Our Ref: NG/RM/24279
Date: 21st November 2024

Nicola Griffiths
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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 28th October 2024**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
I would like a copy/copies of the Trusts policy and procedures in place for Community Mental Health Teams/ inpatient mental health services relating to the implementing the Care Programme Approach between 2017 and 2024, including policies set aside after the implementation of 'Combined Healthcare transforms care planning for patients' January 31, 2024

Please see Appendix 1 attached.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

Document level: Trust
Code: 1.84
Issue number: 3

Care Management Policy (including CPA).

Lead executive	Executive Director of Nursing and Quality
Authors details	Quality Assurance and Improvement Manager

Type of document	Policy
Target audience	All Trust staff involved in Care Management & CPA
Document purpose	The policy provides a set of standards and expectations to ensure that Care management standards and processes are in place to ensure safe and efficient care and treatment of service users.

Approving meeting	Quality Committee	Meeting date	7th March 2019
Implementation date	December 2017 Ratified at Trust Board March 2019	Next Review date	30th June 2025

Trust documents to be read in conjunction with	
1.64	Effective Care Planning Policy
1.17	Admission, Discharge and Transfer Policy
1.62	Physical health assessment and examination policy
MHA01	Supervised Community Treatment Procedure
MHA16	Mental Capacity Act policy
MHA09	Section 117 Aftercare under the Mental Health Act
4.25	Consent Policy
7.01	Confidentiality of patient and employee Records Policy
1.41	Clinical risk assessment policy
4.01	Safeguarding Children Policy Statement
4.01a	Preventing Harm to Children from Parents with Mental Health Needs
4.22	Children Visiting Mental Health & Learning Disabilities Hospitals
1.70	Managing Allegations of abuse made against a person or persons working with Children or Vulnerable Adults
4.43	Prevent Policy
1.75	Domestic Abuse Policy
112a	Safeguarding Adults Policy Statement
1.55	Advance statements and advance decisions to refuse treatment

Document change history		Version	Date
What is different?	Amendments made to standards	2	May 2018
Appendices / electronic forms			
What is the impact of change?			

Training requirements	There are no specific training requirements for this policy.

Document consultation	
Directorates	All Heads and Clinical Directors of each Trust Directorate
Corporate services	Document quality group and Senior Operating Team Meeting
External agencies	N/A

Financial resource implications	None

External references
1.

Monitoring compliance with the processes outlined within this document	SLT performance monitoring, including clinical safety matrix audit assurance.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favorable / More favorable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	No	The policy applies to people of all ages and intervention is determined by complexity of need.
– **Disability** (remember to consider physical, mental and sensory impairments)	No	Level of care is determined by complexity of need and based on professional judgement of care coordinator in consultation with the individual and / or family.

– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	The CPA determination criteria requests specific consideration to people in potentially isolated groups.
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	Safeguarding considerations would be determined via clinical risk assessment on an individualized basis but recognizing pregnancy and maternity as potentially higher risk / need.
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	The CPA determination criteria requests specific consideration to people in potentially isolated groups
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	The CPA determination criteria requests specific consideration to people in potentially isolated groups
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	The CPA determination criteria requests specific consideration to people in potentially isolated groups
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		

Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	NA
Enter details here if applicable	
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	NA

CONTENTS

Quick reference flow chart
Care Management Process Summary & Quality Indicators

Referral in

Triage
MH Liaison, Access, HUB

Open episode, create appointment and complete Triage forms on EPR
Triage assessment includes outcome summary
Triage risk assessment includes a plan.
Risk assessment & plan to be available within Lorenzo within 24hrs of triage assessment.

Reported separately from full assessment as evidence of risk assessment and care plan

Require admission to secondary care service

Do not require secondary care

Discharge OR Transfer to non-specialist secondary care

Assessment
Adult, NOAP, LD, CAMHS Substance misuse

Community
Open team episode, review if CPA is required **within 24hrs of assessment** if not registered and identify care coordinator **within 7 days of assessment**

Complete Risk Assessment and Initial Assessment in EPR
Within 24hrs of assessment

Complete overarching CPA or Standard Care Plan in EPR
A copy should be available to the patient within 4weeks of assessment; 7days post a review and 12hrs of an admission to an inpatient setting

Care co-ordinator must be a community clinician & professionally registered at band 5 or above.

In-patient Admission
Ward 1, 2, 3,5,6,7, A&T, Darwin, summers view, Florence

Inpatient - Admit to ward

Register for CPA **72hrs of admission (if continued admission is required)** if not already registered and identify care coordinator **to be allocated within 3 days of admission.**

Complete Risk Assessment and Initial Assessment in EPR
Within 12hrs of admission

Complete intervention plans in EPR
Within 12hrs of admission

All service users must be offered face to face follow up within 48hrs of discharge and a CPA review 4 week post discharge if admission is longer than 72hrs.

