Care Management & CPA/Care Support Policy

POLICY NUMBER & CATEGORY	**C01**	**Clinical**
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EXECUTIVE DIRECTOR	**Medical director**	
POLICY LEAD	**CPA development manager**	
POLICY AUTHOR (if different from above)	**Amendment provided by Deputy Medical Director**	
FORMULATED VIA	CPA Quality group	

POLICY CONTEXT

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

POLICY REQUIREMENT

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

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

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

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1 INTRODUCTION

1.1. Rationale (Why)

The policy aims to reinforce an integrated approach across the Trust to provide systematic assessment processes and effective care planning for our service users. The policy reflects the requirements of national guidance including:

- Refocusing the Care Programme Approach (DOH March 2008)
- Best practice in Managing Risk
- Suicide prevention strategy
- Mental Health code of Practice

The care programme approach (CPA) introduced in 1991 describes four core elements:

- Comprehensive **Assessment** of health and social care needs including risk
- An agreed **Care Plan**
- Appointment of a named **Care Co-ordinator**
- Regular **Review** and, where indicated, agreed changes to the care plan

1.2. Scope (Where, When, Who)

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

1.3. Principles (Beliefs)

- This policy reflects the following principles in relation to assessment, care planning, and care co-ordination and review arrangements for all service users regardless of age or clinical setting:
- To provide a holistic, integrated and consistent approach to care management across all services and with our key healthcare providers (social care, primary care and other secondary healthcare providers).
- All service users receiving treatment, care and support will receive quality care based on an individual assessment of their health and social care needs including risk and vulnerability, an evaluation of their strengths, and identification of their goals, aspirations and choices.
- Assessment, care planning and review will focus on improving outcomes for service users and their families across their life domains, helping them to achieve the outcomes that matter to them.
- The approach to assessment, care planning and review will be collaborative, placing the service user and their family at the centre of care in order to maximise their involvement and supporting the principle ‘No decision about me without me’.
- Ensuring that the service users’ needs are regularly reviewed and kept up to date whilst minimising duplication and repetition.
- Ensuring clear accountability for care planning with a single person who has overall responsibility for care co-ordination.
- Recognising the need to plan and provide care which is sensitive to the individual, recognising diversity in relation to race, faith, age, gender and sexual orientation and other special requirements that the service user may have in order to ensure equitable and appropriate access to services, interventions and information.

- The Trust positively supports individuals with learning disabilities and ensures that no one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities

services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2 POLICY (What) –

2.1 All people using secondary mental health services will be supported in accordance with the care management standards identified within this policy. Those taken on for care and treatment will receive care in line with one of the two care management arrangements identified by this policy: **CPA** or **Care Support**.

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

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

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

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

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

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

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

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

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

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

2.12 Service users will be supported to understand information recorded about them and details of their planned care through access to interpreting and information support,

including BSL for deaf people, and provision of plain language, easy to read versions where appropriate.

2.13 Service users will be provided with information about advocacy services.

2.14 All ICR, CPA and Care support information will be recorded on RIO fully, accurately and on time.

3 PROCEDURE

3.1 Assessment

3.1.1 On entry to secondary mental health services all service users will receive a comprehensive assessment of their health and social care needs including risk and vulnerability. The assessment will be undertaken by a registered professional and recorded on RIO using the Assessment Summary document and a Trust approved risk screening or assessment tool.

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

3.1.3 Subject to the service users' agreement, the assessment may include contributions from carers, relatives, friends or an advocate; however, the person's views may be overridden where there is significant risk.

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

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

3.1.6 At the end of the assessment process a formulation and care plan should be agreed.

3.1.7 The outcome of the assessment should be considered by the multi-disciplinary team to confirm allocation to CPA or care support as guided by CPA criteria. The rational for the decision should be recorded in the assessment summary as one of the outcomes of assessment, and CPA or Care support status should be recorded on RIO.

3.1.8 A named care co-ordinator or lead clinician must be identified and recorded on RIO.

3.1.9 The outcome of the assessment should be communicated to the service user and referrer within a maximum of two weeks from the date of assessment

3.2 **CPA criteria** – to achieve a consistent approach to the identification of service users with higher support needs, national guidelines should be used to help decide who would benefit from support under CPA. These are considered on the basis of risk and vulnerability (including vulnerability arising from a reduced ability or difficulty associated with personal tasks and the ability of the person to protect themselves), complexity, engagement and intensity of intervention and support. A full list of considerations can be found in appendix 1.

