CPA Plus are admitted to hospital on either a short term or long term basis the CPA Plus review requirements will be suspended for the duration of their inpatient stay due to the relational security of the environment where they are being managed and the subsequent impact of this on risk management. The inpatient review processes will supersede the CPA Plus review requirements during the admission period. An MDT decision will need to be taken regarding reinstating CPA plus as the part of the discharge planning process prior to the individual being discharged from the inpatient setting

7.5.4 Section 117 responsibilities

The CPA provides the context for all assessments and care planning for people with serious mental health problems, including when they are detained in hospital and

when their discharge is being planned. This includes those who require after care under section 117 of the Mental Health Act (MHA).

Before service users subject to the MHA are discharged there will be a CPA meeting at which consideration is given to the legal responsibilities that apply under Section 117.

All service users who are entitled to services under section 117 and are on CPA will be allocated a care coordinator who will be responsible for reviewing care offered under section 117 in line with the section 117 policy.

Where a person is placed in a residential/nursing home outside of the Trust's footprint and is under section 117 the care coordinator within Pennine Care will retain responsibility for the overall care management in that they should be part of the review process and ensure services being funded under section 117 are still required.

Where service users move from one area to another handover for the day-to-day management and monitoring of Section 117 arrangements should be agreed at a CPA meeting.

Whilst it is the responsibility of both health and the local authority to decide when after-care provided under s117 should end, in practice the decision for each organisation responsible is taken through multi-disciplinary decision making and the operation of the CPA.

The joint decision to terminate services under Section 117 MUST be taken at the CPA/Section 117 Review Meeting and the decision to terminate that individual service carefully documented.

Refer to the section 117 policy for further guidance

7.5.5 Acute Inpatient (including PICU) / Home Treatment Admission and Discharge

Acute in-patients, and people supported by Home Treatment Teams, will normally be supported through CPA (especially if subject to compulsory detention) but in some cases, they may not.

If a service user requires Home Treatment intervention or an acute hospital admission the responsibility for care co-ordination under CPA will remain with the identified Care Coordinator (key worker for those not on CPA).

The crisis assessment documentation (including risk assessment) should be completed by the care coordinator / key worker, where possible in conjunction with the inpatient ward or Home Treatment Team, and should be used to inform the admission assessment.

This information should be sent to the ward / Home Treatment staff on admission. A copy of the latest community care plan and most recent assessment or review documentation, should also be given to the ward/ Home Treatment staff on

admission or within one working day of admission if access to the information is not available at the time of admission.

The care coordinator / key worker should attend the next review meeting, maintain regular contact throughout the admission and be actively involved in planning for any home leave and in the discharge planning processes.

Those admitted as a first contact and / or are not already open to secondary care mental health services will be considered for eligibility for secondary care mental health services in the community. Where eligible, allocation to an appropriate worker will be completed as soon as possible. On admission the Trust approved initial assessment documentation should be forwarded to the ward/ Home Treatment team and where not already completed, completed by the ward / Home Treatment within 5 days of admission.

As part of the discharge planning process from an in-patient admission a review and discharge care plan must be completed. This should be done in conjunction with the service user and their carer (where relevant) the inpatient and community staff. Where the patient is subject to CPA the care coordinator is responsible for ensuring the completion of the review and care planning documentation. (Except where a short-term hospital stay is an identified element of an existing plan or part of a recognised or persistent pattern of behaviour and care). A copy of the care plan should be given to the service user as part of the discharge process.

It is important, however, that what may be brief in-patient stays are not unnecessarily prolonged in order to wait for an assessment and/or review meeting to take place. In these circumstances, and subject to ensuring appropriate support is available and the risks around discharge are assessed, a decision can be taken to defer assessment or review.

As a minimum this should describe arrangements for immediate follow up care and contain details for the care coordinators / key workers and or the responsible community team (where one has been allocated). It should also include details of who to contact and how to access services out of hours.