In-patient staff to contact Community team immediately if no care coordinator.

Care coordinator to commence care plan within 5 days of admission

Variation to above
LD services may use paper to support “easy read”
Substance Misuse will use Nebula/Halo as EPR
Healthy Minds will use IAPTUS as EPR
Dragon Square Short break ward 4 & NOAP memory services have clearly defined standards within their operational policies.

1. Policy Introduction / Background

This policy identifies the core assessment and care planning requirements for all service users treated by secondary mental health services within the Trust.

1.1 Policy Requirement

All people using secondary mental health services will be supported in accordance with the care management standards identified within this policy. Those accepted for care and treatment will receive care in line with one of the two care management arrangements identified by this policy.

All service users receiving treatment and care from secondary mental health services will be provided with a care plan, developed in partnership with them, that is Personalised, clear and accessible.

All service users receiving treatment and care from secondary mental health services will be allocated a named healthcare professional who will be responsible for the co-ordination of their care.

1.2 Trust Exceptions

Some services provided by North Staffordshire Combined Healthcare NHS Trust (NSCHT) are not delivered as specialist secondary care services but have been secured through tenders as Primary Care or Universal Services that a range of NHS or Non-NHS organisations may provide. These services must be clearly identified via each directorate's or relevant team's standard operating procedures, as they will use a range of care management approaches outside CPA or Standard Care.

These services are:

- Primary care services provided by the secondary mental health service
- Assessment only service
- Triage only service
- Local Authority social care service
- Consultation service
- Short break service
- Substance Misuse
- Ward 4 (Patients are admitted to ward 4 with a primary need linked to their physical health recovery and therefore they do not require to be discharged under CPA and do not require the formal 4 week review. 7 day face to face on discharge remains relevant)

NB – the Trust have set an expectation to achieve face to face follow up within 48hrs of discharge from an inpatient facility.

Within each of these services the team's operational policy will clearly outline their care management approaches which will remain compliant with the Trusts values and ensure that safe, appropriate, person centered care is delivered.

1.3 Policy Aim:

The policy aims to reinforce an integrated approach across the Trust to provide systematic assessment processes and effective care planning for service users within the Trust.

The policy reflects the requirements of national guidance, including:

- Refocusing the Care Programme Approach (DOH March 2008)
- Best Practice in managing risk
- Suicide prevention strategy
- Mental Health Code of practice

This policy identifies the core assessment and care management requirements for all service users treated by secondary mental health services within the Trust.
The policy is therefore applicable to all clinical staff working in secondary mental health services.

1.4 Key Principals:

The policy reflects the following principals in relation to assessment, care planning and care co-ordination and review arrangements for all service users regardless of age or clinical setting.

- To provide holistic, integrated and consistent approach to care management across all Trust secondary mental health services, alongside the trusts other key providers (social care, primary care and other healthcare providers).

- All service users receiving care, treatment and support will receive quality care based on an individual assessment of their health and social care needs including risk, vulnerability, and an evaluation of their strengths and identification of their goals, preferences and opinions.

- Assessment, care planning and review will focus on improving outcomes for service users and their families in all aspects of their life, helping them to achieve outcomes that matter to them.

- The approach to assessment, care planning and review will be collaborative, placing the service user and their family at the centre of care, maximising their involvement and supporting the principal of 'no care about me without me'.

- Ensuring that the service users' needs are regularly reviewed and kept up to date whilst minimising duplication and repetition.

- Ensuring that clear accountability for care planning with a single person who has overall responsibility for care co-ordination.

- Recognising the need to plan and provide care which is sensitive to the individual, recognising diversity in relation to race, faith, age, gender and sexual orientation and other special requirements that the service user may have in order to ensure equitable and appropriate access to services, interventions and information.

2. Policy Synopsis

- All people using secondary mental health services will be supported in accordance with the care management standards identified within this policy. Service user's accepted for care and treatment will receive care in line with one of the two care management arrangements identified by this policy: **CPA** or **Standard Care.**

- On entry to secondary mental health services, all service users will receive a core assessment of their health and social care needs, including risk.

- All assessments will be considered by the Multi – disciplinary team at the earliest opportunity to confirm whether the individual's needs are best met by secondary mental health services and to identify the required care management.

- All service users receiving care and treatment from secondary mental health services will be allocated a named healthcare professional who will be responsible for the co-ordination of their care, supporting their involvement and liaising with family, carer and where relevant, other agencies.

- All service users will be actively involved in making decisions about their care and treatment as they wish to be. Where appropriate the views of carers and other interested parties will be sought and any wishes laid out in an existing advance Statement will be taken into consideration.

