Northamptonshire Healthcare NHS
NHS Foundation Trust

# Care Programme Approach Policy and Practice Guidance

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## 1.0 Document Control Summary

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| **Policy Title** | Care Programme Approach Policy and Practice Guidance |
| **Policy Purpose** | The aim of this document is to give staff more detailed guidance to support them in the implementation of the Care Programme Approach across NHFT |
| **Status: - review or New** | Review |
| **Trust Board Approved** | 06.07.2016 |
| **Areas affected by the policy** | Mental Health and Learning Disability Services within Northamptonshire Healthcare NHS Foundation Trust (NHFT) |
| **Policy originators/authors** | Anne Rackham |
| **Consultation and Communication with Stakeholders including public and patient group involvement** (if necessary) | DMT<br>Mental Health Clinical Executive<br>CPA Policy Review Task and Finish Group |
| **Archiving Arrangements** | A central register will be maintained by the Quality Support Team which will hold archived copies of this guidance. |
| **Register of Procedural Documents** | A current copy of this policy will be held on a central register, on the Trust Hub |
| **Equality Impact Assessment** (including Mental Capacity act 2005) | |
| **Monitoring Compliance and Effectiveness** | See Section 28 |
| **Meets national criteria with regard to:** | |
| **NHSLA** | Discharge / Transfer of Service User |
| **NICE** | Not Applicable |
| **NSF** | Standards 4, 5 and 6 |
| **Mental Health Act** | Code of Practice |
| **Other** | Refocusing the CPA Policy and Positive Practice Guidance, Department of Health 2008 |
| **Further comments to be considered at the time of ratification for this policy** | |
| **If this policy requires Trust Board ratification please provide specific details of requirements** | |

## 2.0 Introduction

The Care Programme Approach (CPA) was introduced in England in 1991 to provide the framework for the delivery of secondary mental health services.

The main principles of the CPA are:

- Assessment of a person's health and social needs;
- Formulation and implementation of a personalized care plan to meet the service user's assessed needs;
- A named individual responsible for coordinating the care called the CPA care coordinator and who should ensure co production of care with the service user and carers;
- Regular reviews of the personalized care plan;
- Service user and where appropriate carer coproduction throughout assessment, care planning and interventions;
- Multi-disciplinary/multi agency working.

The CPA process does not apply to individuals for whom it is decided after assessment that the appropriate intervention is:

- To take no further action;
- To give advice on management to another health/social care agency/professional;
- Where care will be provided solely by Primary Care.

## 3.0 Purpose

The aim of this document is to give staff, service users and carers more detailed guidance to support them in the implementation of the Care Programme Approach across Northamptonshire. The document is based on national guidance detailed in the Mental Health National Service Framework, Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach and more recently Refocusing the Care Programme Approach; Policy and Positive Practice Guidance.

The principles of the CPA are relevant to the treatment and care of younger people with mental health problems receiving interventions from child and adolescent services, older people with mental health problems and people with learning disabilities who also have mental health problems.

## 4.0 Duties

**The duties outlined in CPA policy are integral to section 6.0 please see below**

## 5.0 Definitions

## 6.0 Policy Process

### 6.1 Personalised Mental Health Care: Statement of Values and Principles

The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals hopes and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second, coproducing care as a partnership of professional by lived experience and professional by training.

Care, assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care realising their hopes and aspirations.

Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the CPA care coordinator is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, teamwork and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

## 6.2 No CPA

The term No CPA will be used to describe the system of provision of mental health services to those with more straightforward needs and who are not receiving services from NHFT secondary mental health services.

No CPA will apply where following assessment it is identified that the service user has:

- Straightforward needs (needs are not complex and can be met by one discipline);
- Lower risk;
- Contact with only one agency or no problems with access to other agencies/support.

## 6.3 CPA

The term CPA is used to describe the approach used in NHFT Mental Health services to assess, plan, review and co-ordinate the range of treatment, care and support needs for people who have complex characteristics.

