Solent NHS
NHS Trust

CPA and Standard Care Policy

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	*This Policy sets out the requirements around Care Programme Appraoch*
Document Type	[√] Policy [ ] SOP [ ] Guideline
Reference Number	Solent NHST/Policy/AMH 006
Version	6
Name of Approving Committees/Groups	Policy Steering Group Assurance Committee
Operational Date	June 2017
Document Review Date	June 2020
Document Sponsor (Job Title)	Operations Director
Document Manager (Job Title)	Quality and Standards Lead AMH and SMS
Document developed in consultation with	AMH Governacne and Essential Standards Group AMH Divisional Governance Group
Intranet Location	Policies / Clinical Policies
Website Location	
Keywords (for website/intranet uploading)	Care Programme Approach. Lead Professional, Care Coordinator

Amendments Summary:

Amend No	Issued	Page	Subject	Action Date

Review Log

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	24/3/16	R Webb		
2	6/12/16	R Webb		
3	10/2/17	R Webb		

Executive Summary:

The purpose of this policy is to describe and outline the process of Care Programme Approach. (CPA). This approach is used to assess, plan, co-ordinate and review those with a mental health problem or a complex set of needs.

The policy addresses professional roles and responsibilities set out within this approach and considers the requirements of those leading in this process and key points of transition for example transition from Child and Adolescent Mental health Services to Adult or transition between providers or teams.

The policy revisits the values and principles around CPA and these would apply to a number of services within the organisation namely Adult and Older Persons Mental Health, Learning Disabilities and Child and Adolescent Mental Health Servcies.

Table of Contents

Item	Contents	Page
	Glossary of Terms	5
1.	Introduction & Purpose	6
2.	Scope & Definitions	6
3.	Process / Requirements	10
4.	Roles & Responsibilities	22
5.	Training	22
6.	Equality Impact Assessment and Mental Capacity	22
7.	Success Criteria / Monitoring Effectiveness	22
8.	Review	23
9.	References and Links to Other Documents	23
	Appendices	
1.	Characteristics and Criteria for Levels of Care Planning Process	25
2.	Components of an Assessment	28
3.	Crisis and Contingency Plan	34
4.	Review Process and Good Practice Guidelines	35
5.	Section 117 Flowchart	39
6.	Care Co-ordinator / Lead Professional Responsibilities	40
7.	Care Programme Approach and Other Care Processes	42
8.	Fair Access to Care Services (Department of Health)	44
9.	Equality Impact Assessment	46

Glossary of Terms
Glossary of Terms used throughout this document:

- **Service User / Client / Patient**
  These terms are regularly used by staff working across health and social services. For the purposes if this document we have chosen to use the term "Service User".

- **Carer**
  This term applies to informal Carers who provide regular and important support to the Service User. A Young Carer is defined as someone aged 18 or under.

- **Care Programme Approach**
  A Government Policy designed to improve the delivery of care to people with mental health problems. It requires health and social services and other agencies to work together with Service Users to provide an agreed programme of care.

- **Care Coordinator**
  The person responsible for co-ordinating the care a Service User receives when they are living in the community, an inpatient in hospital or serving a prison sentence. This is the person a Service User will have the most contact with and is usually a Community Psychiatric Nurse, Social Worker or Occupational Therapist.

- **Lead Professional**
  The Lead Professional could be from any Professional Group.

- **Care Contributor**
  This applies to any person contributing to a Care Plan for a Service User regardless of service area of origin, e.g., with AMH, Third Sector or informal Carer.

- **Named Nurse**
  The person responsible for a Service User's care when they are in hospital. He/she works closely with the Service User.

- **AMH**
  Adult Mental Health.

- **RSST**
  Recovery & Specialist Services Team.

- **AC**
  Approved Clinician.

- **Advanced Decisions**
  To refuse treatment (legally binding)

- **Advanced Directives**
  Inclusive of wishes (not legally binding)

- **Young Carer**
  A young carer is someone aged 18 or under who helps look after a relative who has a condition, such as a disability, illness, mental health condition, or a drug or alcohol problem. (NHS Choices)

CPA and Standard Care Policy

1. INTRODUCTION & PURPOSE

1.1 The Care Programme Approach is the Integrated Health and Social Care planning process used in Adult Mental Health Services since the early 1990's.

1.2 It was borne out of a number of influential Government led Health and Social Care publications/guidance which were concerned with producing "joined up" holistic care planning to prevent those who access secondary care services from "slipping through the net" or being subjected to repetitious assessments and therefore improving the overall quality of care. The status and necessity of robust CPA was endorsed in all national directives most notably the National Health Service Framework.

1.3 There has been a national review of the Care Programme Approach led by the Department of Health and the main recommendations can be found in the document 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance (2008) (DH).

1.4 The underpinning messages are encapsulated on Page 18 where it says:-

"Services should aim to develop one assessment and Care Plan that will follow the Service User through a variety of care settings to ensure that correct and necessary information goes with them".

1.5 This is really no different to the intention of CPA since its inception however, there are key fundamental changes which are described and set out clearly in this Policy guidance. Of most significance is the removal of levels of CPA, and the proposal of Standard Care Planning process to sit alongside this.

1.6 The objectives of the CPA and Standard Care planning processes are to ensure that the needs of all Mental Health Service Users are assessed and that appropriate care is delivered to meet those needs identified, regardless of the setting, e.g., Residential, Community or Prison.

1.7 The care planning processes start at the first point of contact with the Service User and only end upon discharge from the service.

1.8 The guidance in this document refers to the implementation across Solent NHS Trust and Social Services Department of Portsmouth City Council.

2. SCOPE & DEFINITIONS

2.1 What is the Care Programme Approach?
"*The CPA is care management for those of working age in contact with Specialist Mental Health and Social Care Services*".[1] It should be noted that in the 2008 Refocusing The Care Programme Approach it states *"the principles should be applied to any individual receiving these services regardless of their age."*

[1] National Service Framework for MH DOH HSC1999/223:LAC(99) 30.9.99

It was introduced in 1991 to provide a framework for effective mental health care.[2] [3]

The four main elements include:

- A systematic process/arrangements for the integrated assessment of health and social care needs of those accepted in the Secondary Care Mental Health Services.
- The formation of a holistic Care Plan which identifies the care required from a variety of providers.
- The appointment of a Care Coordinator to keep in touch with the Service User, monitor and coordinate the care; and
- Review, in a timely manner, facilitating agreed changes if needed.

From 2008 (October), CPA no longer has two levels standard and enhanced. CPA now relates to Service Users with the most complex characteristics (as outlined below).

2.1.1 What is Standard Care Planning?

This level is a new development to come out of the 'refocusing' agenda. Essentially it is the planning and review process for Service Users who require specialist secondary care Mental Health services input but have more straight forward needs. National Standards will apply but with local arrangements.[4]

2.2 **Values and Principles:**

2.2.1 The DH provides a Statement of Values and Principles in 'The Refocusing CPA'[5] publication for services to use as a basis of local discussion as the primary 'focus' of reviewing approaches for care planning in line with recent initiatives.

2.2.2 The following summary will apply to Service Users who are accepted by secondary Mental Health Services.

2.2.3 All Service Users have the right to a holistic assessment of individual health and social needs and risks.

2.2.4 Risk assessment will be provided in line with Solent NHS Trust and Portsmouth Health and Social Care Department and Portsmouth City Council Guidance on clinical risk assessment. The evidence on which the judgement is made should be recorded on the central IT system for the service. This should be available to all relevant professionals.

It is important to be aware that best practice indicates the benefits of self-assessment and care planning in conjunction with professional assessment with the person.

---

2 Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach 1999 (DH)
3 (HC(90)23/LASSL(90)11)

4 'Refocusing CPA' (DH) 2008
5 Refocusing the CPA (DH) 2008

2.2.5 All services users will have either a Care Coordinator or Lead Professional, i.e., an individual or small team of individuals known to the Service User, who will co-ordinate or facilitate the care support/ treatment programme.

2.2.6 Ideally all Service Users will have an agreed and signed Care Plan. This may not always be possible and the care team should seek alternative methods/techniques to ensure Service User and Carer understanding and recorded that the Service User has declined to sign.[6] [7] [8] Where a care plan is refused by a Service User or declines a copy this should be documented in electronic records as offered but refused.

2.2.7 Where a Service User has straightforward needs and contact with only one agency, the designated Lead Professional is responsible for facilitating the Service User's care and may record a Statement of Care agreed with the Service User in clinical/practice letters/notes and this will constitute a Care Plan. This will however, need to be signed of by Service User and input into central IT record system.

2.2.8 All Service Users will be informed of the level of care planning, whether subject to the CPA or Standard Care Plan processes. This will be based on an 'in the round' view of individuals' needs.

2.2.9 The CPA is used to describe the approach used in Specialist Secondary Mental Health Services in Portsmouth for those people whose needs involve more complex characteristics.

2.2.10 The term Standard Care is used to describe the system and provision of care for those with more straightforward needs.

2.2.11 It is well recognised that Carers often provide the majority of care to people with mental illness. Carers are entitled to a personal assessment and Care Plan, as well as contributing to Care Programme Approach planning meetings. Young Carers' needs must be considered at all points of the process (further information is provided in other guidance).

2.2.12 All Carers having required an assessment and Care Plan must have a regular review at least yearly, taking into account any local standards.

Best practice indicators are of a Carer's self-assessment in conjunction with Carer's Service Assessment.

2.2.13 Reviews, as with care planning, must place the Service User at the centre of the process and be conducted in line with individual needs. This should be regarded as an ongoing process and be provided in a timely manner. As such those with the most complex and changing needs will require more frequent reviews. All reviews must take into account safeguarding of vulnerable people, children and adults and should ensure the facility is in place to harness the skills and resources required to improve the well being of vulnerable people.

[6] MCA 2005 Code of Practice and Local Guidance
[7] Interpreting Services
[8] Advocacy Services

2.2.14 It is particularly important that the need for Care Programme Approach is considered by Lead Professionals at review.

2.2.15 All care team members providing input or support have a responsibility in the event of sudden relapse or concerns for health and safety, to notify the Care Coordinator or Lead Professional of such concerns.