All service users (including those who discharge themselves) will be followed up **face to face** within 7 days of discharge from hospital. If this is not possible the reason why face to face contact has not taken place must be agreed with consultant / senior manager and clearly documented in the service users notes.

All service users assessed as being high risk during their admission should be followed up **face to face** within 48 hours of discharge this must be agreed with the care coordinator as part of the discharge planning process. If this is not possible the reason why face to face contact has not taken place must be clearly documented in the service users' notes. Arrangements for more intensive follow up and support within the first 3 months post discharge should also be written in the care plan.

7.5.6 Rehabilitation and High Support Directorate (RHSD) Admissions

RHSD inpatients will usually be supported through CPA as they will usually be subject to detention under the mental health act (for indivudlas not subject to CPA standard key worker processes apply).

If a service user requires an admission to an RHSD unit the responsibility for care co-ordination under CPA will remain with the identified Care Coordinator.

A copy of the latest community care plan and most recent assessment or review documentation, should be given to the RHSD unit staff on admission.

The care coordinator should attend the planned review meetings, maintain regular contact throughout the admission and be actively involved in planning for any home leave and in the discharge planning processes.

As part of the discharge planning process a review and discharge care plan must be completed. This should be done in conjunction with the service user and their carer (where relevant) the RHSD staff and the care coordinator. The care coordinator is responsible for ensuring that the review and care planning documentation is completed but this may be undertaken by the RHSD team. A copy of the care plan will be given to the service user as part of the discharge process. The care plan should describe arrangements for follow up care in the community and contain contact details for the care coordinator, it should also include details of who to contact and how to access services out of hours.

The 7 day/48 follow up requirements as outlined above apply to individuals discharged form RHSD units.

7.6 Discharge from Secondary Care Mental Health Services

For service users who are not on CPA, discharge from Secondary Care Mental Health Services will normally occur when:

- Treatment is complete **and/or** the service user is sufficiently well recovered to be managed in Primary Care
- The service user wishes to be discharged and it is safe to do so
- The services user has moved and transfer to another Trust has been completed (see section 7.10)
- The service user dies

Where the service user is under CPA discharge could occur if

- Treatment and recovery is sufficiently progressed to otherwise warrant transfer to non CPA and the criteria for discharge above , **or**
- The service user wishes to be discharged and refuses to transfer to non CPA **and**
- All reasonable attempts have been made to explore alternative strategies for maintaining engagement (see appendix 1)
- A multi disciplinary review has been held and a care plan (inc detailed Crisis, risk management and contingency plans) formulated and agreed.
- The service user has moved and transfer to another Trust has been completed (see section 7.10)

Failure to attend an appointment or loss of contact with service users should not be treated as automatic grounds for discharge (see appendix 1 & 2 for further guidance).

All service users discharged from Pennine Care secondary care mental health services will be provided with a discharge plan outlining how to maintain their mental well-being and if required how to seek access to services in the future. The discharge plan should be agreed by and shared with all care providers and should contain information relating to early warning / relapse signs and identified risks. Any arrangements for obtaining support outside of specialist mental health services should also be clearly described.

The discharge plan must address any needs / risks that arise in connection with the service users having childcare responsibilities.

When discharge takes place without a final face to face contact with the service user, a discharge plan should be sent to them at their home address and relevant others informed. If the person's whereabouts is not known at the point of discharge, reasonable efforts should be made to establish these with the aim of forwarding the discharge plan e.g. via the GP.

Discharge from community secondary mental health services should be planned and will not occur out of hours (i.e. Monday – Friday between 5pm and 9am, weekends and bank holidays).

7.7 Risk Assessment and Management

A primary aim of this CPA policy is to facilitate the identification of risk in order to manage it effectively. Risk minimisation (rather than elimination) is the goal of good practice. In the context of mental health services risk is identified as:

> "…the likelihood of an identified behaviour occurring in response to changing personal circumstances. The outcomes are more frequently harmful for self or others, though occasionally they may have a beneficial aim in pursuit of a positive change"
>
> *Morgan, S. (1998), Assessing & Managing Risk: a Practitioners Handbook, Pavilion Publishing, Brighton*

Key to risk management is the *continuous process* of risk assessment leading to intervention followed by reassessment of risk. Practitioners are required to make this process explicit.