There is a clear expectation in NHFT mental health services that professional staff will positively promote the coproduction of assessment and personalized care plans with service users and their carers where appropriate. This is essential if personalised care programs are to be effective.

Service user's will:

- Have their needs and problems assessed by a professionally qualified person;
- Co-produce their personalised CPA care plan;
- Have their care plan explained to them, in a manner that is accessible to them taking into account issues of equality and diversity;
- Be encouraged to sign their CPA care plan;
- Have a copy of their CPA care plan;
- Know they can request the support of a friend, relative or advocate at any time;
- Be given information about their condition and treatment, the risks of the treatment and information about alternatives;
- Have a choice who their CPA care coordinator will be (within the limits of resources and clinical appropriateness);
- Be informed who their CPA care coordinator is;

- Be informed who to contact in the absence of their CPA care coordinator and out of hours;
- Have the role of the CPA care coordinator explained to them and how they will coproduce care with them;
- Have a crisis and contingency plan that is personal to them;
- Be aware that they can ask for a CPA review at any time;
- Have all requests for a review considered by the care team;
- Be told the reasons why if it is decided a review will not be held;
- Be informed that any information they give may be passed to other members of the team and other agency's if they have a need to know this information;
- Be informed that information will be kept about them in a paper clinical record and in electronic format on the trust information system;
- Be informed that they have a right to access their clinical records;
- Be given a leaflet explaining to them what CPA is;
- Have specialist communicators arranged if they have communication difficulties, including where their first language is not English.

A list of characteristics is given below to consider when deciding if support of CPA is needed:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity;
- Current or potential risk(s) including:
    - Suicide, self-harm, harm to others (including history of offending);
    - Relapse history requiring urgent response;
    - Self-neglect / non concordance with treatment plan;
    - Vulnerable adult; adult / child protection e.g.
        - Exploitation e.g. financial / sexual;
        - Financial difficulties related to mental illness;
        - Disinhibition;
        - Physical/emotional abuse;
        - Cognitive impairment;
        - Child protection issues.
- Current or significant history of severe distress/instability or disengagement;
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability;
- Multiple service provision from different agencies, including housing, physical care, employment, criminal justice, voluntary agencies;

- Currently/recently detained under the Mental Health Act or referred to crisis/home treatment team;
- Significant reliance on carer(s) or has own caring responsibilities
- Experience disadvantage or difficulty as a result of:
    - Parenting responsibilities;
    - Physical health problems/disability;
    - Unsettled accommodation/housing issues;
    - Employment issues when mentally ill;
    - Significant impairment of function due to mental illness;
    - Ethnicity (e.g. immigration status, race / cultural issues, language difficulties, religious practices, sexuality or gender issues);
    - All service users who are admitted to psychiatric in patients services will be considered to be on CPA for the duration of their admission, this must always be reviewed prior to or at the point of discharge to determine whether or not the service user needs to remain on CPA.

There is not a minimum or critical number of items on the list that should indicate the need for CPA. As well as the characteristics staff and service users will need to use their clinical and professional experience and judgement.

Service users with a learning disability and severe mental health and / or severe challenging behaviour issue will have their care provided using the CPA process.

Service user's requiring CPA will have:

- Working relationship with a care coordinator who is a qualified professional
- A comprehensive multi-disciplinary, multi-agency assessment;
- An assessment of social care needs against FACS (Fair Access to Care) Northamptonshire County Council eligibility criteria;
- Comprehensive formal written personalized care plan including risk and safety/contingency/crisis plan;
- Ongoing review with a formal multi-disciplinary, multi-agency review at least once a year;
- Carers identified and informed of their rights to their own assessment.

### 6.4 Assessment

All service users who have been accepted by NHFT mental health services will have a thorough assessment of their health and social care needs including a risk assessment, carried out by a qualified professional. This assessment will be

coproduced with the service user and where appropriate their carer as central participants in the process.

Assessment is recognised as one of the first and most important stages in the CPA process but obviously remains a constant activity throughout a person's care.

