Gateshead Health
NHS Foundation Trust

Policy Title	Care Programme Approach
Policy Number	MH27
Version Number	3.0
Ratified By	Mental Health Act Compliance Group
Date Ratified	26/03/2019
Effective From	04/04/2019
Author(s) *(name and designation)*	David Gilbert, Clinical Nurse Lead, Mental Health
Sponsor	Michael Laing, Associate Director Community Services
Expiry Date	01/03/2022
Withdrawn Date	

Unless this copy has been taken directly from Pandora (the Trust's Sharepoint document management system) there is no assurance that this is the most up to date version

This policy supersedes all previous issues

Version Control

Version	Release	Author/Reviewer	Ratified by/Authorised by	Date	Changes (Please identify page no.)
1.0	30/06/2011	Susan Dodds	Central Team	24/06/2015	P14 P15
2.0	25/08/2015	Judith Gibson	Mental Health Committee	24/07/2015	
1.3		David Gilbert	Mental Health Act Compliance Group	26/03/2019	

Contents

Section **Page**

Appendices

Care Programme Approach and Care Co-ordination

1 Introduction

The term Care Programme Approach (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 in contact with the service who have complex characteristics (as outlined below). It is called an "approach" rather than just a system, because the way that these elements are carried out is as important as the actual task themselves.

Gateshead Health NHS Foundation Trust is committed to the principle that all Service Users should have access to high quality, evidence-based mental health Services. This document sets out the policy governing the operation of the Care Programme Approach (CPA) within Gateshead Health NHS Foundation Trust. The approach of the organisation to individuals' care and support puts that individual at the centre of care and promotes the values and positive practice within the Department of Health guidance Refocusing the Care Programme Approach (CPA) and Effective Care Co-ordination in Mental Health Services. The policy has been developed around the following values and principles:

- The approach to individuals' is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties.
- It recognises the individual as a person first and patient/service user second. Care assessment and planning views a person holistically, seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.
- Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care.
- The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long-term engagement, requiring trust, team work and commitment.

2 Policy scope

This guidance is focused on the support needed for individuals receiving secondary mental health services. The principles should be applied to any individual receiving these services regardless of their age. The Mental Health Act 2007 established a new, simplified single definition of mental disorder which does not distinguish between different categories of mental disorder, so the same criteria apply to all individuals. The same conditions apply in CPA.

3 Aim of policy

The purpose of this policy is to describe a consistent and effective system of care provision for those people who access the Mental Health Services provided by Gateshead Health NHS Foundation Trust. In this Policy CPA relates to people with complex mental health needs. CPA describes the approach used to assess, plan, co-ordinate and review the range of treatment, care and support needed. The policy will also describe service and practitioner responsibilities for those in contact with services but not managed through CPA.

4 Duties (roles and responsibilities)

Trust Board
The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

Chief Executive
The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this policy.

Mental Health Act Managers' Committee
The Mental Health Act Managers' Committee will monitor the Trusts compliance with CPA.

Executive Directors, Associate Director and Service Line Manager
Are responsible for ensuring staff are aware of and adhere to this policy and that their actions comply with the CPA.

Consultant Psychiatrists
Consultant Psychiatrists are responsible for reviewing the need for CPA, or continued need of CPA, at each patient review or ward multi-disciplinary team meeting.

Care Co-ordinator
The Care Co-ordinator will take a proactive and co-ordinated approach to co-ordinating and managing care in partnership with the service user and carer(s).

Named Nurse
The Named Nurse, for patients admitted into an in-patient setting or receiving Day Care support, is responsible for liaising with the Care Co-ordinator and other significant people involved in the care management of that patient to keep them informed of reviews and patients progress.

All Clinical Staff
All clinical staff will adhere to this policy when assessing or providing care and treatment (directly or indirectly) to individuals suffering from a mental illness.

5 Definitions

Care Programme Approach (CPA) – Policy and positive practice guidance produced by The Department of Health.