The Trust Approved risk assessment, formulation and management framework has been fully integrated into the CPA processes and documentation.

See the Trust Clinical Risk Assessment and Management Policy for further guidance.

7.8 Safeguarding Children

In line with the national requirements for Safeguarding children all assessment, review and discharging planning processes must consider the safety and wellbeing

of children whether the child is the service user themselves or known to the person being assessed.

A consultant psychiatrist should be involved in all clinical decision making for services users who may pose a risk to children.

Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met.

A referral must be made:

a) If service users express delusional beliefs involving their child

and/or

b) If service users might harm their child as part of a suicide plan.

For further guidance please refer to the Trust safeguarding children policy

7.9 Carers

Mental health problems impact upon more than the individual, and those close to them often provide a great deal of support and find that their own needs are increased as a consequence.

Carers have a vital role to play in supporting people with mental illness therefore wherever possible carers should be

- Involved in the care planning process
- Provided with the information they need to give care effectively & safely
- Offered a carer's needs assessment

All forms of enagaement with carers should be undertaken in accordance with the principles of the Triangle of Care which is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing

Sometimes sharing information with carers raises complicated ethical, legal and clinical issues. The relationship between people with mental health problems and those close to them will vary between individuals, and over time that variation often prevents a challenge, partly because it prevents reliance upon hard and fast rules. However, understanding and working with these relationships are a key part of working in mental health. It is important not to assume that the nature and extent of a carer's role should always remain the same. Sometimes change is needed in the interests of both the carer and/or service user.

Whilst there is sometimes tension, conflict and alienation between service users and carers (especially at times of acute illness, but also at other times); generally the starting point for working with carers should be one of partnership to support them in their role as carer.

Carers should receive up-to-date copies of the service user's care plan and crisis plan, with the service user's consent. Efforts should be made to ensure that carers are involved in the drawing up of the plan and should be invited to meetings where the care plan and crisis plan will be discussed as appropriate.

Occasionally service users do not wish clinicians to share information about their illness with their carers. This can lead to a difficult situation for service users, carers and clinicians because:-

- Service users can feel under undue pressure to allow personal information to be shared
- Carers can feel excluded and even at risk
- Clinicians are torn between their responsibilities to the service user and their desire to support the service user's carers

Under most circumstances service users have a right of confidentiality. This means that they can have the right to tell clinicians not to share information with their carers..

If the service user refuses to allow the carer to be involved in these meetings or to receive a copy of the care plan and crisis plan then this must be recorded in the service user's record along with the reasons for the refusal. Where issues relate to risks that the carer may have to manage or experience then consideration must be given to sharing this information and any action plan with the carer without the service user's consent. Further guidance on the steps that should be taken can be found in the Trust confidentially policy.

7.9.1 Carer's Assessments

Both Pennine Care and its Local Authority (LA) partners have responsibilities around carer's assessments.

Because the Local Authority responsibility is a statutory one, and because arrangements for carer's assessments vary from borough to borough, this policy does not require that a standardised form/process be used, however the details of any identified carers and whether a carers assessment has been offered must be recorded on NCRS/PARIS as part of the service users assessment and review documentation.

7.10 Other Planning Frameworks

There are a number of other assessment and planning frameworks that need to be taken into account alongside the secondary mental health service pathway and implementation of CPA. These are outlined below:

7.10.1 Partnerships

The CPA framework is a mechanism through which the Trust and its partners deliver their responsibilities for assessment and care management towards those people within mental health services in line with their obligations within an integrated service.

In ensuring the service user's journey through services is as smooth as possible we work with our partners to ensure communication and information sharing enables the individual's recovery and is not seen as aversive.