The assessment has several key purposes:

- It is a way of identifying the issues, hopes and aspirations from the service user's point of view, the carer's point of view and the professional's point of view;
- It is a way of identifying the need for further or specialist assessments;
- It determines whether further treatment or intervention is required from mental health services and if it is in what way;
- It assesses the level of risk in the past, present and potential;
- It identifies whether the service user requires care and treatment provided by CPA or not;
- It establishes a level of information that will be needed to support the co-produced planning of care;
- It identifies any service shortfalls/unmet needs.

The assessment process must be:

- Explained and be a collaborative piece of work with the service user;
- Carried out with the service user as coproduced as possible;
- Systematic;
- Thorough and comprehensive;
- Carried out in the most appropriate setting;
- Shared with those involved in the service user's care;
- Agreed between agencies and disciplines to ensure that service users and carer's are assessed under a single procedure;
- Documented in appropriate section of the electronic patient record.

A full assessment of needs should include:

- Individual's hopes, aspirations and strengths;
- Identification of the presenting problem;
- Psychiatric functioning;
- Psychological functioning;

- Social functioning, social needs and social circumstances, including level of support from family, friends and carers;
- Physical health needs
- Parenting responsibilities and the impact of parenting (past, current and potential);
- Child care issues and child protection;
- Accommodation status and needs;
- Personal circumstances including those of family and carers;
- Needs arising from co-morbidity and co-existing problems such as substance misuse, personality disorder and learning difficulties;
- Financial status and needs;
- Leisure, occupational status and employment needs, training and education;
- Risk to the service user and risk the service user poses to others;
- Need for positive risk taking;
- Medication management;
- History of violence and abuse;
- Level of support and intervention(s) required;
- The individual's ability to self-manage their mental health problems;
- The likelihood of the individual to maintain contact with the service;
- Communication needs;
- Cultural needs;
- Gender needs;
- Religious needs;
- Disability issues.

Information should be validated where possible from at least two sources.

### 6.5 Risk Assessment

Practitioners should refer to the NHFT Working with Risk CLP021 and where appropriate abide with the requirements of the policy.

### 6.6 HoNOS

All practitioners should refer to the NHFT HoNOS policy CLP043 and where appropriate abide with the requirements of the policy.

## 6.7 Section 117

The CCG (Clinical Commissioning Group) and Local Social Services Authority (LSSA) have a statutory duty under section 117 to provide after-care services for mental health service users who have been detained in hospital under sections 3, 37 (whether or not with restriction under section 41), 47 or 48 of the Mental Health Act 1983, until they are jointly satisfied that this is no longer necessary.

After-care services can be defined as a service which:

- Is provided in response to an assessed mental health need;
- Reduces the prospect of the service user being readmitted to hospital for treatment for his/her mental disorder.

Section 117 applies to all service users who meet the criteria above even when they have been discharged from the section prior to discharge from the hospital or unit.

If the service user is unwilling to receive aftercare services this should not be equated with an absence of need of such services.

The principles of CPA and section 117 are the same and the guidance provided in this document should be followed for all service users.

## 6.8 Inpatient Care

All service users who are admitted to psychiatric or learning disability inpatients services will be considered to be on CPA for the duration of their admission**, this must always be reviewed prior to or at the point of discharge to determine whether or not the service user needs to remain on CPA.**

For practical reasons any service users that are deemed not to require CPA following their discharge will need to remain on CPA up until the point of discharge from hospital.

All inpatients will be allocated to their respective responsible clinician (RC) for the purposes of care coordination. It is accepted that the logistics of arranging the care will be undertaken by a named nurse.

All inpatients should have a CPA meeting convened at the earliest opportunity after admission. One of the primary purposes of this meeting will be to determine what care will be required when the service user is ready to be discharge.

Fundamentally this meeting must identify whether or not the service user is subject to CPA after discharge.

Where prior to admission a service user is on CPA and has a designated care coordinator, this professional will remain in place and work with the inpatient team. For the purposes of inpatient treatment the RC will assume responsibility as lead professional and this will be reflected in the electronic patient record as a concurrent episode.