Mental Health Act 1983 (MHA) – Legislation allowing the forced detention in hospital of those patients with complex needs who are at high risk of harm to themselves or others.

Carer(s) – The term carer is used in this policy to describe an individual who provides or intends to provide practical and emotional support to someone who has a mental health problem. A carer may or may not live with the person and could be a friend, relative, partner or neighbour.

Care Co-ordinator – This term is used to describe the lead professional who is responsible for managing all aspects of the persons care.

Care Plan – A Care Plan is a written document which clearly states an agreed plan of care management with clear details of who is responsible for addressing elements of care and support.

Dual Diagnosis – A term used to describe a dual diagnosis of mental health and drug and alcohol misuse problems.

Recovery – Used to describe a persons personal process for tackling the impact of mental health problems on their daily living despite their possible continued or long term presence. Recovery may not always mean “cure”.

Mental Capacity Act 2005 (MCA) – Legislation to empower people to make decisions for themselves wherever possible, and protect people who lack capacity by providing a flexible framework that places the individual at the heart of the decision-making process.

Deprivation of Liberty Safeguards (DoLS) – An amendment to MCA stating the process required in order to deprive a person of their liberty in hospital or a care home.

6 Characteristics to consider when deciding if support of CPA needed

The characteristics of those needing CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with Dual diagnoses; and who are at higher risk.

To provide clearer guidance to services so that they can better target engagement, co-ordination and risk management the following characteristics have been identified as most indicative of those who require care delivered within the CPA framework.

- Severe Mental Disorder (including personality disorder) with a high degree of clinical complexity
- Current of potential risk(s) including:
  - Relapse history requiring urgent response
  - Self-Neglect or non-concordance with treatment plan
  - Vulnerable adult; adult/child protection
  - Suicide, self-harm, harm to others (including history of offending)
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity, e.g. Substance misuse, learning disability
- Currently/recently detained under the Mental Health Act (MHA), or referred to a crisis/home treatment team
- Multiple service provision from different agencies
- Significant reliance on carer(s) or has own, significant caring responsibilities
- Those who experience disadvantage or difficulty as a result of;
  - parenting responsibilities
  - physical or sensory health problems/disability
  - unsettled accommodation
  - employment issues when mentally ill
  - significant impairment of function during periods of mental ill health
  - Ethnicity e.g. immigration status; race/cultural issues; language difficulties; religious practices; sexuality or gender issues.

6.1 Principles to consider for CPA in Older Peoples services

- Severe mental disorder (including functional mental health needs) with high degree of clinical complexity
- Significant risk to self or others / rapid onset of symptoms which requires
- immediate assessment and treatment
- Needs require a period of inpatient care
- Mental Health needs are having significant impact on activities of daily
- living and requires prompt assessment and interagency treatment plan
- Current or potential risks including suicide, self-harm, harm to others, relapse
- Social history, self-neglect, vulnerable adult, adult/child protection (e.g. exploitation, disinhibition, physical abuse, cognitive impairment).
- Service user is subject to Safeguarding Adults proceedings
- Self-neglect behaviour (deliberate, caused or accidental) which puts service user at significant risk
- Current or significant history of severe distress/instability or disengagement
- Non-physical co-morbidity e.g. substance/alcohol misuse, learning disability
- Multiple service provision from different agencies
- Currently/recently detained under MH Act, or referred to crisis/home treatment team
- Significant reliance on carer/s, or has own caring responsibilities
- disadvantage or difficulty as a result of:
    - parenting responsibilities
    - physical health problems/disability
    - unsettled accommodation;
    - employment status/issues
    - significant impairment of function when mentally ill

The level of care (under CPA) is defined following assessment. The MDT should discuss the outcome of the assessment and agree on the level of CPA or Standard Care taking in to account level of risk and all elements referred to above under characteristics and principles

6.2 Standard Care

Potential list Characteristics to consider when deciding if Standard Care is appropriate;

- The person has less clinical complexity and more straightforward support needs in respect of their mental health
- Risks to self and others are assessed as low
- The person is able to self-manage their health and wellbeing, either with or without support