2.2.16 It is the responsibility of the Care Coordinator or Lead Professional, after discussion with care team, to arrange a review of Care Plan/Statement of Care. Although reviews should be timed according to the Service User's needs. Best practice suggests at least 6 monthly.

2.3 Equality of Opportunity and Diversity:

2.3.1 The following section is an extract from the CPA and Care Standards Handbook (3rd Edition) (page 5 – 6).

"*The wider principles, areas and factors to consider in equality of opportunity and diversity are set out clearly and should be considered in conjunction with local policies/guidance*

2.3.2 The following equality issues must be considered throughout Mental Health Services and the CPA process: age, disability, gender, sexual orientation, race and ethnicity and religious beliefs.

2.3.3 Equality of opportunity relates to four main areas:

- The development of policy and procedures

'*..the Department of Health (DH) is required to assess the impact of any policy proposals on different groups in the community in terms of equality of access and impact on the rights and needs to those groups'*

- The needs for services

'*Mental Health Services need to develop and demonstrate cultural competence'*

- Access to services, resources etc.,

'*An interpreter, or in the last resort a family member will be necessary when language is a barrier'*

- Treatment once within the service

'To help ensure that quality mental health services are provided to all, appropriate to their needs, services must also pay attention to the potential for inequalities in outcomes of individual care assessment and planning, and the service they provide'

2.3.4 Important factors:

- The discrimination people experience may contribute to their mental distress and ill health

- There have been 'significant over-estimates of non-white patients assessed as being violent by mental health professionals compared to white patients in contrast to their subsequent behaviour'

- There has been a tendency to organise services generally in ways which are 'blind' to the actual needs of such individuals and the groups to which they actually belong; and

- In relation to Carers, services need to be sensitive to different cultural models,
  particularly an appreciation of the role of kinship networks and extended families, and to the impact of age, e.g., young Carers.

If a Care Coordinator/Lead Professional is to ensure that the needs of the people they work with are met then they have a duty to work in what has been called a 'critical' way.

This involves being sensitive to and continually questioning:

- Their own assumptions;
- Peoples' interpretation of any individuals language and behaviour; and
- The impact of discrimination on individuals.

2.3.5 In Summary Values and Principles Quality and Diversity cover **key themes** in the ethos and development of mental health services as follows:

- Social inclusion and recovery
- An 'in the round' view of individuals.
- Self care
- Carers needs
- Partnership working
- Engagement

3. PROCESS/REQUIREMENTS

3.1.1 Initial Assessment Process

Everyone referred to the Secondary Mental Health Service should receive a systematic assessment of their individual mental health needs. This initial assessment aims to identify the needs and where they may be met and must include all elements necessary to make a decision about CPA/Standard Care Planning.

The process should take into account the following guidelines:

3.1.2 The assessment will be:

- Carried out with the individual concerned enabling them to identify their own needs.[9] [10]
- Undertaken with due regard to confidentiality
- Thorough and comprehensive including unified health and social care domains to prevent repetitious assessments and provide the most holistic and relevant information (commonly agreed for risk assessment).

[9] Please refer to Effective Care Coordinator in Mental Health Services : Modernising the Care Programme Approach. NHSE October 1999 Catalogue No: 16736

[10] Please refer to earlier sections of this document, 1, 2 and 8.

- A single assessment which provides access for both health and social care based on a single point of access.
- Ensure Service Users needs, strengths and choices are taken into account, not only what the professional/services can offer.
- Explained to the Service User in an appropriate format and setting.

3.1.3 The Process will include:

- The involvement of Service User and Carer (where appropriate) including recording their own views of their illness, perhaps in the notes/Care Plans.
- Prompt assessment for young people with the first signs of psychotic illness.
- Identification of any Advanced Statements and Advance Decisions (see Mental Capacity Act)
- The capacity of the Service User must be assumed; unless it is established they lack it.
- If possible attempts should be made to identify whether or not the Service User has a lasting power of attorney or a deputy (appointed by the Court of Protection - COP) or an order has been made, by the COP, on a specific issue.[11] [12]
- Service Users may have their own caring responsibilities and if so these should be explored and any appropriate support, Contingency and Crisis Plans put in place for both the Service User (as Carer) and for the person they care for.

3.1.4 Components of an assessment will include the following information, more detailed explanations for each can be found in Appendix 2;

- Referral
- Passport Details
- Initial Needs and Risk Assessment
  **(*A full Risk Assessment should be completed for every client at the first assessment and reviewed every 6 months thereafter, unless a significant event dictates that this is done sooner. Any significant incident* must also be linked to the appropriate *risk area of the patient record system* promptly. A standard risk assessment document which will be found on the central recording system will be used by all services. Format of template may differ between services*.)
- Current Situation
- Psychological/Mental Health
- Consider are there any impairments or disturbances in the functioning of the mind or brain that are likely to affect capacity and if so, what steps can be taken to promote capacity?[13]
- Medication
- Co-Morbidity and Co-existing Problems
- Previous Mental Health History
- Personal and Family History
- History of physical, sexual or emotional abuse at any time
- Children's Needs

[11] The CPA and Care Standards Handbook, CPAA 3rd Edition 2008 pg 31 paras 2 to 6 inclusive.

[12] Please refer to Trust Policies on Decision Making/Advance Decisions/Lasting Powers of Attorney.

[13] Please refer to current Trust Mental Capacity Act Policy.

(There is further information available to support knowledge and understanding of children's needs. Appendix (3))

- Medical History and Physical Health
- Social
- Diversity/Cultural/Spiritual/Religious Needs
- Daily Living
- Accommodation
- Employment, Leisure, Occupation Status
- Benefits/Financial Status
- Special Needs
- Carers Needs

3.1.5 Additional Areas to Consider:

Include:

- Level of support (practical and emotional) and intervention required.
- Use of Personalised Budgets or Direct Payments to support additional needs.
- Informal support network
- Ability to manage self care of mental ill health
- Likelihood of maintaining appropriate contact with services.[14]
- Service Users strengths and aims.[15]
- Cultural, gender and access needs.
- Advocacy and legal advice.

3.1.6 Risk Assessment and Risk Management Plan:
"*The Best Quality of Care can be provided only if there are established links between the Needs Assessments of Service Users and Risk Assessment*".[16]

"*Risk Assessment is an essential and on-going element of good mental health practice and integral component of all assessment, planning and review processes*".[17]

"*Risk Assessment is an essential and on-going part of the CPA process"*[18]

"*Risk Assessment is about weighing up both the possible beneficial and harmful outcomes and stating their likelihood*"[19]

3.1.6.1 The above statements concerning risk assessment share the commonality of 'process'. Risk Assessment and management thereof should always be based on the principle that assessment of risk is structured (as part of assessment process) evidence based and as consistent as possible across a range and settings and across service providers. A clear Risk Management Plan should always follow the Risk Assessment and Needs Assessment. This is essential for good communication between practitioners and agencies. Any locally agreed policies and procedures

[14] Effective Care Co-ordination/Modernising the CPA paras 57 and 58
[15] Effective Care Co-ordination/Modernising the CPA para 88
[16] Rethinking Risk to Others in Mental Health Services. The Royal College of Psychiatry June 2008 pg 10.
[17] Capabilities for Inclusive Practice. DH August 2007.
[18] Effective Care Co-ordination in Mental Health Services DH
[19] Learning Materials on Mental Health; Risk Assessment. The University of Manchester/DH 1996ISBN0906107709

relating to the management of risk should be informed by 'Best Practice in Managing Risk'. [20]

3.1.6.2 Risk assessment tools, while helpful, should be used to augment an overall clinical judgement as part of assessment conducted with the Service User.

3.1.6.3 'Clinical Judgement' can be described as a balanced summary of prediction derived from knowledge of the individual, present circumstances and what is known about the disorder from which the individual suffers.

3.1.6.4 Information derived from using tool based assessments must be combined with information gathered on the many other aspects of the person's life and situation in the comprehensive initial and ongoing assessment.

3.1.6.5 Risk Assessment is an integral part of the assessment process beginning at the initial assessment stage. At any point of the assessment process Service Users who present with sufficient risk to cause concern must be discussed with relevant manager/service and may need urgent action. A Risk Assessment Summary and Management Plan should always follow a risk assessment.

3.1.6.6 Any relevant information should be shared with other professionals directly involved in the care, under the information sharing guidelines.

3.1.6.7 The Solent Safeguarding Policies (Adults and Children) should be applied when there are any safeguarding concerns. [21]

3.1.6.8 An essential part of ensuring as safe a service as possible is a formal process for identifying risk factors and managing services and people to minimise those factors. Risk Assessment and management is not a precise science and the elimination of risk is simply not an achievable objective. Moreover, an element of positive risk taking is essential for individual personal development/choice.

3.1.6.9 A risk history detailing significant events/incidents in the past which may have a bearing on the assessment should be made available. Details of assessed risk must be included and recorded in the agreed documents /IT system and if assessment shows no evidence of risk or levels below which warrant action, this should also be recorded. It is equally important to record the absence of risk and positive risk taking following an assessment.

3.1.6.10 Taking these guidelines into consideration, the risk assessment and subsequent plans should include the following areas:

- Risk history (used to inform Risk Assessment and Management Plan).
- Intentional self harm
- Unintentional self harm
- Risk from others (Include Safeguarding Children and Adults)[22]
- Risk to Others (Include Safeguarding Children and Adults)

[20] 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. DH June 2007

[21] Safeguarding Adults Policy: Safeguarding Adults from Abuse 2008 Providers 1.doc..

[22] Safeguarding Adults Policy: Safeguarding Adults from Abuse 2008 Providers 1.doc. Safeguarding Children: Solent NHS Trust Safeguarding Children (Child Protection Policy) (COR/028).

- Forensic history and current circumstances
- Positive risk taking.

3.1.7 Assessment Summary and Outcomes:

- The Summary of the assessment should include all aspects of need identified from the initial assessment process. In addition there should be proposed plans to meet the need and an indication of outcomes. The outcomes will also reflect the level of care planning required: (Format of summary may be agreed at service level)
- Standard Care Plan
- Care Programme Approach
- Discharge from Adult Mental Health Services.