- All service users receiving care and treatment from secondary mental health services will be provided with a care plan, developed in partnership with them,

that is clear and accessible. This will be provided within 4 weeks of their initial assessment and acceptance into secondary mental health care (NB - for service users admitted directly into Inpatient settings an initial intervention plan will be available within 12hrs of admission).

- The care plan will be based on assessed needs, including risks and vulnerabilities, of the service user, it will be relevant to their current circumstances, and care setting, and will focus on meeting outcomes, goals for recovery and wellbeing and towards discharge.

- All clinicians will be responsible for ensuring that their interventions are included in the care plan and provide evidence of the service user's involvement in decisions about care and what is important to them.

- All services users will have their care plan reviewed as determined by their needs and changing circumstances. It is expected that this would usually be at least every six months but as a minimum standard must be annually unless clinical presentation, the service user / carer, or operational service standards recommend more frequent review periods.

- All service users will be given information about Advance Statements and Advanced Decisions and provided with the opportunity to develop one if they wish to do so.

- All service users receiving care and treatment from secondary mental health services will be screened at assessment and reviewed to identify informal carers.

- Service users will be supported to understand information recorded about them and details of their planned care through access to interpreting and information support, including BSL for the deaf, and provision of plain language, easy read versions where appropriate.

- Service users will be provided with information for advocacy services.

- All care records and information will be fully recorded in the Trusts EPR system, this will be completed accurately and in real time.

3. Responsibilities

3.1. Board Level Responsibility

The Executive Director of Operations has accountability and responsibility for the development, implementation and review of this policy on behalf of the Chief Executive.

3.2. Clinical Directors, Clinical Leads, Heads of Directorate, Service Managers and Team Leaders

Managers and clinical leaders are responsible for ensuring that processes and procedures are understood and carried out by all staff involved in care management. They are responsible for ensuring that systems are in place to identify, manage and mitigate risks to staff, service users and the public. This is supported through supervision processes and performance management.

Managers should ensure that care coordination is an integral part of a clinician's role; this requires clinicians to:

- Be competent in delivering mental health care
- Have knowledge of the service user, their carer's and family
- Have knowledge of community services and the role of other agencies
- Care co-ordination skills
- Have access and authority to allocate resources at an appropriate level
- Have appropriate supervision including review of caseload size
- Have skills in Direct Payment / individualized budget procedures and the skills required to properly, meaningfully and supportively explore Direct Payment/ individualized budget alternatives with service users.
- The role of managers should include monitoring, audit, and quality improvement and performance management.

3.3. All Clinical/Practice staff

All clinical/practice staff are responsible for adhering to this policy when involved in the assessment, planning or review of care for individuals accepted into secondary mental health, substance misuse and learning disability services.

4. Procedure

4.1 Assessment:

- On entry to secondary mental health services all service users will receive a core assessment of their health and social care needs including risk and vulnerability. The assessment will be undertaken by a registered professional and recorded in the Trusts EPR system (Lorenzo) using the Initial assessment document and the Trust approved risk screening or assessment tool.

- The assessor must ascertain and appropriately record (name, age, date of birth, relationships to) of any children in the household or with whom the service user has significant contact with. Details of other dependents in the household must also be recorded.

- Subject to the service users' agreement, the assessment should include contributions from carers, relatives, friends or an advocate; the persons views may be overridden where there has been a significant risk identified.

- The assessment will identify and take into account the views and needs of any identified informal carers.

- The assessment will lead to a decision about the inclusion on CPA and should therefore identify the service users mental health needs and areas of risk in sufficient detail to enable confirmation of care management arrangements: **CPA** or **Standard Care.**

- At the end of the assessment process formulation, a care plan should be agreed.

- The outcome of the assessment must be considered by the multi-disciplinary team to confirm the allocation to **CPA** or **Standard care** as guided by the **CPA determination criteria** (appendix 1). The rationale for the decision should be recorded in the assessment summary as one of the outcomes of the assessment. **CPA or standard care** status should then be recorded within the EPR system (Lorenzo).

- A named care co-ordinator (irrelevant of CPA or Standard care status) must be identified within the EPR System (Lorenzo) within 7days of being accepted into secondary care services.

- The outcome of the assessment should be communicated to the service users and referrer within a maximum of two weeks from the date of the assessment.

NB – For Patients admitted into hospital:

- The **CPA** status of all service users admitted to inpatient hospital wards will be reviewed during the first 72hrs of admission (with the exception of Edward Myers Unit, Ward 4 and Dragon Square short break service).
- If the admission continues beyond the initial 72hr period it is expected that the person will be registered for **CPA**; if the person remains on standard care then the rationale for this must be recorded in the EPR using the **CPA determination tool or the individual's core assessment.**
- All patients discharged from hospital will have a face to face contact within 48hrs of discharge from the ward, including any inpatient discharged within the 72hr period. Also patients discharged within 72hrs will be discharged on standard care.
    - If further involvement with secondary care is not indicated at the point of discharge then the 48hr face to face appointment will be carried out by the home treatment team.
    - If involvement with secondary services is still not indicated at the face to face then standard care can be discharged and discharge standards and processes implemented.
    - If a patient is discharged within the 72hr period and is waiting for a care co-ordinator to be appointed (within 7days) the home treatment team will complete the 48hr face to face appointment and hand over to the care co-ordinator once they have been appointed.