- Agreed contact with the service for treatment or support is likely to be maintained
- People who have recovered from a complex episode of mental illness and are well supported in their community
- People who are engaged and responsive to their treatment, intervention and care plan
- The agreed care plan does not indicate the requirement for frequent contact with several members of the MDT

6.3 Mental Health Act and CPA

All service users subject to Supervised Community Treatment (SCT) or subject to Guardianship under the Mental Health Act (section 7) should be supported by CPA. The CPA is policy and practice guidance, it is not statute law and therefore the Trust must work within the legal framework in which Mental Health Services operate. Staff may need to refer to relevant legislation such as; Mental Health Act (1983), Mental Capacity Act (2005), Human Rights Act (2000) and Data Protection Act (1989).

6.4 Roles and Principles

The Role of the Care Co-ordinator

Care Co-ordination has two critical functions:

1. Establishing and maintaining a professional relationship with the service user and significant others based on regular contact.

2. Co-ordinating and monitoring the assessment, planning, delivery and review of care, including risk. (Facilitating care: see Appendix 3, Care Programme Approach Guide: flow chart)

A Care Co-ordinator cannot be appointed without their prior agreement. The appointment and / or any change of the Care Co-ordinator should be discussed and agreed with the service user and the wider care team for that individual user of the service.

The Care Co-ordinator must take a proactive and co-ordinated approach to co-ordinating and managing care in partnership with the service user and carer(s). The role of the Care Co-ordinator will be allocated to the practitioner, who, based on the outcome of the assessment, is best qualified to support the needs led care plan and resource allocation, taking in to account appropriate knowledge, skills, experience and capacity.

The Care Co-ordinator, will be a professionally qualified team member (e.g. Medical, Nursing, Social Worker, Occupational Therapist, Psychologist), who has

the authority to co-ordinate the delivery of the care plan across agencies, professionals and services.

Where a service user is currently receiving support from services and is admitted to hospital the Care Co-ordinator maintains the lead role. The inpatient area must take responsibility for ensuring the Care Co-ordinator is aware of the admission. The Care Co-ordinator will take a lead role on discharge planning. Where the service user remains in hospital for a prolonged spell it may be appropriate for a member of the inpatient team to take on the Care Co-ordinator role. The team must agree this transfer of responsibility.

For service users admitted to hospital who are not known to services the Named Nurse will take on the Care Co-ordinator role. They will refer to the relevant community team where, following liaison, a community based worker will be identified to take over the Care Co-ordinator role at a mutually agreed time.

It is important that care co-ordinators are able to support people with multiple needs to access the services they need. It is not the intention that the Care Co-ordinator necessarily is the person who delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required. This approach supports the principles of 'New Ways of Working', which aims to use the skills of all in the most appropriate, effective and efficient manner. Choice of gender along with cultural or religious needs should be considered when identifying a Care Co-ordinator taking into account resources available.

Key Elements of the Care Co-ordinators role

- Care Co-ordinators need to lead and co-ordinate the assessments required to produce a Care Plan. This should be developed in collaboration with the service user.
- Provide the main link with the services required for the service user and, as such, ensure accessibility for the service user
- Ensure that, where applicable the service user/carer has a copy of the care plan
- Monitor the care plan and review it as appropriate
- If there are other agencies working with the family then the care plan needs to articulate how the different services will impact on each other and how communication with the family and each other will take place
- Be familiar with the service user and consult them on their wishes

Role of the Lead Professional

This role leads on the care, treatment and interventions for people supported on Standard Care. A Lead Professional is a competent practitioner from the multi-disciplinary team who is identified as the most suitable to monitor and review the treatment and care of the service user that the MDT agree as having less complex needs and lower level interventions.

A key function of this role is care planning and delivery of treatment and support, as well as monitoring and review against agreed outcomes.