With CCGs across the Trust we work in partnership to ensure those requiring Continuing Healthcare Assessments receive them in a timely and efficient manner through our agreements with the CCGs, working with them closely to ensure consistency in assessment and care planning.

7.10.1.1 Resource Allocation

A key feature of assessment and care management is the allocation of resources. Local Authority and CCG resource allocation panels and processes need to be effectively navigated for the Mental Health Assessment and Care Planning systems to be effective. Again, it is important to be aware and up-to-date with regard to local arrangements.

7.10.1.2 Continuing Health Care Framework

The National Framework for Continuing Health Care was implemented in October 2007.

Designed to determine when the NHS should fund the totality of a care package, it incorporates a separate assessment and decision-making process to the mental health assessment and care planning processes.

Where continuing healthcare decisions are being considered and made, the national framework and local procedures (determined by CCGs) need to be followed. Assessments and care plans formulated through the mental health assessment and care planning processes may well be used in formulating the continuing care assessment.

Local procedures, issued by CCGs should be referred to.

7.10.2 CPA and CAMHS / Children's Common Assessment Framework.

CPA should be applied to those children and young people who fit the characterisation set out above.

Specific issues raised in the national policy guidance are:

- The greater rate of change and variation that can occur with children's needs (e.g. because of new settings of child development issues).
- Children may be dealt with within more complex inter-agency systems and assessment processes.
- The families of children are often very involved in working with CAMHS and need to be fully involved in decision-making under CPA.
- Involving children themselves in decision-making requires particular attention.

Local teams are likely to have experience of cross-agency meetings for Looked after Children (LAC) and family group conferences and should draw upon this expertise in developing care plans for children and young people.

To ensure continuity of care the care coordinator should follow the transition protocol for transitions from CAMHS to adult services.

As CPA is not the only care planning method for children and young people, its use needs to be coordinated with the other systems e.g. Choice and Partnership Approach (CAPA) ,the (children's) CAF, and any local systems for Looked After Children.

Children, more than adults, are likely to be subject to multiple care plans and review Mechanisms from multiple agencies e.g. Looked After Child Reviews, Special Educational Needs reviews, (children's) Common Assessment Framework (CAF). All professionals and agencies need to work together to ensure minimum duplication of information, meetings and clarity of roles (especially who is leading) to avoid confusion and risk. CPA needs to be seen in the context of other planning mechanisms for children with complex needs

It is vital that CAMHS staff do not under estimate the importance and usefulness of the CPA and that when attempting to avoid duplication that CPA should not be considered extra to the requirements of young people engaged within CAMHS. CPA should not be neglected in favour of other multi agency frameworks. CPA should be seen as the primary framework for the approach taken to the care of service users in CAMHS and as a frame work that informs and demonstrates how CAMHS interfaces with other multi agency frameworks**.**

It is important to have clarity at the interface between different care planning systems and to ensure that actions, roles and responsibilities are clearly marked out and understood.

7.11 Transfer / Discharge of CPA Responsibility

7.11.1 Within the Trust

Any decision to transfer the care of a user between workers/services within the Trust (for example Team to Team) should occur as part of a **review** and in line with any agreed **transfer protocols.** Prior to the transfer, the *transferring* Care Coordinator should ensure that:

They have contacted the receiving worker/service and passed on the relevant information/documentation e.g. current care plan, Mental Health Review (including risk assessment). The receiving team/service has made arrangements to allocate a new Care Coordinator and appropriate services have been set up.

The transferring Care Coordinator remains responsible for the care of the user 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 **1 month** after the transfer is agreed.

The transferring Care Coordinator must ensure that the full care record is transferred to the receiving team/worker as soon as receiving team takes over responsibility for the managing the service users care.

Transfer between community secondary mental services should be planned and will not occur out of hours (i.e. Monday – Friday between 5pm and 9am, weekends and bank holidays)

Out of hours transfers between inpatient services will be planned and will follow the acute services, CAMHS or RHSD bed management policy.