4.2 Care Planning:

- All services users' receiving care and treatment from secondary mental health services will be provided with a care plan developed in partnership with them that is clear accessible, without jargon, professional's terms or abbreviations.

- The care plan should provide clear evidence of the service user's views, preferences, involvement in decisions about care and personal goals for recovery.

- The content of the care plan should be explained to the service user and they should be provided with their copy within 4 weeks of assessment or 7 days of review. (NB – Service Users admitted into the service directly to an inpatient ward will have an intervention plan within 12hrs of admission).

- Once the care plan is agreed any changes must be discussed with the service user and others involved before being implemented.

- Where a service user is unable, or declines to engage in care planning, a statement to this effect must be provided within the care plan. Where possible the service users' views should be represented, informed where appropriate, by

consultation with carers or advocate or with reference to any Advance Statement or decision that have been made.

- Where an advanced statement exists, the care co-ordinator should ensure that the key components are incorporated into the care plan.

- Where a decision in the care plan is contrary to the wishes of the service user or others, the reasons for this should be explained to them and documented. Reasons for disagreements should be regularly reviewed and alternative options sought and discussed to enable agreement where possible.

- The content of the care plan should be based on the assessed needs of the service user including identified risks and physical health issues, and must reflect the service user's current circumstances and care setting. The detail in the plan must be adequate for the purpose, setting out the practicalities of how the service user will receive treatment, care and support to allow other workers to action the plan if necessary. A comprehensive care plan will acknowledge and take into account the wide range of issues that may affect treatment and recovery, and will identify ways in which steps are being taken to address these needs.

- Where the service user may be at risk of a restrictive practice, a personalised plan (referred to in the Mental Health Act Code of practice as a behavioural support plan) should identify the potential risks, triggers and a positive plan to reduce the risk of restrictive practices (Within Lorenzo this will be an 'Intervention plan'). The plan should include how the service user would like to be treated in the event that this does occur.

- The care plan will be focused on recovery and wellbeing and should define the recovery outcomes and goals that have been agreed with the service user and others involved, including, where appropriate, family and carers. The aim is to facilitate moving on and discharge from secondary mental health services where possible.

- The care plan will clearly identify how outcomes are to be achieved. All clinicians are responsible for ensuring that their interventions are included in the care plan and for providing evidence of the service users' involvement in decisions about care.

- The care plan will indicate the level of involvement, views and opinions of any carers involved in the service user's care. In the absence of any carer involvement the care plan will give indication as to why.

- Care plans must include a crisis plan which identifies early warning signs, individual coping strategies, and actions to be taken by the service user, family, carers, and/ or the wider care system in a crisis or, if a service users mental health deteriorates, contact details for the care co-ordinator and information about who to contact out of hours (24/7 contact point).

4.3. Review:

- All service users will have their care reviewed as agreed or determined by their needs and changing circumstances. It is expected that this would be at least every six months but as a minimum standard must be annually, unless clinical presentation or local service standards recommend more frequent review periods or the service user or carer request an earlier or more frequent review period (for example, inpatient settings).

- The period between reviews should be determined by the care co-ordinator in conjunction with the service user and their carer and the MDT. The date of the next review must always be specified, although it is acknowledged that changes may occur. The care co-coordinator is responsible for organising the review.

- All service users discharged from an inpatient stay which was longer than 72hrs, home treatment care or prison and remain in receipt of secondary mental health services must have a review within 4 weeks of discharge (in addition to the 7 day face to face review). NB – all patients discharged from a hospital admission will receive a 48hr review as indicated on page 12.

- A review must involve, as a minimum, the care co-ordinator and the service user unless the service user is unwilling or unable to be involved.

- The review will provide a structured opportunity to evaluate progress in achieving care plan recovery goals; consider changing needs and the requirement for support under CPA.

- There will be a clearly documented summery of the review process, including any decisions made, recorded in the progress notes of Lorenzo as follows:

4.4. MDT Review:

A formal review comprising of a multi-disciplinary discussion may be called by a member of the care team including the service user or carer. This will usually be where need, circumstance or risk has changed, the purpose being to review the plan of care with a view to confirming existing actions or making appropriate adjustments to the care plan. This will be recorded under the MDT review section of Lorenzo.