Additional Responsibilities
There are additional responsibilities expected of Care Co-ordinators and Lead Professionals linked to CPA and Standard Care e.g. ensuring completion of outcome measures such as Mental Health Cluster Tool (MHCT), Mental Health Minimum Data Set (MHMDS)

6.5 Risk Assessment and Management

Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes. Everyone referred to secondary mental health services will receive an assessment of their mental health needs by their named nurse which incorporates all aspects of risk.

Risk management involves developing flexible strategies aimed at preventing any negative event occurring or, if this is not possible, minimizing the harm caused. Risk management should take into account that risk can be both general and specific. Knowledge and understanding of mental health legislation is an important component of risk management. The risk management plan should include a summary of all risks identified, situations in which identified risks may occur, and action to be taken in response to crisis. **Staff should also refer to the Trust Policy MH02 Clinical Risk Management.**

Harm Minimisation and Risk Management

It is expected that risk information is co-produced with the person and involves and is shared with their carers / family or other supporters wherever consented/ necessary/ appropriate. A risk management plan does not prevent positive risk taking, more-so encourages considered reasonable risks that support wellbeing.

Harm minimisation and risk management will be clearly documented and reviewed regularly as part of the review and care planning process. Refer to the Trust's Harm Minimisation Policy

In some cases harm minimisation and& risk management may involve public protection strategies e.g. Multi-Agency Public Protection Arrangements (MAPPA), Safeguarding Children and Adults, Multi-Agency Risk assessment Conference (MARAC). Local arrangements should be followed in these instances.

Assessment

Assessment is a collaborative process that fully involves the person in decisions about their life and supports them to achieve their recovery. The aim is to get a full picture of the person, what needs they have and what goals and outcomes they want to achieve and should not only focus on what professionals and services can offer.

To avoid duplication the assessment and care plan should follow the person throughout their involvement with all Trust mental health services, e.g. Inpatient, community, liaison.

It should be assumed that the person has mental capacity unless otherwise indicated and if not arrangements made for support either from an appropriate individual such as a carer or family member or an independent advocate.

A comprehensive assessment will be completed when the person is referred to services and should include;

- The person's capacity to be fully involved in the assessment, understand information and express their needs and wishes
- A clear explanation of the nature and purpose of the assessment
- Assessment of the person's psychiatric, psychological and mental health needs
- Any history of mental health illness/contact with services/admissions/treatments
- Risks to the person or to others
- History of trauma, including violence and abuse
- Any co-morbidity and co-existing problems
- Physical health needs, disabilities and any known diagnosed conditions
- Communication needs (including alternative formats, assistance or interpreters)
- Substance or alcohol misuse
    - Current medication
- Social care needs, social circumstances, informal support networks
- Caring responsibilities
- Details of the person's carers, family or other supporters

- The person's personal goals and what they want to achieve
- Housing status and needs
- Financial status and needs
- Religious, spiritual or cultural needs
- Leisure, vocation and employment,
- Identify the need for further specialist assessment and refer/transfer appropriately to the relevant service, agency or profession
- The need or wish for advocacy
- Any Advance decision, lasting power of attorney and /or statement of wishes in existence
- The service user's need for support by CPA, Standard Care or other agencies
- To know what help / support / treatment the person wants the service to provide

6.6 Care Planning

Care planning requires a thorough assessment of the person's needs and developing a care plan in collaboration with the person is part of the process of understanding their situation, strengths, and the outcomes they would like to achieve. It is likely to involve consideration of:

- Mental healthcare
- Psychological needs of the person and, where appropriate, of their carers
- Physical healthcare
- Nutritional and hydration needs
- Daytime activities or employment
- Appropriate accommodation
- Identified risks and safety issues
- Specific needs arising from co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder
- Specific needs arising from drug, alcohol or substance misuse (if relevant)
- Parenting or caring needs
- Intended outcomes
- Emotional support

A care plan is an overarching summary of the identified needs and agreed interventions, outcomes and support for an individual. It is a formal written record setting out what is planned, the reason, when and by whom. It exists for the benefit of the person and must be written in a format that makes sense and is meaningful to them, i.e. avoid unnecessary jargon or complex language including acronyms.