3.1.8 The basic principles of good practice for discharge are:

- Involvement of service user and family members
- Identification of all agencies that will need to be involved in ongoing care., including GP
- Arranging a multi agency discharge planning meeting to ensure that all parties are clear about the Care Plan, risks, Crisis and Contingency Plan, roles and responsibilities.

The safeguarding of children and adults should also be included at this stage.

3.1.9 HONOS:
Health of the Nation's Outcomes Scales rating will be completed at significant points of change within the Care Pathway and should be undertaken in line with clustering requirements.

3.1.10 Signatures:

People involved in the initial Needs and Risk Assessment should be identified, e.g., Service User (person assessed), Practitioner(s), as assessor(s) and Carer/representative and a signature obtained. If not possible record reason.

The permission to share form should be used at this assessment.

Copies of the Identified Needs and Risk Assessment or Assessment Summary should be made available for relevant person/party. GP's would usually receive a copy.

3.1.11 Specialist Assessments:
If it is necessary, a specialist assessment would be requested by a Care Coordinator or Named Nurse.

As an example, the following individuals or agencies can be referred to in isolation or jointly to provide an additional specialist assessment:

- Medical
- Psychology

- Social Work/Social Care Children/Adults services
- Occupational Therapy
- Substance misuse
- Leaning Disability and Adult Mental Health
- Art Therapy
- Health Services
- Specialist Nurses
- Older Persons Mental Health Service
- Housing
- 3rd Sector Services.

(The above list is only an example and is not exhaustive.)

3.1.12 Other Assessments:
Also consider need for assessment in the following areas:

- Safeguarding Adults
- Safeguarding Children/potential long term effects of parental mental illness on children.
- Mental Health Act Assessments
- Mental Capacity Act
- Deprivation of liberty
- Assessment under Care Act 2014 (came into force May 2015)

3.2 Care Planning – Delivering Services Appropriate to the needs of AMH Service Users:

3.2.1 A Care Plan is essentially:

- A formal record of needs, actions and responsibilities made with a Service User (or Carer) at the centre of the process.
- It summarises the identified needs and how they are to be met, setting out what is going to be done; Why? When? And by whom?
- The needs identified in 'the assessment' will inform the care planning requirements.
- The Care Plans will be recorded in the appropriate part of the electronic record keeping system or as a service agreed template.
- For those subject to Standard Care (not on-CPA) a 'Statement of Care' may be seen as a Care Plan and should be documented in clinical practice notes and in a transferable CPA Policy version 5 Solent Format NHSLA APPROVED (2).doc 12 format so it is accessible to the Service User, e.g., a letter. This will also need to be accessible within the electronic records system (see previous section 4.4).

The Service User must be given a copy of their Care Plan and crisis and contingency arrangements.

3.2.2 The agreed Care Plan will be:

- Developed in collaboration (where possible) with the Service User identifying the care and treatment which will be overseen by the Care Co-ordinator.

- Should be written in first person (Service User view).
- The plan will outline expected outcomes and how these will be achieved.
- If the Service User disagrees with any part of the planned care, his or her reasons for disagreement must be recorded on the Care Plan.
- A CPA review should be inline with the clustering undertaken by service in OPMH and AMH (and other sevices where applicable). Review should also take place where changes in situation/circumstance or care are identified or the complexity of someones presentation/risk requires it. A review for all Service Users should take place at least annually.
- Details of the contribution of all involved agencies.
- Appropriate crisis and contingency arrangements.
- Care Plans should focus on, and seek to promote, recovery by recognising, reinforcing and promoting Service User's **strengths** at an individual, family and social level. Care Plans should take into account the diverse needs of the Service User, reflecting cultural spiritual and ethnic background as well as gender and sexuality and should include action and outcomes in all aspects of an individual's life where support is required. This is described as relating to a person "in the round", e.g., psychology, physical and social functioning.

3.2.3 Care planning will therefore need to take account of:

- "Choice" for individuals
- Advance decisions/directives/statement of wishes
- Direct payments within context of care management provision. [23]
- Individual budgets (47)
- A record of unmet need. Identifying unmet need has two important aspects:
    - To ensure a robust, person centred, collaborative Care Plan is in place to support the individual.
    - To identify areas relating to current provision and/or potential service development for commissioning consideration.

- Utilising and supporting the care contributor role in the care planning process.

3.2.4 Crisis and Contingency Plans:

This has been consistently highlighted from National Guidance to local experience as an **IMPORTANT** area of all assessment and planning processes. This should apply to those who are accepted into the Mental Health Specialist Services regardless of whether in community or in-patient settings and inclusive of those on Standard Care or the CPA.

3.2.4.1 Crisis and Contingency Planning should, as far as possible, be inclusive of areas of service involved and Service User and Carers (if appropriate, e.g., has own assessment/plans) plans should be reflected in each others.

3.2.4.2 When a patient is on Standard Care the Crisis and Contingency Plan will be included in the letter from the Lead Professional.

[23] An Introduction to Direct Payments in Mental Health Services: Information for people eligible to use Mental Health Services and Carers. C.S.I.P.

3.2.4.3 These plans form a key element of the overall Care Plan and must be based on the individual's wishes and circumstances. It is important to include advanced decisions and directives. Contingency planning helps lesson the likelihood of crisis developing by detailing arrangements to be used where at short notice, either the practitioner involved is not available or part of the Care Plan cannot be provided, further information is available in appendix 4.

3.3 Acute Care Pathway / Oakdene and Community Interface

If the Service User has been admitted to a residential unit, the Named Nurse will either:

- Refer to the appropriate Recovery Team as soon as possible following an admission. If the Service User has no existing Care Coordinator, the Recovery Team will allocate a Care Coordinator within 24 hours according to current operational arrangements.

  Or

- Contact the existing Care Coordinator within 12 hours of admission (excluding weekends and Bank Holidays) to ensure the recovery and discharge planning process begins as soon as possible following admission.[24]

3.3.1 Within a residential unit the Named Nurse will coordinate the care planning within the context of reviewed Care Plans and in collaboration with the named Care Coordinator. A flexible approach is imperative between these interfaces as resource in each area may vary. Any operational issues impinging on implementation of care planning must be taken to appropriate managers within the service structure.

3.3.2 A care planning meeting must be held prior to discharge from Oakdene or the Acute Care Pathway. This may be an initial care planning meeting, if an individual is new to the service or a review if it is an existing Service User. The Care Coordinator remains responsible for the completion of the joint agency Care Plans.

3.3.3 Named Nurses who work on Oakdene will be more actively involved in discharge planning and work with the Service User in a Care Coordinator role or until the Care Plan has been arranged and agreed.

3.3.4 It is essential that the Care Coordinators and Named Nurse work together in recovery and discharge planning, sharing responsibilities and ensuring there is a coordinated approach to the Service Users care and treatment.

3.3.5 An important aspect of care planning is to include all those who contribute to the Care Plans in any discussions and reviews. The care contributor format indicates what areas need to be considered when recording contributions to care for clinical entries' and reviews.

3.3.6 Health care support workers and any other staff on units who provide aspects of care should be involved in process and recording input.[25]

[24] Please refer to Operational Acute Care Pathway and Individual Interface Service Areas, Operational Policies. Particularly RSST.

[25] Care Contributor Form in Appendix 6 – Staff within AMH should include such details on electronic system.

3.4 Discharge from Hospital

The Department of Health has highlighted the potential of increased risk upon discharge or leave from hospital settings.

3.4.1 7 Day Follow up

The first 7 days after discharge have been identified as a high risk period for clients, there is an increased likelihood of:

- Risk of disengagements
- Loss of contact
- Disruption of services
- Harm to individuals and others

It is therefore required that all service users are followed up within 7 days of discharge.

3.4.2 Inpatients going on leave should have close community follow up with a co-ordinated Care Plan. This should include more intensive provision for the first three months following discharge from inpatient care, specifically for the first post discharge week of everyone who has a severe mental illness or history of self harm (previous 3 months).[26]

3.5 Criminal Justice and Offenders

In Portsmouth, City Adult Mental Health Services interface with Criminal Justice Services in a number of ways including:

- Hampshire Liaison and Diversion Service,
- Through Recovery teams, with Service Users who meet the criteria for secondary mental health care services. Detailed guidance within this area can be found in a number of reports and documents cited in the references.[27]

3.6 Reviews:

3.6.1 Review Principles:

Care Plans will be reviewed and evaluated on an ongoing basis to monitor progress in meeting identified needs. The needs of people with mental health difficulties can change rapidly and it is important that planned reviews are carried out. Review meetings should be brought forward if there is marked and unexpected change in the Service Users situation, or if there is a marked divergence from the plan of care. All Service Users should have a Care Plan review as per their cluster review, where needs remain unchanged. All those involved have a responsibility to ensure the Care

[26] Safety First: Five Year Report of the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness. DOH 2001. Please refer to Inpatient Operational Policies and Protocols.

[27] Criminal Justice and Offenders.

• Changing the Outlook: A strategy for Developing and Modernising Mental Health in Prisons DOH 2001.

• 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 (DH June 2007) Pgs 5, 21, 45.

• Discharge Arrangements and Ongoing Care for Prisoners with Mental Illness: Liaison Between the NHS and The Prison Service. Joint Prison Service/NHS Guidance 27 July 2000.

• The CPA and Care Standards Handbook 3rd Edition Section 11, Criminal Justice and Offenders Pgs 49 – 54 inclusive. Include processes relating to offenders in detail.

Coordinator or Lead Professional is advised of any problems or issues that they observe to ensure that an appropriate review meeting is arranged to discuss them.

The review meeting will be planned in advance and is for everyone involved in providing the Care Plan

It is a shared process in which everyone's opinion, need for information and opportunities for choice are respected.

3.6.2 The purpose of the review is to:

- Assess the needs of the Service User against all the areas **defined in the Care Plan.**
- Assess the effectiveness of the Care Plan.
- Assess the progress made and relevant outcomes.
- Amend the Care Plan as necessary including review of purchased care package.
- Amend the crisis and contingency arrangements as necessary.
- Review Section 117 arrangements (where appropriate).
- Discharge the Service User from the service when appropriate.