3.2.1 In addition, a number of key groups have been highlighted nationally who should always be considered for inclusion on CPA: parental responsibilities, significant

caring responsibilities, significant reliance on carer(s), dual diagnosis, history of violence or self-harm, unsettled accommodation.

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

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

3.3 Care Planning

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

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

3.3.3 The content of the care plan should be explained to the service user and they should be provided with their own copy within 7 days of assessment or review.

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

3.3.5 Where a service user is unable or declines to engage in care planning, a statement to this effect must be provided within the care plan. Where possible the service user's views should be represented, informed where appropriate, by consultation with carers or advocate or with reference to any Advance Statement or decision.

3.3.6 Where an Advance Statement exists, the care co-ordinator/lead clinician/named nurse should ensure that the key components are incorporated into the care plan.

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

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

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

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

3.3.11 The care plan will clearly identify how outcomes are to be achieved. All clinicians (including tertiary services) are responsible for ensuring that their interventions are included in the care plan and for providing evidence of the service user's involvement in decisions about care.

3.3.12 Care plans should include a crisis plan which identifies early warning signs, individual coping strategies, and actions to be taken by the service user, family, carers, and/or the wider care system in a crisis or, if a service user's mental health deteriorates, contact details for the care co-ordinator/lead clinician and information about 24 hour access to services.

3.4 **Review**

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

3.4.2 The period between reviews should be determined by the care co-ordinator/lead clinician, in conjunction with the service user and their carer and the MDT. The date of the next review must always be specified, although it is acknowledged that changes to this may occur, especially if the review is some months away. The care co-ordinator/lead clinician is responsible for organising reviews.

3.4.3 All service users discharged from in patient, home treatment care or prison must have a review within 4 weeks of discharge.

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

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

3.4.6 There will be a clearly documented summary of the review process, including any decisions made, recorded on RIO as follows:

3.4.7 **CPA review** - In preparation for the review, the care co-ordinator should review and update the assessment summary and appropriate risk assessment. All professionals involved (including tertiary services) should provide an evaluation for the

interventions they are responsible for delivering in the appropriate section of the CPA care plan.

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

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

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

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

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

3.5 **Care support** reviews for service users on Care Support may take place in the context of a visit or outpatient contact. There should be consideration of the need for CPA if complexities of need, circumstances or risk have changed such that more co-ordinated care is indicated. The care support plan or standardised follow up letter will constitute evidence of the review.

3.6 **Care management standards for CPA**

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

3.6.2 Once the need for care under CPA has been established, a care co-ordinator must be allocated within 7 days.

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

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

3.6.5 Where the service user has been under the care of a forensic team there should be an assessment for violence using a structured judgment approach.

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

3.6.7 As a minimum, it is expected that service users on CPA will have face-to-face contact with a member of their care team at least every four weeks. Where circumstances do not allow for this or where the service user has expressed a preference for less frequent contact this should be recorded in the care plan. This may also apply where the needs of the service user change, progressing towards step down to care support.

3.6.8 The care co-ordinator will retain their role at all points of the care pathway (including in patient admission, care under home treatment, and in line with prison pathway guidelines), providing input at key planning meetings (including admission, discharge and CPA review) and maintaining contact with the service user at a frequency defined in the care plan for each individual.

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

3.6.10 The care co-ordinator is responsible for ensuring that CPA information remains current and relevant by reviewing and updating the assessment summary, risk assessment and CPA care plan:

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

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

- A formal review and where appropriate a handover to a lead clinician or GP
- An exchange of appropriate information with all concerned including carers
- Plans for review, support and follow up as appropriate
- A clear statement about the action to take and who to contact in the event of relapse or change with a potential negative impact on the persons wellbeing
- An appropriate exchange of risk information

3.7.1 Service users discharged from in patient or home treatment care should remain on CPA until the first care review within 4 weeks of discharge. Exceptions to this may apply, for example where a service user is admitted for a period of assessment and no further follow up from secondary mental health services is indicated. In these cases, policy related to step down from CPA should be followed and all decisions clearly recorded in the MDT review document as part of the inpatient or home treatment discharge planning process.

3.8 Care management standards for Care support

3.8.1 A statement of care should be agreed between the service user and lead clinician and recorded on the care support plan; this will constitute the care plan. This should contain any relevant information regarding support, care and treatment including shared care arrangements), intended outcomes and information about risk and relapse prevention strategies. It is also good practice to include a contingency plan.

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

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

3.8.4 The lead clinician is responsible for ensuring that information in the risk assessment remains current and relevant.