5. The Care Programme approach (CPA)

The approach was introduced in 1991 describes four core elements:

- **Assessment** – Comprehensive assessment of health and social care needs including risk
- **Care plan** – an agreed plan of care. This needs to be carried out in partnership with the service user, clearly outlining their views, preferences, goals and strengths.
- **Care Co-ordinator** – Every patient will have an appointed named care co-ordinator.
- **Review** – Every patient will have their care reviewed and where indicated, agreed changes will be made to their care plan.

5.1. CPA Criteria:

As identified in the CPA review (DH, 2008) the following characteristics will be considered when deciding if support of CPA is needed:

- Severe mental disorder (including personality disorder) with high degree of clinical complexity.
- Current or potential risk(s), including:
    - Suicide, self-harm, harm to others (including history of offending)
    - Relapse history requiring urgent response
    - Self-neglect/non-concordance with treatment plan
    - Vulnerable adult; adult/child protection, e.g.
        - Exploitation (financial/sexual)
        - Financial difficulties related to mental health
        - 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 or referred to crisis/home treatment team.
- Significant reliance on carer(s) or has own significant caring responsibilities.
- Experiencing disadvantages or difficulty as a result of;
  - Parenting responsibilities
  - Physical health care
  - Unsettled accommodation/housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Ethnicity (e.g. immigration status, race/cultural issues, language difficulties, religious practices), sexual or gender issues.
- Those individuals who require Community Treatment Orders will be on CPA with care planning and review processes meeting the statutory requirements.

Key groups are service users:

- who have parenting responsibilities
- who have significant caring responsibilities
- with a dual diagnosis (substance misuse)
- with a history of violence or self-harm
- who are in unsettled accommodation
- are unable to maintain lasting and consenting contact with services.

NB – In line with the Trust's gatekeeping standards and principals it is expected that service users who are admitted to inpatient settings (with the exception of Edward Myers unit, ward 4 and Dragon Square short break service) will be experiencing one or more of the above characteristics and are likely to meet the criteria of **CPA**, however there are occasions when patients are admitted to the inpatients wards and do not meet the criteria, this will therefore be reviewed and determined within the initial 72hrs of admission as indicated above on page 12.

- The needs of individuals from these key groups should be fully explored to make sure that the range of their needs are understood and addressed through appropriate liaison and support when deciding their need for support under **CPA**. The decision and reason not to include individuals from these groups should be clearly recorded in the core assessment and / or subsequent review records.

- Significant reliance on carers requires careful consideration if a decision not to allocate to **CPA** is to be made in these circumstances. Care can be provided through an informal care network (family / friends) or formal network (care agency). Where a service user has a significant reliance on carers, it is critical to consider if a breakdown in the care network would result in an increase in the vulnerability of the service user, which would put them at risk. If this is the case, the CPA should be applied until such a time where day to day care arrangements are sufficiently robust to ensure that the service user is not at increased risk of harm as a result of personal vulnerability.

5.2. Care Management standards for CPA:

- Where a service user has been assessed as needing CPA or are admitted to inpatient hospital wards, the care co-ordinator will be a registered professional experienced in mental health work with the appropriate skills to perform the core functions of the role (Appendix 2).

- Once the need for care under CPA has been established, a care co-ordinator must be allocated within 7 days (for service users admitted to inpatient wards a care coordinator will be allocated within 3 days).

- Care co-ordination should facilitate access and support for service users to benefit from the full range of health and community support needed including: physical health, housing, education, work skills, training, employment, voluntary work, leisure activities and welfare benefits.

- Care co-ordination should ensure that all aspects of a comprehensive risk assessment are undertaken and formulated into a clear management plan which is communicated to all those who need to know.

- The care co-ordinator is responsible for ensuring that the service user is provided with a copy of their care plan in line with the care planning requirements in section 3.3 of this policy.

- As a minimum, it is expected that service users on CPA will have face to face contact with a member of their care team at least every four weeks. Where circumstances do not allow for this or where the service user has expressed a

preference for less frequent contact this should be recorded in the care plan. This may also apply where the needs of the service user change, progressing towards step down to standard care.

- The care co-ordinator will retain their role at all points of the care pathway (Including inpatient admission, care under home treatment and in circumstances where patients are receiving out of area care), providing input at key planning meetings (Including admission, discharge and CPA review) and maintaining contact with the service user at a frequency defined in the care plan for each individual, but as a minimum within the first 7 days of admission.

- The care co-ordinator is responsible for scheduling and organising CPA reviews. It is expected that this would be at least every six months but as a minimum standard must be annually, unless clinical presentation or local service standards recommend more frequent review periods or the service user or carer request an earlier or more frequent review period.

- The care co-ordinator is responsible for ensuring that CPA information remains current and relevant by reviewing and updating the assessment summary (initial assessment document on Lorenzo), risk assessment and CPA care plan:

    - When there is significant change
    - Prior to transition or transfer (including inpatient / home treatment admission / discharge and change of team care co-ordinator)
    - CPA review.