During an inpatient stay communications between service user, carer, community teams and inpatient staff is essential. It is expected that community staff will support service user whilst in hospital by providing all information required to ensure a smooth transition into hospital and in particular will be central to discussions for planning discharge, this will enable a continuous pathway for service user and carer.

**Initial follow up following hospital admission**

If a service user is on CPA at discharge they will have a 7 day follow up appointment following discharge arranged by the ward staff with the community teams. Please refer to CLP056 for process.

**Inpatients care for services users subject to 117**

Where a service user is subject to 117 aftercare arrangements they must not be discharged from hospital or unit without a current section 117 aftercare plan in place.

Section 117 aftercare planning should commence at the point of admission to hospital.

It is the named nurse's responsibility to initiate and arrange the section 117 meeting while a service user is in hospital.

The Mental Health Act 1983 Code of Practice suggests that the following people should be involved and consulted at each Section 117 meeting:

- Service user;
- Service user's responsible clinician;
- Nurse and others involved in caring for the service user in hospital;
- Mental health social worker;
- CPA care coordinator;

- Representative of any relevant voluntary services involved in the service user's care (subject to the agreement of the service user);
- In the case of a restricted service user, the probation service;
- Any informal carer and/or the person's nearest relative (subject to the agreement of the service user);
- Nearest relative (subject to the agreement of the service user);
- Representative of housing authorities is accommodation is an issue;
- An employment expert if employment is an issue;
- An independent mental health advocate if the service user has one;
- The service user's attorney or deputy if the service user has one;
- Service users GP and / or primary care team representative;
- Any other representative nominated by the service user.

Subsequent section 117 meetings (CPA review) must be held prior to a:

- Mental health review tribunal;
- Hospital managers renewal/appeal;
- Any significant changes to the agreed after care plan (all changes to the agreed plan must be documented);
- Granting section 17 leave of absence.

(The number of section 117 meetings (CPA reviews) held prior to discharge will vary dependent on the above. Meetings must not be delayed without good reason.)

It is the CPA care coordinators responsibility to ensure that the Section 117 (CPA review) is documented on the CPA care plan. It is the CPA care coordinators responsibility to ensure that section 117 is clearly indicated on the form and on the trust clinical information system. If for any reason a CPA care coordinator has not been allocated it is the named nurse's responsibility to complete the CPA care plan.

**Section 117 Aftercare in the Community**

When a service user is discharged from inpatient care Section 117 meetings (CPA reviews) will continue to take place until such time as it is deemed appropriate to end the section 117.

If the service user no longer meets the criteria for CPA then a decision may be taken to consider termination of section 117. Section 117 would still remain applicable until the decision has been taken to terminate this; see Section 117 aftercare policy No: CLP050 for further guidance.

It is the CPA care coordinator or lead professionals responsibility to:

- Arrange with the service user the section 117 meetings;
- Ensure the care plan is documented;
- Ensure section 117 is clearly identified on the care plan;
- Ensure section 117 is clearly identified on the trust clinical system.

### 6.9 Supervised Community Treatment

Service users who are on a Community Treatment Order (CTO) are subject to CPA and are entitled to Section 117 aftercare arrangements.

The CTO should form part of a coherent care plan under the CPA.

The CTO should be reviewed as part of the CPA review. Each review should consider whether SCT is meeting the service user's treatment needs and if not what option is best for their future care.

On discharge from SCT the service user will remain entitled to after-care services under section 117 of the Act and the team should ensure the services the service user needs continue to be provided.

Further guidance on SCT should be sought from the Mental Health Act 1983 Code of Practice and the policy for CTO CLP050.

### 6.10 CPA and Single Assessment Process (SAP)

An older person's physical health and social care needs can be highly complex and often involve several disciplines and agencies other than mental health. In such instances it will not always be necessary for the CPA framework to be used.