3.8.5 For service users who are subsequently identified as needing care under CPA (including referral to home treatment or admission to in patient care), the lead clinician is responsible for ensuring that the risk assessment and assessment summary is updated to reflect the current situation and circumstances of the service user.

3.8.6 The lead clinician must give on-going consideration to the need to step up to CPA if risk or circumstances change in line with CPA criteria (appendix 1) and in consultation with the multi-disciplinary team.

3.9 Carers

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

3.9.2 Regardless of the care management arrangements, CPA or Care Support, anyone who is identified as giving care to the service user on a regular and substantial basis must be told of their right to an assessment of their caring, physical and mental health needs by the care co-ordinator/lead clinician within the first 6 months of the person care and annually thereafter.

3.9.3 Carer involvement should be agreed with the service user including any information the service user does not wish to disclose.

3.10 **Young carers –** children under the age of 18 who provide substantial personal and/or emotional care to another family member.

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

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

3.11 **Out of area placements**

3.11.1 As part of setting up an out of area placement, arrangements need to be agreed between the clinical team and commissioners via the mental health joint funding panel about delivery of care/treatment, care co-ordination, monitoring and review, and arrangements for bringing placements to an end, which may include arrangements for further accommodation, treatment and care. In forensic cases, there will also be considerations of medical and social supervisors.

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

3.11.3 Where it remains the responsibility of BSMHFT, as the service area of origin, to ensure implementation of the CPA process links between the care co-ordinator and the provider are central to the placement and under CPA mandatory.

3.12 **External care co-ordination**

3.12.1 It is the responsibility of the mental health service from the area of origin to ensure implementation of the CPA process.

3.12.2 As a provider service, BSMHFT should support links with care co-ordinators to facilitate care and discharge planning and attendance at CPA reviews.

3.12.3 As a provider service, BSMHFT will liaise with the care co-ordinator regarding delivery of the agreed plan of care and communicate any difficulties or changes to the care co-ordinator.

3.12.4 It is expected that the care co-ordinator from the area of origin will make available all existing CPA documentation and attend CPA reviews.

3.13 **Neuropsychiatry** – In the context of CPA, the team responsible for the service users mental health needs will provide care co-ordination and neuropsychiatry will be responsible for providing specialist input to the care and treatment plan for the identified medical condition. Neuropsychiatry will contribute to the care plan in line with the care planning requirements in section 3.3 of this policy.

3.14 **Care Co-ordination during prison detention**

3.14.1 Where a service user engaged with secondary mental services is detained in prison, the care co-ordinator/lead clinician must retain their role and make every effort to maintain contact with the service user liaising with prison based staff in order to facilitate continuity of care, including if the service user is transferred to another prison. This is essential at the time of release from prison.

3.14.2 Once the care co-ordinator/lead clinician is made aware that a service user has been detained in prison, they must contact the prison mental health team and make available the most recent assessment, risk assessment and care plan.

3.14.3 Where a service user is detained for a prolonged period of time, the care co-ordinator/lead clinician must be involved with a review of the persons care at least once a year; this may involve a formal meeting or an exchange of reports.

3.14.4 Where a care co-ordinator leaves or is no longer able to undertake this role, the team manager is responsible for ensuring that another care co-ordinator/lead clinician is allocated or that the case is periodically reviewed until such time as the service users forthcoming release from prison when a care co-ordinator must be allocated.

3.14.5 All service users released from prison must have a care review within 4 weeks of release.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	Responsible for adhering to the procedures as laid out in this policy including ensuring that all information is recorded fully, accurately and on time in line with data quality policy requirements and trust data entry timeliness standards and for reporting any failures to comply	
Service, Clinical and Corporate Directors	Will ensure all staff in their areas are aware of and understand the policy and that it is implemented into practice within their areas of responsibility Will investigate any failures to comply and ensure remedial actions are taken	
Policy Lead	Ensure the policy is kept up to date - Coordination of monitoring and assurance	
Executive Director	The Medical Director has overall responsibility for ensuring compliance with and timely review of this policy	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	
Number of versions produced for consultation	Enter number here
Committees or meetings where this policy was formally discussed	

CPA Quality Group		27/11/15
Where else presented	**Summary of feedback**	**Actions / Response**

6 REFERENCE DOCUMENTS

7 BIBLIOGRAPHY

- Refocusing the Care Programme Approach (DOH March 2008)
- Best practice in managing risk
- Suicide prevention strategy
- Mental Health 1983: Code of Practice (DOH April 2015)
- Offender Mental Health Care Pathway (DOH January 2005)