The care plan serves as a communication tool between the person, their carer, family as well as professionals and other services involved.

The care plan should include;

- A written record of the identified needs from assessment, the person's personal goals, treatment, interventions and expected outcomes
- Psychological and other therapeutic support to promote recovery and&/or prevent deterioration
- Details about prescribed medications
- Actions to address physical health problems or reduce the likelihood of ill health
- Any risks to self or others, including carers, family and anyone providing support
- Information and an out-of-hours contact number for services and guidance on actions in the event of a crisis
- Clear information for the person, their carer / family about what to do in the event of deterioration in the person's presentation.
- risk assessment
- Any specific provisions/entitlements of after-care under section 117 of the Mental Health Act 1983
- Any provisions of Direct Payments or Individual Budgets
- Contact details for the named Care Co-ordinator or Lead Professional
- Contact information for all named parties involved in providing support
- Plans for discharge, transfer or transition, if anticipated within the timescale of the plan.
- The next planned review date

The care plan will be co-ordinated by the Care Co-ordinator for people supported by CPA, who will send to the person, their GP and anyone else with responsibility for providing support to the person including, voluntary and independent sector providers. Any exceptions to this will be recorded in the health care record with a clear rationale. With the person's agreement their carer, family or identified supporter may also have a copy.

NB – People supported on Standard Care may receive their care plan outlined in clear statements within a letter. With the person's agreement their carer, family or identified supporter may also have a copy of the letter. The GP must also receive a copy of this letter/statement as a minimum standard.

Crisis & contingency Plans

This section of the plan should identify triggers for relapse, the persons relapse signature (or any aspect known, the person themselves or a family member or carer can often inform this information) then clearly outline the following information;

- Contact details of the Care Co-ordinator/ Lead Professional/Community Team telephone number
- An Out-of-Hours urgent advice contact telephone number

- GP contact telephone number
- Family and friends contact telephone numbers
- Useful information and contact numbers
- Any caring responsibilities (spouse, family or pets)
- Medical conditions or allergies
- Medication provision (& what not to use, e.g. known negative response)
- Preferred languages (to communicate)
- What helps or does not help in an emergency or crisis

Review

Review of the person's needs and care plan should be an ongoing process every time the person has contact with clinical staff. Any concerns should be relayed to the Care Co-ordinator or Lead Professional immediately. A review must always involve the person, all professionals involved in delivering aspects of the care plan, the GP should be invited and where possible/appropriate their carer / family.

When to hold a formal review:

- Before discharge from hospital other residential setting
- Minimum every 6 months for CPA – or at any time (sooner) if required (due to a change in risks/presentation/transfer to another service is required or requested by any professional involved, the carer or service user.
- Minimum every 12 months for Standard Care – or at any time (sooner) if required (due to a change in risks/presentation/transfer to another service is required or requested by any professional involved, the carer or service user.
- When there is a significant change to the person's needs and individual circumstances, particularly where any risks are identified as new or escalated.
- When there is a significant change in care or support provided either from carer's, family or other providers.

A formal review will focus on:

- Progress and achievements
- Needs identified and any changes
- The views of the person, their carers / family
- Sharing and updating of harm minimisation information
- An update from professionals or services involved in providing care or support
- Any new information regarding Advanced Statements
- The Crisis plan
- Social care needs
- The need for support by CPA or Standard Care and rationale for moving from one to the other
- Any MHA/MCA issues, S117, guardianship, DoLs applications

- Updating of the care plan
- Highlighting any unmet needs
- Transfer to another service
- Always consider discharge from mental health services and the service users choices

6.7 Hospital/Community Interface

Admission is effectively a change in the location in which the care is delivered and therefore, service users already supported by CPA will continue the process during their in-patient stay.

Staff must follow the principles of the Mental Capacity Act 2005 with regards to the service user's capacity to agree to admission and treatment and regard must be given to any restrictions that may propose a Deprivation of Liberty. (See Gateshead Health NHS Foundation Trust Care Standard 28F Care of the patient under the Mental Capacity Act 2005).