Good practice guidelines in relation to reviews can be found in appendix 5

Where there is a change in a service users risk, presentation or medication identified, which leads to a significant change in an individuals management plan, there will be a follow up with a conversation to the Primary Care provider outlining changes and reasoning and this will be recorded in the electronic records

3.7 Implementation of Care Plan

The Care Coordinator or Lead Professional is responsible for the co-ordination and implementation of the Care Plan including the time, duration, frequency and the person responsible for each allocated resource.

3.8 Monitoring:

The purpose of monitoring is to ensure that planned care continues to meet assessed needs.

It is the responsibility of the Care Coordinator or Lead Professional to ensure the plan of care is monitored.

This will take the form of face to face discussion with the Service User at a frequency agreed at the care planning meeting.
Although the Care Coordinator or Lead Professional is responsible for monitoring the Care Plan, it may be another individual who has regular face to face contact with the Service User. The Care Coordinator/Lead Professional will remain in close contact with them to ensure any changes are reviewed quickly and Care Plans altered accordingly.

3.9 Care Contributors Role in Care Planning and Reviews within CPA

Care contributors refer to those practitioners within AMH, third Sector, other statutory organisations who provide an element of care for Service Users as part of the Care Programme Approach. It is essential they are included in the development

and review of care planning to ensure a seamless and holistic approach within a multi-agency/multi-disciplinary context. There is a separate form for Carer's contribution to the CPA.

3.10 Recording:

All clinical information should either be recorded onto or in the case of those on Standard Care the letters should be uploaded to RiO.

3.11 Discharge from and Transfer from/to Community Teams:

When discharging or transferring a person's Care Plan, accurate and timely communication with all involved is essential.

The Care Coordinator/Lead Professional is responsible for ensuing that the responsibility for the care and treatment of the Service User is formally transferred in a rapid, accurate and secure manner to the receiving services from whom confirmation will be requested either at the CPA/Standard Care transfer meeting or in writing. Transfer Protocol (Appendix 6), in place outlines information required to be received or provided in light of a transfer of care to another Mental Health Service. Tranisiton Protocols regarding transfers between Services should also be followed such as transition between CAMHS and AMH Services with parties agreeing the information required for transfer and joint handover period.

When discharge/transfer is felt to be appropriate the Care Coordinator/ Lead Professional should arrange a Discharge Planning meeting to be attended by all relevant people including a representative from the receiving service. As part of that meeting a Relapse Plan will be agreed and placed in the GP letter and also given to the patient. It will include the following minimum date:

i) What the diagnosis of the patient is.
ii) What the indicators of relapse are
iii) What the roles and responsibilities of all parties including family/carers should be in the event of relapse.

Reasons for discharge/transfer should be clearly documented and recorded on current electronic service record system, noted on any relevant forms and in care notes (if appropriate).CPA Policy version 5 Solent Format NHSLA APPROVED (2).doc 16

Currently when a Service User moves to another health provider unit, the Psychiatrist (as Approved Clinician) from AMH is responsible for ensuring that the information from case recording is transferred to, and accepted by, the new provider unit.

- The Service User will be informed of their new Responsible Clinician, Named Nurse and Care Coordinator before transfer.
- Until such confirmation is received care of the Service User remains the responsibility of the previous service.
- If the Care Coordinator encounters difficulties securing responses from people involved in the transfer, this should be reported to their line manager.
- Information systems should be updated of any discharges and transfers in and out of the service.
- **Standard Care** the process for discharge/transfer of a Service User on Standard Care will follow the same principles and safety measures.

3.12 Discharge from After Care (Section 117 1983 Mental Health Act)

After-care refers to the care and treatment a Service User receives in the community when they are subject to Section 117 Mental Health Act 1983 (this applies to people who have been detained in hospital under Section 3, 37, 45a, 47 or 48 of the act).

Service Users can only be discharged from Section 117 when it is agreed by the statutory agencies that they no longer need any after-care services. After-care services are ones, which are provided in response to an assessed mental health need and reduces the prospect of the Service User being readmitted for treatment for their mental health disorder. The agencies will need to be satisfied that the Service User's mental health stability is not as a result of the provision of after-care services and could therefore breakdown on discharge.

Health and Social Services have a joint responsibility to ensure that appropriate after-care services are provided for each Service User while they continue to be subject to Section 117. Prior to discharge from hospital a care package will be agreed with the Service User. The Care Plan should set out the person's needs, which are Section 117 needs and what services are provided to meet them. Reviews of Section 117 after-care arrangements must take place within three months; repeat after a further three months then at six monthly intervals or more frequently if required. The review must consider the appropriateness of the care plan and whether there is a need to discharge from after-care.

The Service User may at times reject all or part of the Care Plan, in these cases the Care Plan will not be discontinued until every reasonable effort has been made to re-engage the Service User. If the Service User continues to refuse all contact a review will be called where the decision will be made whether discharge is appropriate, or to continue a revised Care Plan in their absence. (A flow chart can be found in Appendix 7)

Any discharge from s117 aftercare must be jointly agreed by health and social care and be in writing.

3.13 Eligibility, Criteria, Care Management:

The Department of Health has suggested practitioners reassure Service Users and Carers that Refocusing CPA into Standard Care and CPA will not impact on eligibility for care management funding. The Fair Access to Care Services Guidance will continue to apply (Appendix 10).

In Portsmouth there is a Care Management Panel where requests for financial assistance in respect of Service Users and Carers (Carers grants) are considered.

Guidance on the above areas is available to all areas of service.

3.14 Care Programme Approach and Other Care Processes:

CPA applies across a range of service, including CAMHS and OPMH, the principles within this policy apply, however additional information can be found in Appendix 9;

- Older Adults – Single Assessment Process
- Health Action Planning (HAP) for People with Learning Disabilities
- Person Centred Planning (PCP) for people with learning disabilities

- Performance Assessment Indicators for service users with learning disability
- CAMHS and CPA

4. ROLES & RESPONSIBILITIES

4.1 Care Coordinators / Lead Professional

The Care Coordinator is crucial to the successful implementation of the CPA and Care Management process.

The Care Coordinator has the authority to:

- Coordinate the delivery of the Care Plan.
- Call a review.
- Access resources.

4.2 Professionals who undertake the roles

Social Workers, Nurses, Psychotherapists/Psychologists (in specific parts of the service, e.g., Early Intervention in Psychosis), Occupational Therapists. They may also undertake the role of Lead Professional or Care Contributor.

Consultant Psychiatrists and Medics – currently undertake the role of Lead Professional and Care Contributor within the context of the Re-Focusing agenda.

4.3 Allocation of Care Coordinator:

The role of the Care Coordinator should usually be taken by the person who is best placed to oversee care planning and resource allocation. Consideration should also be given to the Service User's needs matched against staff skills, qualification and experience. The '**Choice'** agenda must be taken into consideration in relation to specific needs

4.4 Allocation of Lead Professional:

The Lead Professional role will be undertaken by the worker taking responsibility for the person's treatment and care when the person has been assessed as not needing the support of CPA.

(*Further information on the Care Co-ordinator / Lead Professional can be found in Appendix 8)*

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.

5.2 Line Mangers will identify staff training needs through supervision and/or appraisal and ensure that all staff attend the identified training.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Impact Assessment form has been completed, Appendix 11, there have been no issues identified that require action.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 **Outcome Measures:**

"*All practitioners must ensure rigorous evaluation of goals and outcomes of the individuals Care Plan. Individual practitioners will need the skills and be given the support to identify ineffective quality systems and approaches*". [28]

7.2 This is both a means of assessing the severity of each Service User's problems, and monitoring how effective the services have been. There are a number of outcome scales in use that can routinely be used by professionals and by Service Users and Carers.

7.3 The Health of the Nation Outcome Scales (HoNOS) is a brief standardised assessment measure which provides a means of measuring progress. The scales are designed for use by all mental health workers. This is now a requirement by DH and will be used at least annually, but in a timely way also at change points.

7.4 There are other outcome measures highlighted in the CPAA Care Standards Handbook which may be helpful, for example, the Camberwell Assessment of Need – the whole service would need to agree on use of these to ensure consistency of approach across each aspect.

7.5 The Care Quality Commission provides indicators for mental health trusts in relation to performance assessment. [29]

7.6 **Audit:**

As part of ongoing review the Care Programme Approach processes in core areas of the service delivery are audited on a quarterly basis. This will be refined and updated as National guidance dictates. It will be compulsory for each service to complete the audit at the required intervals.

8. REVIEW

This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed three years after initial approval and thereafter on a triannial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Service User Charter.
National Service Framework for Mental Health – HSC1999/223:LAC(99)3427.9.99
Refocusing the Care Programme Approach. DH March 2008
Clinical Practice Algorithms and Pathways to Care. December 2002 National Institute for Clinical Excellence.
Fair Access to Care Services Guidance on eligibility criteria for Adult Social Care (DOH 2002 – Portsmouth City Council)
Care Act 2015
MCA 2005 Code of Practice and Local Guidance
(HC(90)23/LASSL(90)11)
Practice Guidance on MHA and MCA for Portsmouth AMH Services in 2008/2009

[28] Capabilities for Inclusive Practice. DH August 2007
[29] Care Quality Commission, Indicators for Mental Health Trusts 2009/2010.

Effective Care Coordinator in Mental Health Services : Modernising the Care Programme Approach. NHSE October 1999 Catalogue No: 16736
The CPA and Care Standards Handbook, CPAA 3rd Edition 2008
The Care Standards Handbook, Care Co-ordination Association, New Edition 2015
International Clarification of Diseases 10th Edition.
History of Violence and Abuse, Section 4 Assessment in Care Planning (Refocusing the Care Programme Approach (DH 08).
Joint Working Protocol AMH and Child Care (Current version)
Rethinking Risk to Others in Mental Health Services. The Royal College of Psychiatry June 2008 pg 10.
Capabilities for Inclusive Practice. DH August 2007.
Learning Materials on Mental Health; Risk Assessment. The University of Manchester/DH 1996ISBN0906107709
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. DH June 2007
Safeguarding Adults Policy:
Solent NHS Trust Safeguarding Children Policy as above. Joint working Protocol AMH and Child Care 2007 – 2009. NSF For Children Young People and Maternity Services. London DH (Core Standard 5).
Carers (Recognition and Services) Act 1995. Policy Guidance and Practice Guide – DOHLAC(96)7HSG(96)828.2.96.
An Introduction to Direct Payments in Mental Health Services: Information for people eligible to use Mental Health Services and Carers. C.S.I.P.
Mental Health Act and Mental Capacity Act Policies and Procedures – MH and MC
Mental Health Act Code of Practice 2015
Acts Lead Manager, Portsmouth Mental Health Services 2009 onwards.
Safety First: Five Year Report of the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness. DOH 2001. (Inpatient Operational Policies and Protocols).
Criminal Justice and Offenders.