8 GLOSSARY

9 AUDIT & ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Compliance	P Swarbrick	ICR completeness CPA/Care support	Monthly	CPA quality Group Clinical governance Committee	P Swarbrick	
Quality	P Swarbrick	CPA quality audit Care support quality audit	Annual	CPA quality group Clinical effectiveness	P Swarbrick	
CPA review	P Swarbrick	KPI	Weekly	Operations brief	P Swarbrick	

10 APPENDICES

Appendix 1 CPA Criteria

Appendix 2 Key Roles and Responsibilities
Appendix 3. CPA review checklist for patients with a diagnosis of schizophrenia.
Appendix 4 Key Standards
Appendix 5 Clinical guidelines for significant professional disagreements concerning key aspects of a patient's care.

CPA Criteria

The following lists of characteristics are not exhaustive and there is no minimum or critical number of items that should indicate the need for CPA. Clinical and professional experience, training and judgement should be applied to evaluate which service users will need the support of CPA facilitated by MDT discussion

Severe mental disorder (including personality disorder) with a high degree of clinical complexity that is classifiable under ICD10 and can respond to a combination of pharmacological and/or psychological therapies and or behavioural and practical interventions	**Yes**	Care management will be through CPA or Care Support, and a care cluster allocated
	No	Discharge back to referrer with advice

Key groups in BSMHFT for whom CPA will always be applied

Current in patient or recently detained under the mental health act
Under the care of crisis/HTT or AOT
Subject to CTO or guardianship

Key groups in national CPA guidance for whom CPA should always be considered

Parenting responsibilities Significant caring responsibilities Dual diagnosis History of violence or self-harm Homeless or in unsettled accommodation Significant reliance on carer(s) and/or absence of informal/family network of support Reported difficulty or disadvantage in every day interactions arising from race, faith, age, gender, disability/physical health or sexual orientation	People in one or more of these key groups should always be considered for inclusion on CPA and the default position should normally be CPA unless a comprehensive assessment of need and risk shows otherwise **The decision not to offer CPA to a person in one or more of these groups should be clearly documented in the outcome of the Assessment Summary or subsequent review**

In addition, a Yes in one or more of the following domains means that CPA should always be considered

Formally assessed as exhibiting definite indicators or high/immediate risk of:	
Suicide	
Self-injury or harm resulting in risk to physical safety	
Self-neglect resulting in risk to physical safety	
Harm from others (abuse or exploitation from others or society)	
Harm to others resulting in risk of physical safety of others	
Risk to a child or children	
Forensic/offending behaviour	
Accidents	
Formally assessed as experiencing	
Complex psychological problems	
Disabling problems with thinking, feeling or behaviour	
Disabling problems with activities/living skills or in relationships with other people	
Dual diagnosis – actively using illegal/street substances or alcohol with a comorbid mental health problem	
Learning disability with a co-morbid mental health problem	
In receipt of multiple service provision from different agencies including: housing, physical care, criminal justice, employment, voluntary agencies.	

Care Support Criteria

Treatment and/or intervention indicated but formally assessed as having a low level of risk or complexity and not in a key group indicated for CPA. No anticipated concerns or problems with engagement or concordance with treatment and care plans and no problems with accessing other agencies.

Key Roles and Responsibilities

CPA Care Co-Ordinator

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

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

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

Role Boundaries

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

Allocation

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

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

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

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

Considerations for Clinical Psychologists or other Psychological Services - staff may take on the care co-ordinator or lead clinician role:

When it is believed that they are the most appropriate clinician to do so on the basis of their specialist function and where they are the member of the team in most regular contact with the service user and therefore in the best position to monitor and assess changing need.

Only where complex psychological needs are the primary presenting issue and this does not conflict with the philosophy/model of care and the therapeutic relationship between client and therapist.

Where the criteria for CPA are met on the basis of complexity and inclusion in a key group or level of disability/risk but the service user does not require or will not accept/engage with the input of more than one service or agency.

Clinical Psychologists or other Psychological Services staff will not usually take on the care co-ordinator or lead clinician role:

Where the care plan indicates multi-agency input due to a high level of social and or other needs and the primary therapeutic intervention is being carried out by the psychologist or psychological therapist.