If an older person has a mental health need which is not complex or which is without significant risk then their care will be coordinated using the SAP. A lead professional from mental health services will be appointed from within the team overseeing the service user's mental health care. The lead professional will liaise with the SAP coordinator and keep them up to date with what is happening in terms of the service user's mental health care.

Where an older person has complex mental health problems and one or more of the characteristics of CPA then CPA will apply.

Where the CPA framework is used all the relevant guidance in this document should be followed.

The professional from older people's mental health services must make it clear whether they are following the CPA process or not in the single clinical record and the electronic record. Where other agencies are involved there must be clear communication between all involved to ensure that everyone is signed up to their responsibilities and it is clear which process is being used and who is taking the lead coordinating role.

### 6.11 CPA and Framework for the Assessment of Children in Need and their Families

Children and adolescents more than adults are likely to be subject to multiple plans and review mechanisms from multiple agencies. All professionals and agencies must work together to ensure the minimum duplication of information and meetings. There has to be clear clarity of roles, especially who is leading to avoid confusion and risk.

To make CPA a reality in this service communication has to be tailored to children and young people, this includes the language spoken and the documentation used.

The CPA is not the only care planning method for children and young people. Other systems used are the children's common assessment framework (CAF) and local systems for Looked After Children. Practitioners need to be clear which approach to use.

### 6.12 Out of Area Treatment

Acute Outflow – Where a service user is subject to CPA and is admitted in an emergency to a non NHFT bed, local NHFT inpatient services will track the service user and return them to an NHFT bed at the earliest opportunity. It is good practice for the service users care coordinator to communicate with the care provider all relevant detail of the service user care to promote continuity of care.

IPC – Where it has been agreed by NHFT IPC team that a service user requires care with a non NHFT provider care coordination responsibilities will remain within NHFT.

### 6.13 Transfers within Mental Health/Learning Disability Services

Where a service user moves from one area to another, it is essential to maintain continuity of care. This applies to transfers between teams within Northamptonshire Healthcare Foundation Trust adult mental health services and transfers out of the district.

In such circumstances the responsibility for the service user's care remains with the original team until a handover has taken place.

### 6.14 Loss of Contact

There may be occasions when a service user chooses not to maintain contact with the CPA care coordinator and/or other members of the care team.

Loss of contact will be deemed to have occurred when the service user fails to keep appointments and no explanation is received. The trust Access and Waiting Times policy should be followed when the service user misses an appointment.

Where a service user seems to have gone missing from services there is a duty of care to make all reasonable efforts to locate them and to negotiate arrangements for their care and treatment please refer to the policy for Missing Service Users from NHFT (Policy No CLP003).

### 6.15 Discharge

Where appropriate service users should be discharged to primary care promptly as part of promoting their recovery.

A review, which includes everyone involved in the service user's care, will be held before the service user is discharged from Northamptonshire Healthcare Mental Health and Learning Disability Services.

At the review a plan will be agreed which contains at a minimum:

- How the service user can access services if needed;
- Action needed by the GP (primary care practice) if any;
- Service user's relapse signature.

A written copy of the plan (letter format) will be given to the service user and everyone involved in his or her care including the service user's GP.

The closure /transfer checklist should be completed by the CPA care coordinator or lead professional and signed off by their manager.

### 6.16 Carers and Carers Assessments

Northamptonshire Healthcare Foundation Trust has agreed the following definition of a carer with Northamptonshire Carers:

"A carer is someone who looks after or helps to look after a relative, neighbour or friend who has additional needs as a result of disability, illness or aging. The care given is informal in that it does not form part of a paid contract; instead it relies on a sense of responsibility for and commitment to the other driven by feelings of love, duty and concern." (*Blackwell Encyclopaedia of Social Work, 2003*).

Carers provide invaluable support to the people they care for. This role must be recognised and carers should be treated as partners in care, an included and integral partner alongside the team workers involved with the service user, each valuing the others' experience, expertise and knowledge.