- Changing the Outlook: A strategy for Developing and Modernising Mental Health in Prisons DOH 2001.
- 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 (DH June 2007) Pgs 5, 21, 45.
- Discharge Arrangements and Ongoing Care for Prisoners with Mental Illness: Liaison Between the NHS and The Prison Service. Joint Prison Service/NHS Guidance 27 July 2000.
- The CPA and Care Standards Handbook 3rd Edition Section 11, Criminal Justice and Offenders Pgs 49 – 54 inclusive. Include processes relating to offenders in detail.

Commission for Health Improvement (CPA Systems Implementation) DOH 2002
Care Programme Approach – Care Co-ordination, Core Functions and Competencies PSE Consulting Ltd. (Peoples Skills Education). Prepared by Karen Hardacre, Director (Commissioned by DOH)
Capabilities for Inclusive Practice. DH August 2007

Appendix: 1

Characteristics and Criteria for Levels of Care Planning Processes

Once accepted by specialist mental health services, **a full assessment of needs will include the need for support under CPA.**

Care Programme Approach:

The new CPA characteristics/criteria apply to Service Users with more complex needs and higher risk factors. The following is guidance in relation to this as defined in 'Refocusing' documentation.[30]

The characteristics to consider when deciding if support of CPA is needed:[31]

- Severe mental disorder with high degree of clinical complexity.
- Current or potential risk(s) including:
    - Suicide
    - Self harm
    - Harm to others
    - Relapse history
    - Self neglect
    - Non-concordance
    - Vulnerable adults; adult/child protection e.g.,
        - Exploitation, e.g., sexual/financial abuse
        - Financial difficulties related to mental health issues
        - Disinhibition
        - Physical and emotional abuse
        - Cognitive impairment
        - Child protection issues.
    - Arrest or significant history of severe distress/instability or disengagement.
    - Non-physical co-morbidity., e.g., substance/alcohol misuse/prescription drugs misuse/learning disability.
    - Multiple service provision from different agencies, e.g., housing, employment, 3rd sector services, criminal justice, physical care
    - Currently or recently detained under Mental Health Act, or referred to Acute Care – CRHT Team
    - Significant reliance on Carer(s), or has significant caring responsibilities for other(s).
    - Experiencing disadvantage or difficulty as a result of:
        - Parenting responsibilities
        - Physical health care problems/disability
        - Unsettled accommodation/housing issues
        - Employment issues when mentally ill
        - Significant impairment of function when mentally ill

[30] 'Refocusing CPA' (DH) March 2008 pgs 12-14.
[31] Refocusing CPA' (DH) March 2008 pgs 12-15

- Ethnicity, sexuality or gender issues.

CPA is now not automatically applied in hospital or prison.
Key Groups relates to those who should meet characteristics of CPA but are not routinely/consistently being identified and therefore do not receive the level of support they need. The following list refers to key groups who would normally be under CPA:

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

The Department of Health suggest that:

"*The default position for individuals from these groups would normally be under CPA unless a thorough assessment of need and risk show's otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records*"[32]

The Mental Health Act and CPA:
The Department of Health advises that all Service Users who are subject to supervised community treatment (SCT) or subject to guardianship under the Mental Health Act (Secion7) status should be supported by CPA.[33]

Standard Care:
The Standard Care Planning Process will apply to those Service Users who have been accepted into Mental Health Secondary Care and following a full assessment of needs (including the need for support under CPA) have been assessed as having more straightforward needs. These characteristics include:

- Need for only one agency to be involved or
- No problems with access to other agencies/support
- Lower risk
- Only need support from professional(s) as part of clinical/practitioner role. **Lead Professional identified**.
- Service User can manage self-directed care with support.[34] [35]

Transition between CPA and Standard Care:
As outlined previously the formal review process for all Service Users should take into account whether CPA is needed or not. This includes clinical/partnership decision making based on a need for co-ordination support or self directed care. As a Service User's needs change so too will the level of care planning and support needed. The Department of Health have suggested that Service Users and Carers are provided with reassurance that when CPA is no longer needed, this will not remove their entitlement to receive services they continue to be eligible for and need either from the NHS, Local Council or other services.

[32] Refocusing CPA' (DH) March 2008 pg 14 quote.
[33] Practice Guidance on MHA and MCA for Portsmouth AMH Services in 2008/2009
[34] Refocusing CPA' (DH) March 2008 pg 16
[35] See Section 4 'Aim and Standards' 4.4 Standard Care of this document

It is important to use thorough assessment process including risk and crises with Service User and Carer involvement in making changes to care planning processes. Services should be careful not to withdraw CPA prematurely because a Service User is stable because a high degree of support is maintaining well being.

DH Guidance suggests CPA should not be withdrawn without:

- An appropriate review and handover (for example to Lead Professional or GP).
- Exchange of appropriate information with all concerning, including Carers.
- Plans for ongoing review and support and follow up if appropriate.
- Clear plan and statement regarding action to be taken in the event of a relapse or change which may have negative impact on persons mental well being.

Where CPA is appropriate in prison or hospital, the same safeguards should be considered if the person is to be released or discharged.[36]

[36] Refocusing CPA' (DH) March 2008

Appendix: 2

Components of an assessment

Referral

Upon referral into the service information collected should include all relevant information required for access to secondary mental health services. The referral should include comprehensive details about risk, particularly highlighting child protection/safeguarding issues and risks to vulnerable adults/safeguarding issues.

Referrals are usually received from GP's who should be using relevant documentation or relaying information by telephone to the CHRT/or other identified entry points who will process this into defined areas from the form.

Passport Details:

Includes basic initial information relating to the Service User at the referral stage of the process. If the Needs and Risk Assessment is ongoing and involves several practitioners' input there should be an area where the different assessors can enter their details including name and dates of entry. Permission to share should be discussed and obtained from Service Users during this stage of the process.

Initial Needs and Risk Assessment:

The Needs and Risk Assessment is started on first contact with the Service User. The areas identified below should be included and contain prompts to help practitioners and Service Users to identify areas of need. The prompts are there as a guide and are not exhaustive. Practitioners may wish to use other assessment tools to augment their assessment of an individual.

The format may change with updates from National Guidance and Information Technology System(s) used for recording information. Central Records of essential information maintained on all Service Users remains a requirement.

A full Risk Assessment should be completed for every client at the first assessment and reviewed every 6 months thereafter, unless a significant event dictates that this is done sooner. Any **significant incident** must also be entered in the **risk history** promptly. A standard risk assessment document which will be found on the central recording system will be used by all services.

Current Situation:

Can include; Service Users description; circumstances of onset; impact on services user; impact on others; coping skills; relationships; Service Users expectations from the service.

Psychological/Mental Health:

Can include: appearance, behaviour, speech, thoughts, mood, perceptions, cognitive functions, insight, sleep, appetite, coping strategies, help seeking behaviour.

If an ICD[37]10 Diagnosis has been made it must be added here.

The following question must be addressed, bearing in mind capacity is time and issue specific. Consider are there any impairments or disturbances in the functioning of the mind or brain that are likely to affect capacity and if so, what steps can be taken to promote capacity?[38]

[37] International Clarification of Diseases 10th Edition

[38] Please refer to current Trust Mental Capacity Act Policy.

Is an Assessment of Capacity in Relation to a specific issue, needed? YES NO

Medication:

Can Include: contra indications, side effects, side effect monitoring in place (lithium, clozaril), non-compliance with medication, erratic or inappropriate use of medication.
Co-Morbidity and Co-existing Problems:

Can include:
- Any needs arising out of co-morbidity and co-existing problems, e.g.,

Drug/alcohol/substance usage:

Frequency of usage, when last used, trigger factors in usage.
- Learning Disabilities
- Personality Disorders

Previous Mental Health History
Can include any psychiatric admissions with legal status, diagnosis and treatment given, ask what has helped in the past.

Personal and Family History:
Can include: early years, development, schooling, childhood experiences, family psychiatric history must include the following question:[39]

Have you experienced physical, sexual or emotional abuse at any time in your life?

YES	☐	NON STATED	☐	NOT ASKED	☐

(must be recorded).

Brief details of any Disclosure

If question not asked, please state reason.

Children's Needs:
Establishing whether a Service User is a parent of children at the initial assessment stage is critical and should be routine. This should also include those who are temporarily separated from their children, for example a Prison Sentence (DH).[40]
A Service User may be the primary Carer for child(ren) but not necessarily the parent, i.e., guardian. Within the context of this document, the word parent is used to indicate any adult in the household acting in a parental capacity, whenever the relationship to the children or child, the child(ren) needs must always take priority. Any concerns regarding children must be reported to/discussed with the Children and Family Services.

[39] Outlined in : History of Violence and Abuse, Section 4 Assessment in Care Planning (Refocusing the Care Programme Approach (DH 08).
[40] Refocusing CPA' (DH) March 2008, pg 21

Assessment should include Risk Assessment and the actual or potential impact of mental ill health on; parenting; the parent and child relationship, the child and the impact of parenting on adults' mental health. Remember Children and Families services could have vital information that should be included in all aspects of the assessment.[41]

At this stage it is necessary to establish any caring responsibilities, a child/young person may undertake in relation to the parent. This should be further considered within carers needs.

It is important to remember those with parenting responsibilities are one of the key groups the Department of Health has described as needing to be consistently indentified in regards to consideration of inclusion in the CPA.