A care co-ordinator cannot be identified without their prior agreement therefore ward staff will act as co-ordinators until such time.

Anyone admitted to a mental health assessment and treatment ward will automatically be placed on CPA. For those supported by CPA prior to admission, the Care Co-ordinator will retain responsibility and continue to be involved in reviews and discharge planning, and will co-ordinate specific follow-up upon the service users discharge.

For those previously supported on Standard Care or unknown to mental health services, a Care Co-ordinator will be allocated (wherever appropriate the same worker that was fulfilling the Lead Professional role) and will attend ward formulation meetings to provide duties relating to CPA, begin developing a relationship with the service user, family and& carers and follow-up upon discharge from hospital. This would include wherever appropriate meeting the requirements of S117 (after care requirements that are related to the persons mental health needs), which includes co-ordinating the persons care needs involving the NHS (through the local Clinical Commissioning Group & Local Authority).

6.8 Mental Health Act

All service users subject to Supervised Community Treatment (SCT) or subject to Guardianship under the Mental Health Act (section 7) should be supported by CPA. The CPA is policy and practice guidance, it is not statute law and therefore the Trust must work within the legal framework in which Mental Health Services operate. Staff may need to refer to relevant legislation such as; Mental Health Act (1983), Mental Capacity Act (2005), Human Rights Act (2000) and Data Protection Act (1989).

6.9 Advocacy

Services should recognise the positive role that advocacy can play in enabling effective service user involvement in the development and management of their care and the benefits that a skilled advocate can bring in helping service users engage with what can often feel like an overwhelmingly complicated and intimidating system. Section 30 of the MHA gives certain patients access to independent advocacy service's to be delivered by Independent Mental Health Advocates (IMHAs) and the MCA places a legal duty on staff to give certain patient's access to Independent Mental Capacity Advocates (IMCAs).

6.10 When CPA is no longer required

Services should consider at every formal review whether the support provided by CPA continues to be needed. As a service user's needs change or the need for care co-ordinated support is minimised, moving towards self-directed support will be the natural progression and the need for intensive care co-ordinated support and CPA will end. However, it is important that service users and their carer's are reassured that when the support provided by CPA is no longer needed that this will not remove their entitlement to receive any services for which they continue to be eligible and need, either from the NHS, local council, or other services. Services should also be careful that the support of CPA is not withdrawn prematurely because a service user is stable when a high intensity of support is maintaining his/her wellbeing. A thorough risk assessment, with full service user and carer involvement, should be undertaken before a decision is made that the support of CPA is no longer needed. It is also critical that there should be a process for changing arrangements when the need for CPA or secondary mental health services ends. The additional support of CPA should not be withdrawn without:

- an appropriate review and handover (e.g. to the lead professional or GP);
- exchange of appropriate information with all concerned, including with carer's;
- 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 that person's mental well-being.

Where CPA is appropriate in hospital, the same safeguards should be continued for an appropriate period when the individual is released or

discharged. Automatically removing the support of CPA at this point could compromise the safety and treatment of the individual at a vulnerable point in their care pathway. In reviewing a care plan as part of discharge planning from hospital, or other residential settings, appropriate liaison with mental health teams in the community is essential. The period around discharge is a time of elevated risk, particularly of self-harm. This underlines the need for thorough review and assessment prior to discharge and effective follow up and support after discharge.

6.11 Discharge and Leave from Hospital

The person, their carers', family and any additional support should be fully involved in planning any leave and discharge from hospital so that support and other practical arrangements can be made. The period around planned leave or discharge from hospital is recognised as a time of elevated risk, particularly of self-harm, therefore risk assessment and review beforehand is essential.