Sometimes there will be difficulties in involving carer's, relatives and friends. Not every service user will wish to have assistance through informal care relationships and not all carers, family and friends will wish or be able to take on the caring role or sustain it.

If a service user asks that his or her carer, family and/or friend are not involved with their care then their wishes must be respected. The CPA care coordinator /lead professional is responsible for informing other members of the care team. However some service users will nonetheless still rely on their carers especially in times of crisis and every effort should be made to keep the carer sufficiently informed to enable them to carry out their caring role. It is imperative that staff recognise that they can listen and support a carer without breeching confidentiality and often the process of listening is a supportive mechanism needed by the carer. This also can inform the ongoing assessment process with the service user.

In the absence of consent there may be exceptional circumstances in which disclosure of information and contact with involved carers and family can be justified in the public interest. Such disclosure needs to be carefully considered by the care team and legal advice may need to be sort.

Every situation is different and carers must be recognised as individuals.

Carers Assessments

Carers providing regular and substantial care to a service user are entitled to:

- An assessment of their caring, physical and mental health needs repeated on an annual basis;
- Have their own written support plan which is given to them and implemented in discussion with them.

The CPA care coordinator/lead professional will be responsible for ensuring the carer receives an assessment of their needs and subsequent support plan.

CPA care coordinators/lead professional must ensure carers are aware of the carer development and support worker (CDSW) working within their area and the support they are able to offer.

If the carer agrees to the involvement of the CDSW the CPA care coordinator/ lead professional will pass on the carer's details to the CDSW for them to establish contact.

A carer may self-refer to the CDSW at any time.

The CDSW will initiate contact with the carer and assess the type of advice, information and/or support the carer needs.

The CPA care coordinator/lead professional and/or the CDSW will offer the carer an assessment of their needs. The carer may request the assessment to be undertaken by:

- The CDSW;
- The CPA care coordinator/lead professional ;
- Both the CPA care coordinator/lead professional and the CDSW.

If the carer's assessment has been undertaken by the CDSW, the CDSW will discuss the assessment and outcome with the CPA care coordinator/lead professional.

The assessment and support plan will be recorded on the Carers needs assessment document.

A copy of the carer's needs assessment is given to the carer, another copy is retained by the CDSW and the original is filed in the carer's assessment section of the single clinical record.

If the carer has declined an assessment they must be re offered one at regular intervals by the CPA care coordinator/lead professional and/or CDSW.

If the carer declines to have an assessment at any time this will be recorded in the Trust electronic recording system.

The carer's assessment will be reviewed at least annually but more frequently if needed by the CDSW or the CPA care coordinator/lead professional.

Monitoring and evaluation of the process will occur through quarterly reports generated by the CDSW's.

The service users CPA care coordinator/lead professional will maintain close contact with the carer at all times, in some instances through the support of the CDSW. The support should include offering information and an explanation about the service user's mental health and treatment whenever possible.

### 6.17 Young Carers

Mental health young carers are children and young people under the age of 18 whose lives are affected by the need to take responsibility for the care of a person who is affected by mental ill health.

Young carers should receive adequate support to protect them from any adverse effects of having caring responsibilities and to allow them opportunities for leisure, friendship and education. This should include offering information and an explanation about the person's mental illness.

Where a young carer is involved in the care of an adult with mental health problems the CPA care coordinator has responsibility for ensuring there is an assessment of the family circumstances and the needs of the young person and where appropriate refer them to the social services department.

### 6.18 Children

When assessing and providing services to an adult with mental health problems mental health professionals must be alert to the needs of any children in the family or children with whom the service user has substantial contact.

Assessment including risk assessment should enable mental health workers to identify issues, which may indicate significant harm to children and areas of need as perceived by the service user in relation to the child/children.

The illness of an adult will not necessarily have an adverse impact on a child but it may:

- Restrict their education and social activities;
- Give them inappropriate caring responsibilities;
- Cause them to be at risk of injury and/or emotional neglect.