There is further information available to support knowledge and understanding of children's needs. Appendix (B)

Medical History/physical Health:
Can include: current physical health status, is the Service User being treated for any physical health needs? Is the person suffering pain? List any non drug-allergies and dietary requirements, taking into account any impact of mental ill health on physical health and vice versa. A basic physical assessment should be carried out preferably through primary care. **(Refer to Local Guidelines**[42] **written by the Physical Health Matron)**

Social:
Can include: Social functioning, social circumstances, social needs. Ability to make and maintain relationships, evidence of supportive relationships, intimate relationships, sexual problems, communication problems, ability to handle daily activities, hassles or life events.

Diversity/Cultural/Spiritual/Religious Needs:
Can include: Cultural diversity, spiritual beliefs which are individual, religious beliefs, any issues relating to mental health including, victimisation, harassment from others, cultural practices and racial awareness.

Daily Living:
Can include: home, heating for home, essential amenities, ie., washing, cooking, toilet, bed, ability to look after their home, ability to keep adequately clean, able to manage personal care, enough food and fluids, clothing, mobility, ability to use public transport, ability to cope with physical health problems.

Accommodation:
Can include: appropriate, type, flat/house/rented/hostel, fully supported, residential, 24 hour staffed, bed and breakfast, homeless, not paying rent, in debt, unsettled accommodation must be recorded as one of the key groups the Department of Health has described as needing to be consistently identified in regards to consideration of inclusion in the CPA. It is mandatory to complete this.

Employment, Leisure, Occupation Status:
Can include: employed, unemployed, part time, unpaid, seeking work (Employment is on of the key area that the Department of Health require information on and there may be

[41] Please consider needs and risk assessment within the context of the Joint Working Protocol AMH and Child Care (Current version)
[42] Standards on Physical Health Care for People Cared for by Mental Health Service 2009.

similar/additional categories highlighted in the Information Technology's CPA Module which require recording). Leisure, occupational status and potential vocational aspirations and employment needs, training and education. It is Mandatory to complete this.

Benefits/Financial Status:
Can include: income, regular, adequate, inadequate. Enough money to live on. Benefit entitlements, is the Service User receiving benefits due.

Special Needs:
Can include: Has the Service User any special needs or communication difficulties. Physical impairment. Hearing or sight impairment. Language, is there a need for an interpreter?

Carers Needs:
Should include: Has the main Carer been identified? Has a Carers assessment been offered? If accepted, has a referral for Carers Assessment been made to the Carers development worker? Has a Carers leaflet been given? **Has a young persons potential needs as a Carer been identified (children/young people may provide care for parent with mental illness).** This is important as often young carers are likely to be of school age and may not be easily identified. As described in the following quote:

"Young carers undertake a variety of tasks for parents with mental health problems, including advocacy, help with correspondence and bills, liaising with professionals, administering medicines, emotional support and domestic tasks"[43].

Service Users caring responsibilities should be explored. If a Carer is unable to attend the CPA meeting then they must be given the opportunity to complete a Carers' contribution form.

Additional Areas to Consider:

Include:

- Level of support (practical and emotional) and intervention required.
- Informal support network
- Ability to manage self care of mental ill health
- Likelihood of maintaining appropriate contact with services.[44]
- Service Users strengths and aims.[45]
- Cultural, gender and access needs.
- Advocacy and legal advice.

Risk Assessment and Risk Management Plan:
"*The Best Quality of Care can be provided only if there are established links between the Needs Assessments of Service Users and Risk Assessment*".[46]

"*Risk Assessment is an essential and on-going element of good mental health practice and integral component of all assessment, planning and review processes*".[47]

[43] Think Child, think parent, think family doc. – SCIE 09.
[44] Effective Care Co-ordination/Modernising the CPA paras 57 and 58
[45] Effective Care Co-ordination/Modernising the CPA paras 57 and 58
[46] Rethinking Risk to Others in Mental Health Services. The Royal College of Psychiatry June 2008 pg 10.
[47] Capabilities for Inclusive Practice. DH August 2007.

"*Risk Assessment is an essential and on-going part of the CPA process"*.[48]

"*Risk Assessment is about weighing up both the possible beneficial and harmful outcomes and stating their likelihood*".[49]

The above statements concerning risk assessment share the commonality of 'process'.

Risk Assessment and management thereof should always be based on the principle that assessment of risk is structured (as part of assessment process) evidence based and as consistent as possible across a range and settings and across service providers. A clear Risk Management Plan should always follow the Risk Assessment and Needs Assessment. This is essential for good communication between practitioners and agencies. Any locally agreed policies and procedures relating to the management of risk should be informed by 'Best Practice in Managing Risk'.[50]

Risk assessment tools, while helpful, should be used to augment an overall clinical judgement as part of assessment conducted with the Service User.

'Clinical Judgement' can be described as a balanced summary of prediction derived from knowledge of the individual, present circumstances and what is known about the disorder from which the individual suffers.

Information derived from using tool based assessments must be combined with information gathered on the many other aspects of the person's life and situation in the comprehensive initial and ongoing assessment.

Risk Assessment is an integral part of the assessment process beginning at the initial assessment stage. At any point of the assessment process Service Users who present with sufficient risk to cause concern must be discussed with relevant manager/service and may need urgent action. A Risk Assessment Summary and Management Plan should always follow a risk assessment.

Any relevant information should be shared with other professionals directly involved in the care, under the information sharing guidelines.

The Safeguarding Adults Policy should be applied when physical, verbal, sexual or financial abuse is suspected.[51]

An essential part of ensuring as safe a service as possible is a formal process for identifying risk factors and managing services and people to minimise those factors. Risk Assessment and management is not a precise science and the elimination of risk is simply not an achievable objective. Moreover, an element of positive risk taking is essential for individual personal development/choice.

A risk history detailing significant events/incidents in the past which may have a bearing on the assessment should be made available. Details of assessed risk must be included and

[48] Effective Care Co-ordination in Mental Health Services DH

[49] Learning Materials on Mental Health; Risk Assessment. The University of Manchester/DH 1996ISBN0906107709

[50] 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. DH June 2007

[51] Safeguarding Adults Policy: Safeguarding Adults from Abuse 2008 Providers 1.doc. ~~www.portsmouth.gov.uk/living/5770.html.~~

recorded in the agreed documents /IT system and if assessment shows no evidence of risk or levels below which warrant action, this should also be recorded. It is equally important to record the absence of risk and positive risk taking following an assessment.

All people identified in the assessment as needing Standard Care or the CPA planning will require a Crisis and Contingency Plan. See separate section in this Policy.

Taking these guidelines into consideration, the risk assessment and subsequent plans should include the following areas:

- Risk history (used to inform Risk Assessment and Management Plan).
- Intentional self harm
- Unintentional self harm
- Risk from others (Include Safeguarding Children and Adults[52])
- Risk to Others (Include Safeguarding Children and Adults)
- Forensic history and current circumstances
- Positive risk taking.

[52] Safeguarding Adults Policy: Safeguarding Adults from Abuse 2008 Providers 1.doc. ~~www.portsmouth.gov.uk/living/5770 html~~. Safeguarding Children: Solent NHS Trust Safeguarding Children (Child Protection Policy) (COR/028).

Appendix: 3

Crisis and Contingency Plan

A crisis and contingency plan would be useful in the following circumstances; "*the sudden absence of a family member who overseas medication, or the absence of a staff member through unexpected absence".*

The Contingency Plan should include information necessary to continue implementation of the Care Plan in the interim period, for example, telephone numbers of service providers and the name and contact details of substitutes who have arranged to provide interim support.

The following should be included in a Crisis and Contingency Plan:

- Passport information
- Name of Care-Coordinator/Lead Professional as contact in office hours.
- Contact arrangements for other service providers and Carers.
- The following areas/questions should provide helpful information:

    - "What is a crisis for you?"

    This should be based on the persons own definition of a crisis.
    - "What might help you cope in a crisis?"
    - "What has helped in the past?"
    - "People or things that are helpful if you become unwell?"
    - "Is there anything that may indicate you are becoming unwell?"
    - "Are there any triggers you can identify?"
    - "Action to be taken by whom if you are becoming unwell/relapsing?"
    - "Action to be taken by whom if you disengage from the Mental Health Service or appointments are missed?"

Child care issues: It is imperative that care for children is explored. [53]

- Has an advanced directive or decision been made (give details on individual's treatment choices in the event of an acute episode of illness).[54]
- If no advance decision has been made, then explain what these are and support in creating one if appropriate. (45)
- It is also important to identify (as choice) any person the Service User would NOT want to be involved.
- Other dependants, relatives, pets etc.
- Obtain signatures of all involved, dates and date of review.

[53] Solent NHS Trust Safeguarding Children Policy as above. Joint working Protocol AMH and Child Care 2007 – 2009. NSF For Children Young People and Maternity Services. London DH (Core Standard 5).

[54] Please refer to Trust's current Advanced Decision Making policy.

Appendix: 4

Review Process and Good Practice Guidelines:
Service Users and Carers may never have had any contact with Mental Health Services before. The process of assessment, care planning and review could seem strange and have unfamiliar language and abbreviations. Explaining the purposes and care process enables people to more fully engage and be active partners in the process which is more likely to lead to a successful outcome all round. Please be mindful of this and explain as thoroughly as possible the reasoning behind care planning and why a review is taking place. Avoid using jargon and, if appropriate, do simple flow-charts or explanations for people.

Self Assessment is very much integral to the process and should be encouraged at all points. Remember the Care Coordinator is working alongside the Service User or Carer in looking at their own individual needs.

Try to remember to focus on their strengths (within recovery context), weaknesses should not really come into the equation. A good word to replace weaknesses is “challenges”.
A review is an opportunity to set new objectives, goals and outcomes.

The initial care planning will have involved plans reflecting the core areas of someone’s life; for example: employment, meaningful activity in keeping with recovery focus, housing issues, financial benefit issues, medication issues and these should be reflected in any review process together with any new information of areas of somebody’s life that they would like to be taken into account.

As well as reporting on any individual areas within Care Plans, of central importance is the risk assessment.

It is essential review risk and change any Crisis and Contingency Plans as appropriate.

An adequate review must also take into account any legal status that the Service User or Carer is subject to. It may be for example, that at a CPA review consideration would be given to planning a CPA 117 discharge planning meeting and initiating the protocol surrounding this.