It is expected that there is close liaison between in-patient and community staff during any leave and specific follow up within 7 days after discharge from hospital. The Care Plan must be reviewed prior to discharge from hospital. Only in exceptional circumstances will a service user be discharged from hospital on Standard Care. It should be acknowledged that their needs and risks have very probably not become non-complex during this period

Transfers

People can experience transfers of care during their contact with mental health services including between care provider services (geographically, i.e. to/from a neighbouring provider), between CPA and Standard Care, or complete discharge from services. Examples of transfers include:

- Admission to or discharge from hospital or other similar establishment
- Move to/from a different geographical location outside the trust
- Containment or release from prison or criminal justice system establishment
- Change to level of support e.g. CPA to Standard Care or vice versa
- Change of Care Co-ordinator or Lead Professional

It is preferable to hold a review meeting in advance of any transfer in order to share information plan and agree the handover of care. It is the responsibility of the Care Co-ordinator or Lead Professional to co-ordinate this and planning should involve all relevant members of the multi-disciplinary team and other services or providers of support.

It is important to involve the person, their carers', family or other support in any transfer so they can express their views and make informed decisions and choices. The person's health care record must show, as a minimum, up to date;

- Risk assessment
- Care Plan, detailing actions to support the transition/transfer
- Crisis and contingency arrangements
- Documented communication and handover of responsibility – name and contact details of new Care Co-ordinator/Lead Professional
- The agreed date of transfer will happen

Discharge from Services

It is essential to involve the person and their carer, family or supporter in discussions about the level of support needed and the outcomes they want to achieve. Every formal review should consider whether support by CPA is still needed or if discharge from services is appropriate. It is expected that the person is involved in decision making about this. While it is important that support is not withdrawn prematurely as it may be that it is the support that is contributing to the person's wellbeing. When there is no longer a need and there is a planned discharge from secondary care mental health services there must be;

- A review and handover to the individual's GP when discharged back to primary care services
- A plan for support and follow up, by non-mental health statutory services, as appropriate
- A clear statement about actions to take and who to contact in the event of signs of relapse or actions regarding mental health crisis.

CPA is a process and not in itself a measure of eligibility under the national minimum threshold for eligibility (Care Act 2014), therefore transfer from CPA to Standard Care will not alter or remove an individual's entitlement to the services they are eligible for or need, either from local authorities or aftercare provisions under section 117 of the Mental Health Act 1983.

Involving and Supporting Carers, Family and Significant Supporters

A carer is defined under the Care Act 2014 as 'someone who helps another person, usually a relative or friend in their day to day life'.

Carers, families and other supporters are seen as partners and a vital support to the person in their recovery and wellbeing. There is evidence that outcomes are improved when they are appropriately informed, consulted and involved in decisions about the care and treatment of the person they support.

Carers, family and supporters should be identified through the assessment process at the earliest opportunity to;

- Ensure they receive timely and appropriate information about;
- the service, team or ward including contact details
- accessible information on mental health conditions and treatment options
- CPA and Standard Care leaflets

- confidentiality and sharing information
- how to raise concerns including PALS
- how to obtain an assessment of their own needs
- details of carer support groups
- Involve them in decisions about treatment and care planning to support the person wherever possible
- Seek their views about risks and harm minimisation and how best they can support the person
- Identify any risks of harm or potential harm towards themselves
- Specifically identify young carers to ensure they are referred to an appropriate service for support
- Provide information about resources, services, facilities and support groups available to support carers, family and supporters
- Offer emotional support which may include signposting to other support agencies e.g. local authority, MIND, Alzheimer's society, peer support

Carers Assessments

Anyone who provides regular and substantial care, including young people, is entitled to have an assessment of their caring, physical and mental health, leisure and occupational needs, leading to provision of their own care and support plan which is reviewed at least on an annual basis. Carers, family and supporters are entitled to an assessment even if the person they support refuses help form mental health services.

Carers assessments are the responsibility of Local Authorities under the Care Act 2014 and Trust staff should provide information about how to access this assessment and support in line with local protocols in their area of work. Carers are entitled to an assessment even if the person they support refuses help from mental health services

7 Training

Two levels of CPA training will be available to staff within the Trust.