Child protection risks to children should be given separate consideration relating to responsibilities under specific legislation and procedures. Concerns relating to children should be passed on to the CPA care coordinator/lead professional who will share the concerns with the appropriate agencies.

All mental health professionals working with children should be aware of the Northamptonshire Social Care and Health Child Protection Committee Agency Procedures and how to contact the lead nurse and doctor for child protection.

### 6.19 Fair Access to Care Services

Where costed care packages are needed following a full assessment of need the joint commissioning team should be contacted for advice re the correct procedure.

### 6.20 Documentation for the CPA

All service users will have an electronic patient record which contains:

- An up to date assessment of their needs (up dated at least annually);
- An up to date risk assessment (up dated at least annually);
- An up to date HoNOS score and cluster;
- A current coproduced CPA care plan which includes a crisis and contingency plan (up dated at least annually);
- Contact notes as required.

### 6.21 Information Requirements for All

The trust is required to collect data on all service users and enable 24 hour access to care plans for staff providing care to service users. This information is held within the electronic patient record.

Data held on the electronic patient record is subject to confidentiality and data protection guidance.

All team managers receive regular updates on various aspects of CPA to ensure compliance with targets and data quality. These updates include:

- CPA or no CPA status recorded in the Trust information system for all service users open to a team member;
- Number of CPA reviews that are out of date in a given month;
- Updates of national minimum data set and other local data quality requirements;
- 7 day/48 hour follow up for service users discharged from inpatient care where the CPA process is being used.

Managers are required to check this information and to ensure that any data quality issues are rectified.

### 6.22 Confidentiality

The various agencies and disciplines involved in providing mental health care need to ensure that information flows readily to the people who need it whilst still maintaining confidentiality.

The following principles need to be considered regarding what to pass on, to whom and how much:

- Both the service user and those trying to help can be put at risk by a failure to communicate with others involved;
- CPA care coordinators and others involved are entitled to information they need, no more, no less;
- All people involved in the service user's care have a duty of confidentiality;
- The consent of the service user and carer should always be sought before disclosing information;
- If consent has been withdrawn the reasons for this and the implications of not passing information on should be discussed;

- If there are any doubts regarding the passage of information these should be discussed with the multi-disciplinary team and/or the team manager. In some instances it might be necessary to seek legal advice.

Staff should make themselves familiar with other associated policies such as data protection, information sharing policy and the NHS Code of Practice on Confidentiality.

### 6.23 Role of the CPA Care Coordinator

The CPA care coordinator is responsible for coordinating and managing care in partnership with the service user and their carers.

The CPA care coordinator:

- Works in partnership with service users who have complex mental health and social care needs and those supporting them;
- Strives to empower service users to have choices and make decisions to determine their wellbeing and recovery;
- Integrates and coordinates a person's journey through secondary mental health services;
- Enables service users to have a personalised care plan based on his/her needs, preferences and choices;
- Ensures that service users receive the least restrictive care in the setting most appropriate for the person;
- Supports the service user to attain wellbeing and recovery;
- Ensures the needs of carers and families are addressed;
- Brokers partnerships with health and social care agencies and networks which can respond to and help meet the needs of the service user.

Care coordination is based on the following:

- Service users however vulnerable should share in decision-making;
- Service users are knowledgeable about themselves and the effect their conditions may have on their lives;
- Service users should be empowered and enable to inform their own recovery.

All members of the care team will be responsible for communicating effectively with the CPA care coordinator to ensure they can carry out the role effectively.

Along with other responsibilities detailed in this section the CPA care coordinator will:

- Maintain regular contact with the service user and monitor their progress until:
  - they no longer require secondary mental health services or;
  - until the role has been transferred to another CPA care coordinator with their agreement or;
  - the service user no longer requires their care and treatment to be supported by the CPA.
- Identify any unmet needs and take appropriate action;
- Maintain contact with care services providing IPC;
- Remain in contact with the care and treatment of service users who enter the prison system where appropriate.