7.11.2 Between Trusts

All health and social care organisations have the duty to collaborate to ensure proper, co-ordinated care is delivered to people with Mental health needs.

Each district Local Authority Social Services Department and Health Trust will jointly operate a Care Programme Approach (CPA) Policy. 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.

7.11.3 Planned moves for those people on CPA

People who move from one area to another remain the active responsibility of the original authority until a formal hand over can be arranged. The decision to transfer responsibility for the care of a service user to another district should take place in a CPA review meeting, unless exceptional circumstances prevent this.

Appropriate representatives of the receiving district should be invited to attend the meeting e.g. the new care co-ordinator. A timescale for implementing the transfer should be drawn up, subject to the guidelines on timescales below.

The decision to transfer a persons care cannot depend on whether their mental health is stable over an extended period, however, if there is clear evidence of a substantial risk to a person's mental health because of the transfer, then local negotiation should take place about how this should best be effected. By mutual agreement from both areas, a longer period for transfer of care co-ordinator may be identified, or a period when the services work together jointly to deliver care and support. However the receiving area should accept care management responsibility for the person within the timescales identified below.

Timescales: the CPA Review to discuss the transfer of the person's care should take place, if it is a planned move, before the person actually moves to the new area, so that there can be a seamless transfer of care. In exceptional cases where this is not possible, the Review meeting should take place **within 5 working days** of the move.

Following the Review in which the decision is made to transfer the patient to the receiving area, the original transferring Care Co-ordinator will retain responsibility for the management of the care for **no longer than 6 weeks** . This will allow:

- The receiving team to identify a new Care Co-ordinator who can accept responsibility for the person's care
- The establishment of appropriate services in the receiving area
- The transfer of all relevant records to the receiving area. This should be done within **10 working days** of the Review
- A copy of the case notes should be kept in the archive

Relevant records should include:

- Most recent assessment including risk assessment
- Current Care Plan including (inc Crisis , risk management and contingency plans)

The *transferring Care Co-ordinator* should ensure that the above has been agreed before the transfer takes place:

The service user and carer or advocate (where appropriate) should be involved and informed of the transfer details and ideally should meet the receiving care co-ordinator as soon as possible prior to the transfer. The receiving GP should also be in receipt of all relevant information and be aware of the receiving team and the new care co-ordinator's contact details. All electronic/paper databases should be updated with new information. This should be done by the receiving service

It should be stressed, however, that where the person has moved to an area which is a substantial distance from the transferring Authority, such that it would not be reasonable for the transferring Authority to maintain active case and risk management, the receiving Authority should provide interim care and support. The need for this support should be identified at the Review and a formal contingency plan should be put in place. This should include arrangements to ensure a system of effective liaison and rapid transfer back to the original team if the patient moves back to the originating district. When this occurs the original service should resume responsibility for care of the user as soon as possible after receipt of notification and adequate clinical information (i.e. current care plan and risk assessment).

Where a person is placed in residential care in another area, or where they need commissioned services as part of their Section 117 aftercare plan, the original district will maintain financial responsibility. In retaining financial responsibility, the original district also retains responsibility for reviewing and reassessing the suitability of the placement/service, unless it negotiates with the receiving district to undertake this on its behalf. Where CPA responsibility has been transferred to the new Authority, such reviews should take place as part of the normal CPA review process. At the first Review, clear agreement should be reached between both organisations as to exactly how these review processes should be carried out, to avoid confusion and duplication

In line with the "Good Practice Guidance for North West Councils re AMHP assessments for residents who are not in their home area at the time of assessment", the responsibility for applications under the Mental Health Act in respect of service users in funded placements or subject to 117 aftercare, would normally remain with the original district/authority, unless it has been formerly negotiated and recorded that the host district/authority is acting on their behalf. These arrangements should therefore be agreed at the initial Review

7.11.4 Unplanned moves for those people on CPA

Some users will move in an unplanned way between districts. Where this is very local, and the original team/worker is aware of this, s/he should continue working with the user until formal hand over arrangements, described above, can take place.