5.3. CPA review:

- In preparation for the review, the care co-ordinator should review and update the assessment summary (currently referred to as 'initial assessment') and appropriate risk assessments. All professionals involved should provide an evaluation of the interventions they are responsible for delivering in the appropriate section of the care plan.

- Where it is not possible to convene a single meeting of all involved, the review may comprise of a series of conversations and / or reports, co-ordinated by the care co-ordinator. In these cases the care co-ordinator should complete the process by recording all decisions made in the CPA review section of Lorenzo.

- The CPA review process should provide evidence that the following factors have been considered:

    - The views of the service users and their family

- Views and/or reports of all professionals and services involved including tertiary services
- Risks and vulnerabilities, including changes in presentation or shared formulation, and any safeguarding issues
- Ways in which the needs and circumstances of the service user may have changed
- Progress towards outcomes, recovery and potential moving on or discharge from secondary mental health services
- Effectiveness of treatment and interventions, including medication and psychological therapies (have all evidence based interventions been considered)
- Physical health needs and ensure that the GP /or other relevant specialist are engaged
- Social issues, accommodation, finances, employment/ education, daytime activity, relationships
- Legal requirements (including CTO)
- To what extent does the care plan, including crisis and contingency plans require updating
- Has the service user been offered the opportunity to develop an Advanced Statement or do they wish to update an existing document
- CPA status.

- Following the review the CPA care plan should be updated in collaboration with the service user to reflect the agreed changes.

5.4. Step down from CPA:

Decisions to withdraw CPA should always be informed by a thorough risk assessment involving the service user and carer as part of a formal multi-disciplinary review, usually a CPA review. The support of CPA should not be withdrawn prematurely because a service user is stable when a high intensity of support is maintaining wellbeing. The additional support of CPA Should not be withdrawn without:

- A formal review and where appropriate a handover to a lead clinician or GP
- An exchange of appropriate 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 with a potential negative impact on the persons wellbeing
- An appropriate exchange of risk information.
- Service users discharged from Inpatient settings and have been an inpatient for longer than 72hrs or home treatment care should remain on CPA until the first care review within 4 weeks of discharge (This is in addition to the 48hr face to face appointment).

NB - Exceptions to this may apply, for example where a service user has been admitted for a period of assessment (longer than 72hrs, see page 12 for patients discharged within 72hrs) and no further follow-up from secondary mental health services is indicated. In these cases, policy related to step down from CPA should be followed and all decisions clearly recorded in the MDT review document as part of the inpatient or home treatment discharge planning.

- All service users discharged from a hospital setting will have a face to face appointment within 48hrs of discharge from the ward. Telephone or digital follow ups should only be used in a rare exception once all avenues to arrange a face to face contact have been exhausted. Such an exception could apply when a patient has been discharged to a nursing / residential home and a visit is not possible.

6. Care management standards for Standard Care

- Once the need for ‘Standard’ care has been established, a care co-coordinator must be allocated within 7 days.

- A statement of care should be agreed between services user and the Care co-ordinator (this is usually the lead clinician involved in the individuals care) and recorded on the care plan. This will comply with the care planning standards in section 3.3 of this policy and should contain any relevant information regarding support, care and treatment including shared care arrangements. It will also include information about the intended outcomes and information about risk and relapse prevention strategies. It will also include a crisis contingency plan.

- The care co-ordinator is responsible for ensuring that the service user is provided with a copy of their care plan in line with the care planning requirements in section 3.3 of this policy.

- The service user will be reviewed as determined by their needs and change in circumstances. It is expected that this would be at least every six months but as a minimum standard must be annually unless clinical presentation or local service standards recommend more frequent review periods.

- The care co-ordinator is responsible for ensuring that information in the risk assessment remains current and relevant.

- For service users who are subsequently identified for needing care under CPA (including referral to home treatment or admission to inpatient care), the care co-ordinator is responsible for ensuring that the risk assessment and assessment summary (Initial assessment document in Lorenzo) is updated to reflect the current situation and circumstances of the service user.

- The care co-ordinator must give on-going consideration to the need to step up to CPA if risk or circumstances change in line with the CPA criteria (Appendix 1) and in consultation with the multi-disciplinary team.

7. Carers:

- All service users accessing secondary mental health services will be screened at assessment and review to identify informal carers.

- Regardless of the care management arrangements, CPA or Standard Care, anyone who is identified as giving care to the service user on a regular and substantial basis must be informed of their right to an assessment of their caring, physical and mental health needs by the care co-ordinator within the first six months of the person's care and annually thereafter.

- Carer involvement should be agreed with the service user including any information the service user does not wish to disclose. Where a carer is not involved in the care planning and / or risk assessment process, a brief explanation should be reflected within the care plan.