Level I – Awareness session for all support (do not hold a registration qualification in order to practice) which covers the basic principles and functions of CPA.
Level II – Training for all registered staff to enable them to carry out the functions of a Care Co-ordinator efficiently and effectively. It is best practice for staff to update their skills every three years.

8 Diversity and inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy describes the steps that will be taken to recognise the rights of service users and carers. It aims to ensure no service user receives less favourable treatment on the grounds of a protected characteristic in accordance with the Equality Act 2010. It has been appropriately assessed.

9 Monitoring compliance with the policy

Standard / Process / Issue	Monitoring and Audit			
	Method	**By**	**Committee**	**Frequency**
Suicide Prevention Audit	Audit will take place of all cases of serious self-harm.	Mental Health Team	Mental Health Act Compliance Committee	Yearly
Case Note audit	Audit of notes of all known CPA patients	Mental Health Team	Mental Health Act Compliance Committee	Yearly

10 Consultation and review

This policy has been reviewed against the Department of Health's Refocusing the Care Programme Approach, Policy and Positive Practice Guidance, which was written following consultation with service users/carer's and advocates for service users. Comments from Associate Director and Service Line Manager Mental Health Clinical Lead and Mental Health Lead Professionals have been invited.

11 Implementation of policy (including raising awareness)

This policy will be implemented in accordance with policy OP27 "Policy for the development, management and authorisation of policies and procedures" and policy training will be included in the programme of training as detailed in section 7 of this policy.

12 References

Refocusing the Care Programme Approach DoH (2008)

Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. DoH (2007)

Code of Practice. Mental Health Act 1983 DoH (2008)

13 Associated documentation

Ten Essential Shared Capabilities – A framework for the whole of the Mental Health Workforce DoH (2004).

Human Rights in Healthcare – A Framework for Local Action. DoH (2007)

National Service Framework for Older People DoH (2001)

Delivering race equality in mental health care: An action plan for reform inside and outside services DoH (2005)

Everybody's Business: Integrating mental health services for older adults CSIP (2005)

New Ways of Working for Everyone. DoH (2007)

Avoidable deaths; a five year report of the national confidential inquiry into suicide and homicide by people with mental illness. University of Manchester (2006)

Care coordination Association – CCA Audit for CPN and Non CPA 2015.

APPENDIX 1

What Service Users Should Expect

CPA	**NON-CPA**
Support from CPA care co-ordinator	Support from professional(s) as part of clinical/practitioner role
Informed about CPA and what they can expect	Self-directed care with support
Comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks	Full assessment including of need for clinical care and treatment including risk assessment
Full assessment of social care needs	An assessment of social care needs
Comprehensive formal written care plan, including risk and safety/contingency/crisis plan and evidence of service user and carer involvement.	Agreed statement of care with clear understanding of how care and treatment will be carried out, by whom and when and evidence of service user and carer involvement.
Ongoing review with formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly	Ongoing review as required
At review, consideration of on-going need for CPA support	Ongoing consideration of need for CPA if risk or circumstances change
Increased need for advocacy support, self-directed care with support if necessary	Carer's identified and informed of rights to own assessment
Carer's identified and informed of rights to own assessment	

APPENDIX 2

The Ten Essential Shared Capabilities

1. **Working in Partnership.** Developing and maintaining constructive working relationships with service users, carer's, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

2. **Respecting Diversity.** Working in partnership with service users, carer's, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. **Practicing Ethically.** Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carer's within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. **Challenging Inequality.** Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carer's and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

5. **Promoting Recovery.** Working in partnership to provide care and treatment that enables service users and carer's to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying People's Needs and Strengths.** Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carer's and friends.

7. **Providing Service User Centred Care.** Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

8. **Making a Difference.** Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carer's.

9. **Promoting Safety and Positive Risk Taking.** Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carer's, family members and the wider public.

10. **Personal Development and Learning.** Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, contact and reflective practice.

Appendix 3

CARE PROGRAMME APPROACH GUIDE (REFER TO POLICY FOR DETAILS)