Where the move is at some distance and it would be impracticable for the original team/worker to do this, relevant information should be sent immediately to the new

team/worker and discussion take place at the earliest opportunity to effect formal hand over.

In non-urgent situations, a CPA meeting should be called by the originating Authority **within 10 working days** of their notification that the person has moved. The process in Section 7.9.3 and following should then be followed.

Information that should be provided by the Originating Authority for the Receiving Authority for people who are on CPA:

At the very least, the information requirements of the Receiving Authority will be as follows:

- An up to date assessment of need and care plan
- An up to date risk assessment, risk management plan and contingency plan, which particularly considers risks of harm to children and young people in the household
- All current information about the person's legal status under the 1983 Mental Health Act (as amended by the 2008 Mental Health Act)
- Any child protection information
- Any capacity assessments
- Any documentation relating to the use of the Deprivation of Liberty Safeguards
- Any Advance Statements that the person may have made about the care and treatment they should receive

Where there are concerns regarding the transfer of care, including non acceptance of transfer of care, the Care Coordinator should advise their line manager immediately. The Line Manager should then contact the receiving authority to agree the transfer arrangements, if no resolution is reached this should be escalated to the Service Manager.

7.11.5 Planned moves for those not on CPA

By definition, people whose needs are such that they are not on CPA will have well-managed mental health issues, lower levels of risk and less service involvement. However it is still important that their receiving Authority is made aware of them, so as to provide local support as required.

Where the move is a planned one, and the key worker is aware of the move, then the key worker should write to the both the Head of Service (or equivalent) in the receiving Mental Health NHS Trust, and the patient's GP when known. The following information should be given:

- The latest assessment and care plan (or equivalent document)
- Contact details of the Originating Authority, where further information can be obtained as required.

In those situations where the person's mental health was deteriorating to the point that they were to be placed on CPA, a CPA review should be called with the whole

clinical team, and the transfer processes described in Section 7.9.3 should be followed

7.11.6 Unplanned moves for those not on CPA

Where the move that takes place has not been planned, and the key worker has been informed of the person's new home address, the key worker should follow the process in section 7.10.5.

7.11.7 Transfer of care and Safeguarding Children

Where there are dependent children within the household of a service user with mental health needs, special consideration should be given to the implications of the move to another district may have for those children. Children's welfare is a paramount consideration for all professionals. Where there are issues of concern, the relevant child care services from the transferring and receiving district should be crucially involved in the planning arrangements for the transfer, so that children's needs may be properly identified and managed. It is the responsibility of the transferring authority to ensure that the receiving authority children's services are informed of any concerns.

Where a child has a Child Protection Plan and is moving to another Local Authority area, it is imperative that a speedy exchange of information is carried out between districts. This will normally be in the form of a Child Protection Conference. All Local authorities have policies in these areas which can be accessed at the Local authority safeguarding sites. Guidance may also be found within the Trust Safeguarding children's policy.

7.11.8 Transitions in care

Local protocols have been developed for the transition of care between *CAMHS*, *Adult of working age* and *Older Peoples* services.

Transfer need not take place immediately the person reaches the age limit for a particular service.

For further guidance please refer to the Trust Transition protocols

7.12 NCRS/PARIS recording and reporting

The Performance, Planning and Information Department needs to ensure that systems are in place to obtain the necessary information to meet NHS and local authority performance measurement requirements.

Care Coordinators and Key Workers are responsible for ensuring that NCRS/PARIS shows the correct information about whether a Service user is on CPA or not.

Other reporting systems including the 7 day follow up form must also show if a Service user is on CPA or not.

The Heads of Performance and Information will ensure the monitoring of NCRS/PARIS data set is completed and any concerns fed through to the Tier 4 group.