6.1. Standard Care Review:

Reviews for service users receiving standard acre may take place in the context of a visit or outpatient contact. There should be consideration of the need for CPA if complexities of need, circumstance or risk have changed such that more co-ordinated care is indicated. The Standard Care plan or standardised follow up letter will constitute evidence of the review.

7.1. Young Carer:
A young carer is identified as a child under the age of 18yrs who provides substantial personal and / or emotional care to another family member.

- Young carers must be able to benefit from the same life chances as all other children. Their carer support plan must be designed to maximise these opportunities, taking into account any adverse impact that the mental health problems of the parent / family member can have on a child.

- Where permission is given, young carers should be involved in any review process of the person they care for. This involvement should consider how changes to the service users care plan may affect them.

8. Out of area placements & Prison:

- As part of setting up an out of area placement, arrangements need to be agreed between the clinical team and commissioners via the mental health joint funding panel about the delivery of care and treatment, care co-ordination, monitoring and review, and arrangements for bringing placements to an end, which may include arrangements for further accommodation, treatment and care.

- It is expected that the care co-ordinator will liaise with such services to ensure that the Trust continues to fulfil responsibilities to service users and carers as defined in this policy, unless or until such time as formal handover of care has been agreed and taken place.

- Where it remains NSCHT responsibility as the service area of origin, CPA will be mandatory and the care co-ordinator will ensure that CPA processes are the links between the provider and the Trust. The same principals apply for service users detained in a prison setting.

9. Bibliography:

1. Refocusing the Care Programme Approach (DOH March 2008)
2. Best Practice in Managing risk (DOH 2007)
3. Suicide prevention strategy
4. Mental Health 1983: Code of practice (DOH April 2015)
5. Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach, (DOH 1999)
6. Carers (Recognition and Services) Act 1995.

7. Data Protection Act 1998
8. The Mental Capacity Act, 2005 Policy and guidance for service users, carers and practitioners Draft December 2008.
9. The Ten Essential Shared Capabilities - A Framework for the whole of the Mental Health Workforce Dept of Health Aug 2004.
10. Clinical Risk Management -a clinical tool and practitioner Manuel Steve Morgan Sainsbury Centre for Mental Health.

10. Audit and Assurance:

Element to be monitored	Lead	Tool	Freq	Reporting arrangements	Acting on recommendations
Compliance	Performance team	Lorenzo reporting	Monthly	SLT performance Quality committee Teem Dashboards	
Quality	Governance team	ISM CP & RA Audits Lorenzo reporting	Monthly	SLT performance Quality committee Team Dashboards	
CPA review	Performance team	Lorenzo reporting	Monthly	SLT performance Quality committee Team Dashboards	

11. Appendix 1

CPA or Standard Care Determination Guidance

Individuals needing the support of CPA should not be significantly different from those identified under previous CPA guidance as needing the support of enhanced CPA.

In order to have a consistent approach across NSCHT the following guidance must be used in order to identify those service users who will require CPA. This list provides the basis of a reliable and useful tool. However it is also critical to stress that clinical and professional experience, training and judgement should be used in using this list to evaluate which service users will need the support of CPA.

The following table identifies descriptors of which service users should be on CPA and guidance as to what complexities would support decision making.

CARE PROGRAMME APPROACH DETERMINATION AND REGISTRATION		
1. PERSONAL DETAILS		
Surname:	Forename(s):	Title:
Date of Birth:	NHS Number:	Unit Number:
Current Address: Postcode: Telephone:		
2. ASSESSMENT DETAILS		
Please use the table below and tick the box to indicate that the assessed person meets the criteria for (new) CPA.		
1	Mental disorder (including Personality Disorder) with a high degree of clinical complexity	☐
2	Current or potential risks 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 e.g. ○ *Exploitation (financial, sexual etc)* ○ *Financial difficulties relating to mental illness* ○ *Disinhibition* ○ *Physical / emotional abuse* ○ *Cognitive impairment* ○ *Child protection issues* ***Please tick this box if you would like the Clinical Information Team to circulate risk modules to the care team members***	☐ ☐ ☐ ☐ ☐
3	Current or significant history of severe distress / instability or disengagement	☐
4	Presence of non-physical co-morbidity e.g. Learning Disability / Substance Misuse etc	☐

5	Multiple service provision from different agencies including housing, physical care, criminal justice , employment and voluntary / private sector	☐
6	Currently or recently detained under the Mental Health Act or referred to the Crisis Resolution/Home Treatment Team	☐
7	Entitled to receive after-care services under Section 117 of the MHA	☐
8	Significant reliance on carers or has own significant caring responsibilities	☐
9	Experiencing disadvantages or difficulties as a result of: • Parenting responsibilities • Physical health problems / disability • Unsettled accommodation / housing difficulties • Employment issues when mentally ill • Significant impairment of function due to mental illness • Ethnicity e.g. immigration, race/cultural issues, language, religion, gender, sexuality etc	☐ ☐ ☐ ☐ ☐ ☐

3. REGISTRATION

Is support using CPA required? Yes ☐ No ☐ *If criteria 1 and **any** of the other criteria are met, CPA should be considered*

CARE CO-ORDINATOR DETAILS

Important: A community based practitioner must be assigned as Care Co-ordinator in all cases.