### 6.24 Allocation

Under local CPA arrangements the allocation of care coordinators is undertaken by the appropriate community team. All persons referred for allocation will be individually assessed by the community team to ascertain the level of need and appropriateness for care coordination

The CPA care coordinator will be allocated in a timely manner taking into account priority of need by NHFT. Priority will be given to all persons currently inpatient or accessing the crisis team function.

The CPA care coordinator will be from one of the following disciplines:

- Nursing;
- Social work;
- Occupational therapy;
- Psychology;
- Medical Professional.

The allocation of the CPA care coordinator will be agreed during a multi-disciplinary meeting in the appropriate team.

Allocation will take account of:

- Who is best placed to understand and respond to the specific needs of the service user;
- The workloads of prospective CPA care coordinators;

- The needs and wishes of the service user.

The CPA care coordinator will be identified prior to a service user being discharged from hospital where the service user is identified as requiring CPA post discharge.

Where a service user is discharged from hospital, irrespective of their CPA status - the community mental health team will be contacted by the discharging ward to arrange either a 7 day or 48 hour follow up. This will not apply where a service user is discharged into the care of CRHT (see 7 day/48 hour follow up policy – Policy No CLP052).

The CPA care coordinator will agree to take on the role; the team/service manager will resolve any disputes.

**Changes to the CPA care coordinator should be kept to a minimum and handled with care. Allocation should follow the same principles as detailed above.**

### 6.25 Discharge from CPA

A service user will be considered for discharge from CPA when their mental health needs no longer require the involvement of a multi-disciplinary team. This process may take place in either the community or inpatient setting

During the process of discharge from CPA the care coordinator will:

- Discuss and agree with the service user and their carer the options for transfer of care or discharge;
- Ensure a review of the service users' needs takes place before the service user is discharged from secondary mental health services;
- Ensure the service users and those involved in their care are involved in this process and are provided with a copy of the agreed plan on discharge from secondary mental health services;
- Complete relevant documentation within the electronic patient record.

Where a service user is transitioning from hospital or a community team back to primary care and will not require CPA they will remain formally subject to CPA until the actual discharge; records must be amended at actual discharge.

## 7. Training

This policy will require new co-produced training to ensure development of personalized care planning. The CPA documentation is developed through a coproduction process and it is the central tool utilized in practice for the application of any other plans. This new format requires complete coproduction between service user, carer and staff and cannot be completed without. Due to this cultural shift towards recovery focused care this will require training for all service areas by Service users, carers and recovery Board leads. A training schedule will be planned for each NHFT site and the form will be implemented on systm1 in September 2016.

## 8. Monitoring Compliance with this Document

Auditing and monitoring are integral components of the CPA and will allow us to monitor the effectiveness of our CPA processes.

Local audit should focus on:

- Service user and carer satisfaction and engagement including complaints and compliments;
- The use of outcome measures, including user defined outcomes, to measure success;
- The integration of risk management into CPA systems;
- Consideration of equality issues.

The table below outlines the Trust's monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

| Aspect of compliance or effectiveness being monitored | Method of monitoring | Individual responsible for the monitoring | Monitoring frequency | Group or committee who receive the findings or report | Group or committee or individual responsible for completing any actions |
|---|---|---|---|---|---|
| | | | | | |
| Attendance at the Trust and local inductions will be evidenced in staff personal files and held by their line manager. | Ad hoc | Line managers | Annually | N/A | Line Managers |
| Section 6.3, 6.4, 6.5, | Audit | Team | Monthly | Directorate | Operational |

| | | | | | |
|---|---|---|---|---|---|
| 6.6, 6.7, 6.8, 6.9, 6.10, 6.11, 6.12, 6.14, 6.15 of this policy | completed by Team Leaders<br><br>Quality Schedule | Leaders<br><br>Team Leaders | Quarterly | Management Group | Management Group |
| Staff have completed training related to this policy in line with the Trusts mandatory training schedule | Training will be monitored in line with the Statutory and Mandatory Training Policy. | | | | |
| Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is completed showing how any gaps have been addressed. | | | | | |