Full details of the NCRS/ PARIS and other reporting systems recording requirements in relation to CPA are provided in “A Practice Guide to CPA’

8 Implementation of the CPA policy

8.1 Dissemination

The CPA Policy will be disseminated in the following ways:

- Via the Trust Intranet.
- Through management briefing sessions.
- Through Trust Induction.
- Paper copies in each department.
- Local partnership meetings

Whenever the policy is revised a programme of briefing sessions / communications will be delivered to managers. They will then be responsible for ensuring all changes / updates are cascaded to staff within their teams within the stated timescales.

8.2 Training

The CPA training programme has been revised to reflect the requirements of the ‘Refocusing the Care Programme Approach, Policy and Positive Practice Guidance’.

An introduction and overview of CPA is provided at the Trust Induction and Local Induction to service.

CPA training will be delivered as follows:

CPA E-Learning (Level 1) - The programme is based on the national training guide “Refocusing the Care Programme Approach (CPA). This will be available on the National Learning Management system e-learning platform and successful completion of the package will be recorded to the Trusts learning management system for reporting purposes and the learners own training record history.

The e-learning programme must be completed by all staff working in Mental Health & Learning Disability Services to obtain an understanding of the function, process, service user needs assessment, risk assessment & management, carers’ needs, care planning, transfer, discharge and the responsibilities of the care coordinator.

A bespoke face to face version of the course along with the Care Co-ordinator work based assessment competencies (CPA – Level 2) is available for those who are care co-ordinators. This is available on request to the OL&D service

The CPA E-learning course should be completed every 3 years to refresh competencies.

8.3 Refocusing CPA

The current policy has been revised to reflect the National guidance 'Refocusing the Care Programme Approach, Policy and Positive Practice Guidance'. This national guidance supersedes the initial CPA policy.

9 Audit, Monitoring and Review of the Policy

The CPA Service Lead chair's the group and is responsible for ensuring the implementation, review and monitoring of the policy. The policy will be formally reviewed every 2 years.

Audit and monitoring are essential components of the successful operation of the CPA system. Audit will not only explore the numbers of users subject to CPA but also the quality of CPA arrangements.

An Annual audit of CPA will be completed focusing on implementation of and adherence to the policy. This will include requirements for discharge and transfer of service users and information and documentation given to service users. The Audit will be managed and carried out through the Clinical Audit Department. The results of the audit will be fed into the Trust wide Tier 4 group who will make recommendations for improvements and ensure an action plan is developed and implemented.

Any evidence imparted from the audit will be disseminated along with action plans, to all Divisional Integrated Governance Groups, Departmental Managers, and Risk and Clinical Governance Committees.

The weekly Patient Safety Improvement Group will review Serious Untoward Incidents on receipt of an Initial Report. The accompanying documents will include, risk assessments, care plans (Inc Crisis, risk management and contingency plans) that will be scrutinised by the group to ensure compliance with the policy. The group will ensure that service areas have identified action plans where there is evidence to show non compliance. The Risk Department will monitor completion of the action plans. Themes emerging from the PSIG will be fed into the Divisional Integrated Governance Groups by the risk manager for shared learning.

Departmental Managers will ensure, through mechanism of supervision, that CPA practice is monitored. Responsibility for monitoring the 'quality' of care plans will be with each Departmental Manager. Supervision, along with audit initiatives, will ensure standards for care planning are met. Evidence of this will be reported to the CPA Audit monitoring and review group.

CPA training will be monitored by the Organisational Learning and Development Department. Any non-attendance at this training is monitored by the Learning and Development department and reported to Service Managers via email following each course. The Learning and Development department will also send a monthly report of all attendance at required training to the Service Line Managers.

Ethnicity monitoring systems will also be established to ensure the impact of the policy is monitored effectively.

10. Glossary of Terms

Assessment - The *process* of gathering data for the purpose of determining need and eligibility for services.

After-care - A clear purpose of all treatment and care is to equip the patient to cope with life outside hospital and function there successfully without danger to themselves or other people. These objectives apply to *all* patients receiving treatment and care from specialist psychiatric services, whether or not they are admitted under the Mental Health Act 1983 and form the key elements of the Care Programme Approach.