Name: Designation:

Work Base:

Telephone: Signature:

PLEASE INDICATE THE CARE CO-ORDINATOR'S TEAM

Service users needing CPA	Service users needing Standard Care
An individual's characteristics	
Complex needs; multi-agency; higher risk, Admitted to hospital inpatient ward.	More straightforward needs; one agency or no problems with access to other agencies/support; lower risk

What the service users should expect	
Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload)	Support from professional(s) as part of clinical/practitioner role. Lead professional identified (Care Co-ordinator). Service user self-directed care
A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks	A full assessment of need for clinical care and treatment, including risk assessment
An assessment of social care needs against FACS eligibility criteria (plus direct payments)	An assessment of social care needs against FACS eligibility criteria (plus direct payments)
Comprehensive formal written care plan: including risk and safety/contingency/crisis plan	Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinicians letter)
On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be need more regularly	On-going review as required
At review, consideration of on-going need for CPA support	On-going consideration of need for move to CPA if risk or circumstances change
Increased need for advocacy support	Self-directed, with some support if necessary
Carers identified and informed of rights to own assessment	Carers identified and informed of rights to own assessment

Appendix 2

Key aspects of care co-ordination

CPA Care Co-Ordinator
The care co-ordinator will provide a consistent point of contact but is not expected to be the person who actually delivers all components of an individual's care.

The key responsibility of the care co-ordinator is to **proactively oversee** and direct a service users care pathway, keeping all service providers on track, **co-ordinating** and managing the plan of care in partnership with the individual and their carer's.

It is expected that input to the plan of care may be provided by a range of professionals and services particularly when specialist interventions are required.

Role Boundaries
The role of the care co-ordinator is one that requires considerable skill and expertise, and may be undertaken by any discipline, many of whom will be senior clinicians. It is important that the effective functioning of both professional and care co-ordination roles are not compromised by the assignment of responsibilities and tasks that may be more appropriately delegated to junior staff or support workers.

Allocation
The CPA care co-ordinator will be a current registered professional, experienced in mental health work, with the appropriate skills to perform the core functions of the role.
Staff at band 5 must be receiving appropriate supervision through their team manager. Caseload complexity and risk should be commensurate with the level of skill, experience and complexity.

The role should usually be taken by the person who is best placed to oversee care planning and resource allocation and can be of any discipline regardless of care setting depending on capability and capacity.

Decisions about allocation of care co-ordination should take into account:

- Full range of health and social care needs of the individual identified through comprehensive assessment and the development of a detailed formulation
- Allocation to Care cluster – identified care pathway and estimated length of time in service
- Allocation to CPA (level of complexity)
- The workers experience, training and skill base
- The workers level of input to care and relationship with the service user. The care co-ordinator should be someone who will have regular involvement with the service user and will be in a good position to know their changing needs
- Caseload capacity (including specialist resource provision to the team or across teams)
- Needs related to culture and language, caring or parental responsibilities, co-morbidity etc.
- The service user should have a choice of Care Coordinator (particularly where they have had damaging experiences of abuse, or have cultural or religious needs), wherever possible, taking into account resource availability and assessment of any risks.

Authority

The care co-ordinator should have the authority to monitor and co-ordinate the delivery of the care plan and ensure that this is respected by all those engaged in delivering it.
Legitimate authority should come with the role. Care co-ordinators need the authority to do a number of things to ensure that the services people receive are appropriate and co-ordinated properly so as to be most effective:

- Make sure the services understand what the service user really needs by organising a proper assessment of their health and social care needs
- Ensure that the right services are brought together in a planned way to meet the assessed needs and that there is a written plan of care that the service user and team can share

At the very least the care co-ordinator must have the authority to:

- Monitor the care plan
- Evaluate the input of other members of the team
- Negotiate and co-ordinate the delivery of the care plan
- Access resources as appropriate
- Communicate concerns about care delivery
- Enable reviews to take place effectively

Limits to the responsibility of the care co-ordinator

The responsibilities associated with care co-ordination are not limitless.
When other professionals fail to deliver care according to the plan of care or do not comply with related policy guidance they are accountable for this through their own management/organisational structures. However, the care co-ordinator must take appropriate action to ensure the service user's care is delivered.