Reviews may also be used to look at other aspects of peoples care planning in addition to the Care Programme Approach – this might include, for example, a review for the Home Office on a Service User subject to a 37/41 Order – it may also include a review for MAPPA levels.

It is important to remember during any review process to also look at other individuals within the Service User’s life, particularly it is essential to review **children’s and Carer’s** needs as part of the process. Remember always to bear in mind **child protection and vulnerable adults protection issues**.

Young people, who may provide aspects of care and/or live with people with mental illness, are sometimes overlooked. It is essential that the on-going needs and perceived impact upon children in this situation are identified, included and acted on in reviews They may, for example, need support from Carers and/or Children and Families Services.

Some key points regarding the format of reviews:

- How to carry them out?
- Where should they be held?
- What should be considered etc?

The very minimum number of people involved in a review should be the Service User and Care Coordinator/Lead Professional. Of course for very complex situation, it may be possible that a large number of agencies within AMH, outside of AMH from the voluntary sector, independent sector, Carers etc., are all involved in somebody's care.

It is important to remember that a Care Programme Approach review including many different representatives involved in somebody's Care Plan might be quite intimidating for the Service User/Carer involved in the process. Therefore it is helpful to ascertain the views of the Service User or Carer about who or what level of involvement they would like in their CPA.

The Care Coordinator will have been actively involved in coordinating this person's care so will have had contact and feedback from all of those involved in the care planning process and will have a good overview of what that Care Plan has involved. If reports from each of the areas involved in the care planning are delivered to the Care Coordinator approximately 2 weeks before a planned CPA review all the contributors do not need to be present.

This should, of course, relate to Service User/Carer need, not for professionals' convenience at not having to attend a CPA Review. It is always ideal that all of the agencies and representatives participating in Care Plans would attend so that there would be the chance for further discussion.

Regardless of the number of people involved in a review process – the following features should always be present:

There possible a review should really be planned in advance with sufficient notice given, an agenda and an indication of who has been invited and has accepted the invitation to the CPA. If possible given an indication of what reports are being submitted in place of attendance or to supplement attendance.

Please be mindful as Care Coordinator of arrangements for the Service User/Carer's significant others in actually getting to the venue for the CPA. The venue really should be as close to the Service User's address as possible for accessibility, but if this is either undesirable or not possible, please ensure adequate transport arrangements have been made.

Care Plans work better if they are approached from a Service User's perspective on what they consider to be the strengths or particular difficulties in areas of their care planning. Please try to remember to be Service User focused.

Care Plans should be recorded as clearly and simply as possible. Try to use clear statements of specific intervention; the aim of the intervention in relation to trying to meet the need and some kind of measurement for clear outcomes as part of the process.

If Care Plans are recorded well and are individual and specific it should be possible for someone else to be able to read the Care Plan and know what care package to deliver should the Care Coordinator be unavailable at the time. This is particularly important for

crisis and contingency planning for out of hours services who really need good quality succinct information to base any crisis and contingency planning intervention on.
Do not complicate things when recording. Use simple basic language that everybody can understand to describe events, situations and planning. Think about the language used when writing a Care Plan – is it easily understood and does it have practical meaning?

Remember, however, it is not adequate, helpful or safe to just put one sentence words llike for crisis and contingency "refer to CRHT". It needs to be clear about what exactly should be focused on when an assessment is being carried out. Make clear what components of a Crisis and Contingency Plan will be most helpful for the Service User/Carer involved, noting any particular risks that should be taken into account.

Do not forget to include positive risk taking – it may be for example that in particular circumstances together with the Service User and others involved in the care, it has been identified that if particular events occur it would be more positive to take some planned risks than to take a particular action.

Currently for Service Users, with a Standard Care Plan, who typically only have contact with one professional the clinical or practice notes may constitute the record of the review. This may be in the form of a letter to the GP, but it is important to remember that a copy of this must be made available for the Service User together with the Crisis and Contingency Plan that has been updated during the review. This information must be accessible on electronic system for AMH services.

Any additional requirements:

It is important to take into account any Service Users/Carers need for any advocate to be part of the care planning review process. Advocates should be appointed in line with guidelines on recognised providers for AMH services. The role of the advocate in this process will be to act as independent to any other providers of care and will represent the best interest of the Service User defined during consultation with them.

Another important aspect to take into account is the potential need for interpreters where somebody's first language is not English or where they may need to use sign language because they are hearing impaired.

It is not always ideal to use Carers or relatives as interpreters given that they may have a vested interest in what is being interpreted. The Care Coordinator/Lead Professional should always consider using approved interpreting services in these instances.

It is important that a Lead Professional for someone who is subject to Standard Care Planning should remember that there will be funding implications for any additional services that may be being considered for that person.

A review of the need for CPA is a requirement and must take into account the complexity of the issues and number of services involved.

It is important to bear in mind confidentiality when conducting a review of Service User's needs.

During the initial assessment and care planning process, it is necessary to explain local policy guidelines around confidentiality and guidelines on risk management and confidentiality policies and obtained consent to sharing this information on a need to know basis.
It is important to remember that issues surrounding confidentiality and information sharing are sometimes changeable. It is therefore important to re-visit this during any care planning review process.

It is important to remember that both Service Users and Carers should have a review at least on an annual basis, however, the timing of care planning reviews will very often be dependent on events and circumstances in peoples lives. It is good practice to make sure that reviews are timely, relevant and important for the Service User at that time.

Reviewing Care Plans should increase (within 7 day guidance) in particular circumstances such as discharge, leave, transfer of care, relapsing factors etc.

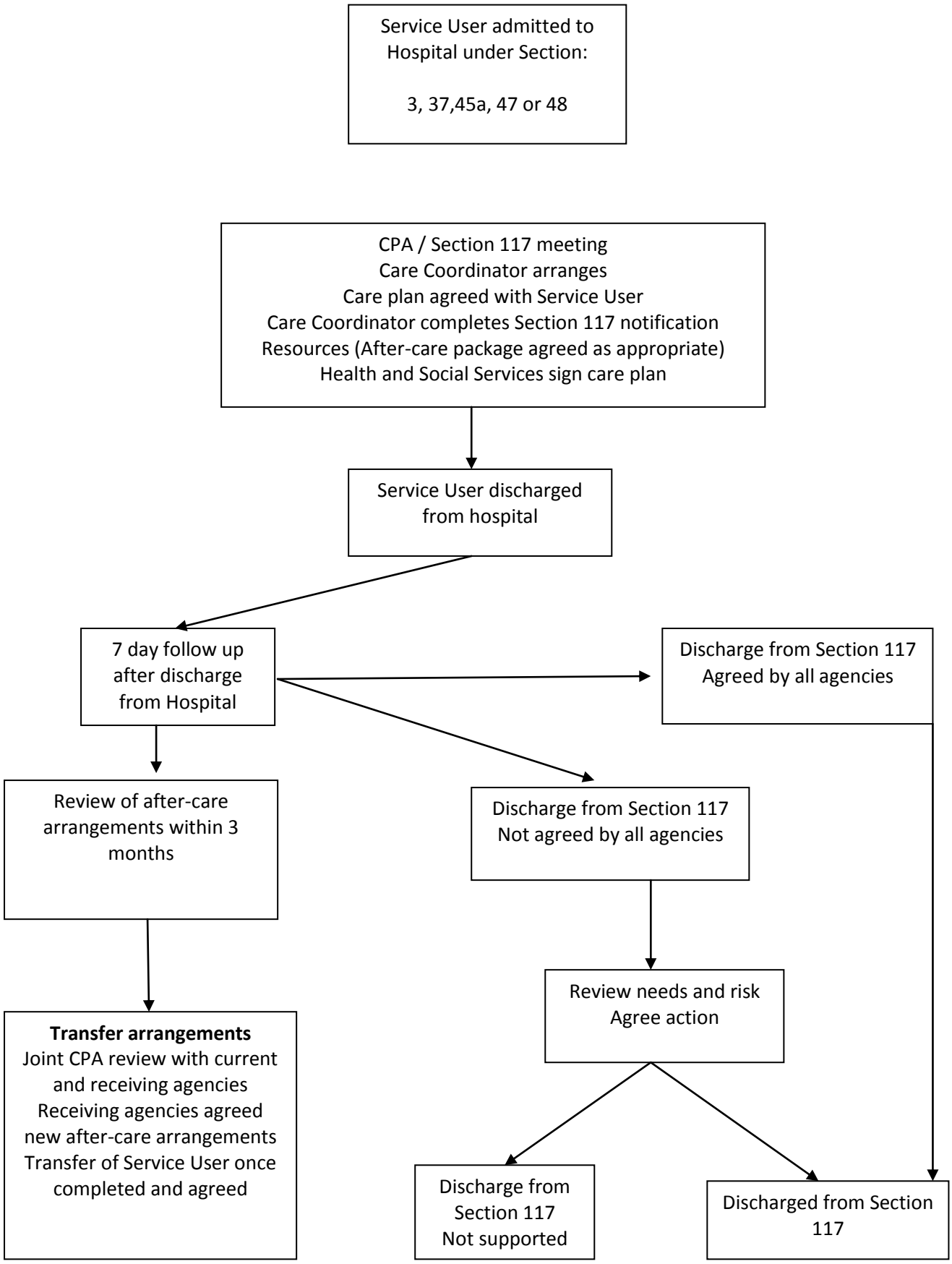
If a Service User is unwilling to attend a review considering their care needs, it is important to continue with review arrangements making them aware of what the specifics of these are. Any recording from that review process should be made available to the GP, Service User and Carer as appropriate. Every effort should be made to re-engage the Service User and keep all involved in the Care Plan informed.

Please be sure to discuss any issues or concerns about any aspect of the review during the supervision process and on a more instant need to know basis with any available line manager/team manager.

A useful practice is to include individuals from services in an advisory capacity in planned reviews (as appropriate) as well as requesting specialist assessments. Agreement should be sought from the Service User/Carer.