Care Coordinator - A mental health professional responsible for co-ordinating the package of care being provided to the service user and (where necessary) carer.

Care Management - The process through which service users are assisted to determine their needs under the eligibility criteria of the *Care Act (2014).* The objectives of Care Management are:

- To meet individual care needs through the most effective use of resources.
- To restore and maintain independence by enabling people to live in the community wherever possible.

- To prevent or minimise the negative effects of disability, illness or mental distress in people of all ages.
- To achieve equal opportunities for all.
- To promote individual choice and self-determination and build on existing strengths and care resources.
- To promote partnerships between users, carers and service providers in all sectors.

Care Plan - A written description of the user's needs and how these will be met.

Carer Assessment - Carers have a right to an assessment of their needs even where the person being cared for has refused an assessment or is not receiving services. Its purpose is to identify needs arising from the caring role and to determine if and how these can be met.

Care Programme Approach (CPA) - CPA was introduced in 1991 as an approach to provide a framework of care for people with severe mental illness, which would minimise the risk that they lose contact with services. It was updated in 1999 via the policy booklet "*Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach*".

Children in Need - The *Children Act 1989* defines that a child is *in need* if:
S/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority; **or** his/her health or development is likely to be

significantly impaired, **or** further impaired, without the provision of such services; **or** s/he is disabled

Appendix 1: Difficult to engage service users – managing non-compliance

- A collaborative approach to care and treatment planning for all service users is good basic practice. The service user's aspirations (where known) should be the starting point for engagement.

- When a user fails to comply or cooperate with proposed care or treatment, the first response is to find out why. The findings from Safety First indicate that around one fifth of suicides were non-compliant with medication in the month before death

- The reasons for treatment and / or the care plan should be fully explained to the service user (and carer). In this way they may be persuaded that it remains in their best interest.

- A user should not be discharged solely on the grounds of refusal of treatment. The care co-ordinator must make reasonable efforts to stay in touch in line with the degree of risk associated with disengagement.

- Efforts to stay in touch should include telephone contact with user or contact with others who are in regular touch with user e.g. carer. These should be clearly documented.

- Problems with maintaining engagement or compliance with treatment should trigger a review of the risk assessment / management plan.

- Where the risk assessment indicates there is a serious and immediate risk of suicide, self-neglect or harm to others assessment under the Mental Health Act should be considered and implemented as quickly as possible.

Appendix 2: Loss of contact

- Key findings from Safety first also indicate that in just under one third of suicides in the community, the deceased had missed their final appointment with the service. Mental health teams made an assertive attempt to re-establish contact (e.g. home visit) in 33% of cases.

- When any service user fails to attend a pre-arranged appointment (including outpatients) or home visit, the worker concerned needs to undertake a risk assessment or consider what this indicates.
- Subject to the circumstances and degree of risk, the following actions should be considered:
    - Sending another appointment, or calling back later
    - Contacting other workers who may have been in touch with the service user
    - Contacting friends or relatives to ascertain the whereabouts and health of the service user

- If it is considered that the service user is at high risk and is at home but simply not answering the door, it may be appropriate to obtain entry to the Service Users home under Section 135 of the Mental Health Act.

- If the service user appears to have moved without leaving a forwarding address it may be appropriate to contact adjoining psychiatric service providers, and if necessary, the police .

- On re-gaining contact with the service user, the care co-ordinator should take the following action:
    - Re-engage the service user and attempt to ascertain the underlying reason(s) for loss of contact with the service user;
    - Discuss with the service user (and where appropriate carer / family) how contact might be maintained or improved in future;
    - Review the current community care plan and risk assessment and amend these in light of the reason for loss of contact
    - Where the loss of contact gives rise to high risk, communicate this to other relevant parties.
- All discussions and actions taken around those with whom contact has been lost should be carefully recorded in the notes. This should include dates, times, discussions and actions taken, including reasons for these.