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

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

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

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

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

Lead clinician (for people on care support)
The lead clinician will be responsible for:

- Ensuring that the service user knows how to contact them and whom to contact in their absence and who to contact out of hours or in a crisis
- Agreeing a statement of care with the service user and recording this on the Care support plan
- Monitoring the care delivered and the outcomes achieved
- Maintaining risk assessment information
- Giving on-going consideration to the need to move to CPA if risk or circumstances change in line with CPA criteria.
- Co-ordinating transition and transfer

All clinicians
The assessment summary and risk assessment will be used to inform care and support through a range of care settings, therefore all services have a responsibility to ensure that existing information

is reviewed and updated to make sure that the assessments reflect the service user's current circumstances and care setting particularly following transfer or transition.

All clinicians and practitioners are responsible for initiating services for which they are responsible as agreed in the care plan and will provide the care co-ordinator with regular updates.

All clinicians are responsible for ensuring that their interventions are included in the care plan.

All practitioners undertaking assessments inform care co-ordinator of the outcome of their assessments, and any resultant actions or recommendations.

Managers

All managers will be responsible for:

- Ensuring that this policy is followed and understood as appropriate to each staff member's role and function.
- Ensuring that staff acting as care co-ordinators are registered practitioners who either have, the required level of skill and competency to carry out the role or, are being supervised to achieve this through the staff development review process .
- Ensuring that individual and team caseloads are actively managed through appropriate caseload management supervision processes.
- Ensuring that where an excessive team caseload cannot be addressed through caseload management activities this is escalated to the appropriate service manager for further action.
- Ensuring that where resource issues for the team are highlighted, the Trust escalation process is followed.
- Ensuring that recommendations from audit processes are actioned.
- Ensuring that staff attends appropriate training in relation to this.
- Ensure ICR documentation standards are maintained and reinforced through appraisal

CPA review checklist for patients with a diagnosis of schizophrenia.

This is to serve as an aide memoire.

1. Is the patient aware of their medication, what it is for and what side effects might they experience? Do they have capacity to make decisions about their medication? Do they feel involved in decisions about their medication? Have they made choices about their medication? Have choice and medication leaflets been made available to patients?

2. Are they aware of the diagnosis?

3. Has anybody talked to them about their illness?

4. Have they been offered BFT? If they have previously declined it have they changed their mind?

5. Have they been offered CBT? If they have previously declined it have they changed their mind?

6. Have they been offered clozapine if they have had two anti-psychotics and not achieved symptom control?

7. Do they have physical comorbidities and are these being managed effectively?

8. Have they been advised re lifestyle issue

9. Is smoking status, BMI and alcohol consumption recorded?

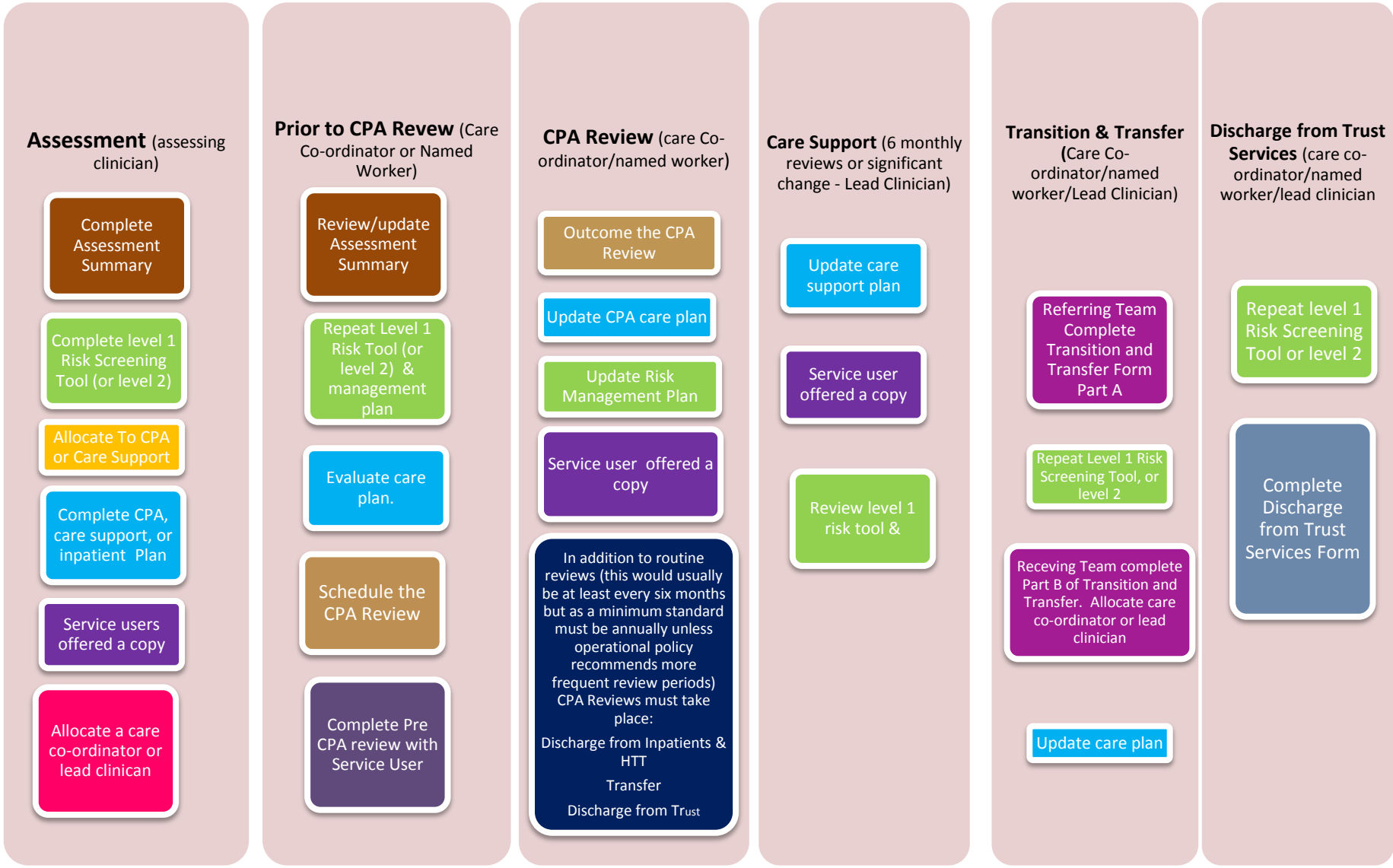
10. Do they have a GP?