Appendix: 5

Section 117 Flowchart:



Appendix: 6
Care Co-ordinator / Lead Professional
The main responsibilities are:

- To co-ordinate ongoing needs assessment, care planning.
- Keeping in close contact with the Service User, ensuring that the Care Plan is delivered.
- Calling reviews and monitoring the quality of the care.
- Advising the other members of the care team of changes in the circumstances of the Service User that might require review or modification of the Care Plan.
- Co-ordinate the formulation of and updating of an agreed Care Plan. Ensuring that the Care Plan is sent to all those concerned.
- Ensure that a Crisis and Contingency Plan is formulated, updated and circulated.
- Ensure that the person is equally involved in the process and has choice, and assistance to identify their goals.
- Ensure other agencies and Carers are involved and consulted where appropriate.
- Ensure that the person understands the Care Coordinator role, knows how to contact them and whom to contact in their absence.
- Ensure that each person is registered with a GP and that he/she is involved and informed as necessary.
- Maintain regular contact with Service User and monitor their progress, whether at home or in hospital. If a Service User who remains vulnerable refuses to take part in the CPA process, all steps should be taken to find out why and to continue to attempt to engage them.
- Organise and ensure that reviews of identified needs take place, and that all those involved in the Service Users care are told about them, consulted and informed of any outcomes. Chair the review meetings if appropriate.
- Explain to the Service User, relatives, and informal Carers what the process is and make them aware of their rights and roles.
- Consider the need for advocacy for the Service User, or Carers if appropriate, and make them aware of advocacy or self-advocacy schemes in the local area.
- Remain in contact with the Service Users who enter the prison system and to be, whenever possible, aware of the Service User's location and likely release date, so that appropriate care can be planned prior to release. Current by work in progress between MENDOS and Gateway/Prison services to ensure CPA standards are implemented (December 2005). Refer to manager from each area of service for further information.
- Identify areas of unmet need and communicate any unresolved issues to the appropriate managers.
- Ensure that care management requirements are met where necessary.
- Arrange for someone to deputise if absent, and pass on the Care Coordinator role if unable to fulfil it.
- Record necessary data on electronic systems.
- Maintain contact with Service User while he or she is on authorised Section 17 leave of absence.

Supervision of Care Coordinators:
Care Coordinators will receive regular supervision and caseload management within the current system of each agency.

Full time Care Coordinators to have a caseload of between 35 and 45 depending on complexity. Caseload weighting tools can be applied to determine specific caseload sizes.

Allocation of Care Coordinator:
The definition, role, function and citing of Care Coordinators for Portsmouth AMH services is defined in Operational Policies.

For the core services, the Care Coordinator is nominated at the referral or allocation meeting at the earliest date within the process. The identification of the Care Coordinator is priority when Service Users are in an Acute Care Pathway and contact established as soon after admission as possible.

It is critical that the Care Coordinator should have the authority to co-ordinate the delivery of the Care Plan and that this is respected by all that are involved in delivering it, regardless of agency of origin. It is also critical that the Care Coordinator can understand and respond to the specific needs of the Service User that may relate to their cultural or ethnic background.

The Care Coordinator will be clearly identified on the Care Plan.

Both health and social care managers should ensure that the Care Coordinator is able to combine the CPA Care Coordinator and the Care Manager roles by having:

- Competence in delivering mental health care (including an understanding of mental illness).
- Knowledge of Service User/family (including awareness of race, culture and gender issues)
- Knowledge of community services and the roles of agencies.
- Coordination skills.
- Access to resources.

A Care Coordinator may be appointed on a short-term basis but it is necessary to acknowledge that people with serious mental health problems have enduring needs and involvement may be long term. Changes of Care Coordinator should be kept to a minimum. A CPA Review meeting should be arranged to facilitate the change.

For dual diagnosis Service Users, i.e., those with a mental health and substance misuse problem, the Care Coordinator will be allocated from the Recovery and Specialist Services Team for the duration of involvement. Dual diagnosis and/or substance misuse workers involved in the Care Plan will be named co-workers.

A Service User may indicate that they prefer to receive services from gender or culture specific Care Coordinator. The wishes of the Service User should be met as fully as possible within the resources available to RSSTs. However it is acknowledged that this may be difficult or impossible for teams to achieve.

Appendix: 7
Care Programme Approach and Other Care Processes:
Older Adults – Single Assessment Process:

The CPAA Handbook describes this process as follows:

The aim of the Single Assessment Process (SAP) is to ensure a person centred approach to assessment and care planning for older people, regardless of operational boundaries. SAP provides a platform to reduce unnecessary duplication or repetition by a variety of health and social care agencies, with its tiered assessment model of:

- Contact
- Overview
- Specialist
- Comprehensive

Where the older person's needs are being met and managed mainly in primary care and social care, and they have a mental health problem which is neither complex nor includes significant risk, care will be co-ordinated through existing SAP Care Managers.

When an older person's mental health and social care package is complex, predominantly mental health-related, and the person meets the criteria for CPA, they will normally require the support of CPA, and will have a mental health Care Coordinator.[55] [56]

In addition to this process the OPMH services in Portsmouth are considering the above within the context of the Common Assessment Framework.

Health Action Planning (HAP) for People with Learning Disabilities**:**

This is an Action Plan offered to people with learning disabilities to describe the health services being provided to support them. It is a written plan which forms part of the person centred plan. It is produced and co-ordinated by the health facilitator in partnership with primary care nurses and GPs.

It is reviewed at the following stages of people's lives:

- Transition from secondary education with a process for ongoing referral.
- Leaving home to move into a residential service.
- Moving home from one provider to another
- Moving to an out of area placement.
- Changes in health status, for example, as a result of a period of out-patient care or in-patient treatment.
- On retirement, and
- When planning transition for those living with older family Carers.

Person Centred Planning (PCP) for people with learning disabilities:

[55] Refocusing The Care Programme Approach DH March 08 pg 56
[56] CPAA The CPA and Care Standards Handbook 3rd Edition pgs 13 and 14

Person Centred Planning is a mechanism for reflecting the needs and preferences of a person with a learning disability and covers issues such as housing, education, employment and leisure.

This is a plan which starts with the wishes and aspirations of the individual with learning disabilities, and which should help the person exercise choice about housing, education, employment, support and leisure. [57]

Performance Assessment Indicators:
The Care Quality Commission requires Mental Health Services to ensure that access to health care for people with a learning disability is adequately tailored to meet their need. The approach to care planning will aim to[58]:

1. Flag up all service users with a learning disability using clinical coding on the electronic recording system. Pathways of care will need to be reasonably adjusted to meet the needs of these patients. This may include joint working arrangements with Learning Disabilities Services

2. Provide, readily available and comprehensive, information to patients with a learning disability concerning treatment options (including health promotion), complaints and appointments, involving services/people with a learning disability throughout development of such material.

3. Ensure mechanisms are in place for identifying and considering the needs of family Carers who support patients with a learning disability.

4. There is a well established local carers service across sectors which is able to provide support and information regarding learning disabilities, relevant legislation and carers rights.

5. Provide routine learning and development opportunities for staff working people who have a learning disability including areas such as awareness, relevant legislation, human rights, communication techniques and person centred approaches.

6. Continue to encourage service user and carer representation within Trust Boards, local groups and other relevant forums; seeking to incorporate their views and interests in the planning and development of health services.

7. Ensure service assurance systems are in place through audits coordinated by the AMH Business Unit, Governance and Quality Improvement Group of which AMH and Learning Disability Services are represented.

CAMHS and CPA:
The NSF for children, young people and maternity services makes it clear that CPA is the system to be used when children and young people are discharged from in-patient services into the community, and when young people are transferred from child to adult services, as it ensures continuity of approach.

Where a criterion of complexity applies in CPA, there is theoretically no lower age limit for the use of CPA.

[57] CPAA Handbook 3rd Edition, pg 13.
[58] Care Quality Commission, Performance Assessment 2009/10 – Indicators for Mental Health Trusts.

Appendix: 8

Fair Access to Care Services (Department of Health)
Eligibility Criteria Care Management

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

Critical – When:

- Life is, or will be, threatened; and/or
- Significant health problems have developed or will develop; and/or
- There is, or will be, little or no choice and control over vial aspects or the immediate environment; and/or
- Serious abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- Vital involvement in work, education or learning cannot or will not be sustained; and/or
- Vital social support systems and relationships cannot or will not be sustained; and/or
- Vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial – When:

- There is, or will be, only partial choice and control over the immediate environment; and/or
- Abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out the majority of personal care of domestic routines; and/or
- Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- The majority of social support systems and relationships cannot or will not be sustained; and/or
- The majority of family and other social roles and responsibilities cannot or will not be undertaken

Moderate – When:

- There is, or will be, an inability to carry out several personal care or domestic routines; and/or
- Involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- Several social support systems and relationships cannot or will not be sustained; and/or
- Several family and other social roles and responsibilities cannot or will not be undertaken.
- Fair access to care services

Low – When:

- There is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- Involvement in or two aspects of work, education or learning cannot or will not be sustained; and/or
- One or two social support systems and relationships cannot or will not be sustained; and/or
- One or two family and other social roles and responsibilities cannot or will not be undertaken.

Information concerning Fair Access to Care / Carers' Grants, Funding Panel is updated periodically/as appropriate through Commissioning aspect of the service.

Appendix: 9

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**
1. What are the main aims and objectives of the document?	To provide guidance and policy on the implementation of the Care Programme approach.
2. Who will be affected by it?	All mental health service users and staff
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	There is clear national expectations which are audited regularly. the outcome is a structured care package that meets service user needs and is based on recovery.
4. What information do you already have on the equality impact of this document?	The policy provides a framework for how the service provides it's service, we have specialist Community Development Workers that support minority groups to access our services.
5. Are there demographic changes or trends locally to be considered?	No
6. What other information do you need?	None

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully against any group?		X	It's based on a national standard
2. Can any group benefit or be excluded?		X	Document is inclusive of all those that meet the criteria of our services
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	
4. Can this actively promote good relations with and between different groups?	X		By providing individualised care
5. Have you carried out any consultation internally/externally with relevant individual groups?		X	
6. Have you used a variety of different methods of consultation/involvement		X	
Mental Capacity Act implications	X		
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		X	

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	

Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

****Retain a copy and also include as an appendix to the document****