11. Do they have a carer? If so, has a carer's assessment been offered/completed and has BFT been offered?

12. Have they had necessary blood tests and an ECG recently?

13. What social issues are impeding recovery?

14. What would they like the team to do more of/ less of/ do differently?


Assessment (assessing clinician)
Complete Assessment Summary
Complete level 1 Risk Screening Tool (or level 2)
Allocate To CPA or Care Support
Complete CPA, care support, or inpatient Plan
Service users offered a copy
Allocate a care co-ordinator or lead clinican
Prior to CPA Revew (Care Co-ordinator or Named Worker)
Review/update Assessment Summary
Repeat Level 1 Risk Tool (or level 2) & management plan
Evaluate care plan.
Schedule the CPA Review
Complete Pre CPA review with Service User
CPA Review (care Co-ordinator/named worker)
Outcome the CPA Review
Update CPA care plan
Update Risk Management Plan
Service user offered a copy
In addition to routine reviews (this would usually be at least every six months but as a minimum standard must be annually unless operational policy recommends more frequent review periods) CPA Reviews must take place:
Discharge from Inpatients & HTT
Transfer
Discharge from Trust
Care Support (6 monthly reviews or significant change - Lead Clinician)
Update care support plan
Service user offered a copy
Review level 1 risk tool &
Transition & Transfer (Care Co-ordinator/named worker/Lead Clinician)
Referring Team Complete Transition and Transfer Form Part A
Repeat Level 1 Risk Screening Tool, or level 2
Receving Team complete Part B of Transition and Transfer. Allocate care co-ordinator or lead clinician
Update care plan
Discharge from Trust Services (care co-ordinator/named worker/lead clinician
Repeat level 1 Risk Screening Tool or level 2
Complete Discharge from Trust Services Form

Appendix 5

CLINICAL GUIDELINE FOR SIGNIFICANT PROFESSIONAL DISAGREEMENTS CONCERNING KEY ASPECTS OF A PATIENT'S CARE

The management of patients is sometimes complicated by disagreements about diagnosis or fundamental aspects of the care plan. This can be particularly problematic where patients transfer between clinical teams when they are discharged from hospital or move between wards.

If such disagreements have the potential to cause disruption to care plans and cannot be resolved by discussion between the Consultants leading the teams and other MDT members as appropriate, a formal case conference led by the Clinical Director (or nominated senior clinician) should be convened to resolve matters leading to a coherent and consistent care plan being delivered. If matters cannot be resolved the situation should be escalated to the Medical Director

The patient and carers should never be left in a situation whereby their care plan changes back and forth because of unresolved clinical disagreement.