Birmingham and Solihull Mental Health NHS Foundation Trust

Care Management & CPA/Care Support Policy

POLICY NUMBER & CATEGORY	**C01**	**Clinical**
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RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**April 2023**	
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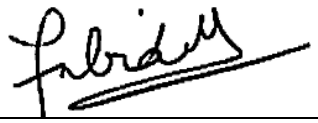
EXECUTIVE DIRECTOR	**Medical Director**	
POLICY LEAD	**Medical Directorate**	
POLICY AUTHOR (if different from above)	**Reviewed by Dr Sadira Teeluckdharry Clinical Director ICCR - CMHTs**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT

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

POLICY REQUIREMENT

All people using secondary and tertiary 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.

All service users receiving treatment and care from secondary and tertiary mental health services will be provided with a care plan, developed in partnership with them, that is clear and accessible. Family and Carers will be involved in this process unless exceptional circumstances dictate otherwise (these should be documented clearly within the patient record).

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

CONTENTS

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 Act 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 and tertiary mental health services within the Trust. The policy is therefore applicable to all clinical staff working in secondary and tertiary mental health services with the exception of

Prison Healthcare services
Addiction services
Services solely providing psychological therapies eg. IAPT

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 that is recovery focussed across all services and with our key healthcare providers (social care, primary care and other secondary / tertiary 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, safety 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 and carers across their life domains, helping them to achieve the outcomes that matter to them, which promotes hope and supports their recovery.
- The approach to assessment, care planning and review will be co-produced, 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’.
- The value of engaging family and carers in the assessment, Care Planning, Risk Management and review process is acknowledged and active measures taken to engage family and carers, as per the Trust Family and Carer Pathway (unless exceptional circumstances dictate otherwise).
- 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.
- Care planning is a key element of recovery focussed practice as set out in the Trust's Recovery for All Strategy; https://www.bsmhft.nhs.uk/service-user-and-carer/recovery/rfa-strategy/

2 POLICY (What)

2.1 All people using secondary and tertiary mental health services will be supported in accordance with the care management standards identified within this policy. People offered care and treatment will receive care in line with one of the two care management arrangements identified by this policy: **Care Programme Approach (CPA)** or **Care Support**.

2.2 All service users referred to the Trust (including Urgent Care Services) will have an assessment of their 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 and tertiary mental health services and to identify the required care management.

2.4 All service users receiving care and treatment from secondary and tertiary 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. The views of family and carers will be sought unless exceptional circumstances dictate otherwise (these should be documented clearly within the patient record). 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 and tertiary mental health services will be provided with a care plan, developed and co-produced in partnership with them and their families where appropriate, that is clear, accessible and promotes hope, choice and recovery. Family and Carers will be routinely engaged in this process, unless exceptional circumstances dictate otherwise (these should be documented clearly within the patient record).

2.7 The care plan will be based on the assessed needs, including risk, safety 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. The views of the family should also be incorporated, unless exceptional circumstances dictate otherwise (these should be documented clearly within the patient record).

2.9 All service users will have their needs and their care plan reviewed as determined by their needs and changing circumstances. The minimum standard is at least 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 and tertiary mental health services will be screened at assessment and review to identify significant others involved in their care and support. Carers will be identified and recorded on Rio as per the Trust Family and Carer Pathway.

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 core clinical documents, CPA and Care support information will be recorded on RIO fully, accurately and on time. This will be the responsibility of the clinician who undertakes the assessment and / or who is informed of or identifies a change in circumstance or risk.

3 PROCEDURE

3.1 Assessment

3.1.1 On entry to secondary and tertiary mental health services all service users will receive a comprehensive assessment of their health and social care needs including risk, safety 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. If this is not possible at initial assessment, then this should be clearly documented as to why not with a plan of who will do it and when by.

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 or is deemed clinically relevant.

3.1.4 The assessment will identify and take into account the views and needs of those involved in the service users care and support (including friends and informal carers).

3.1.5 The assessment will lead to a decision by the MDT about inclusion on CPA and should therefore identify the persons mental health needs and areas of safety concerns in sufficient detail to enable confirmation of care management arrangements: **CPA** or **Care Support**. Please note that for SOLAR and Forensic CAMHS that CPA should be modified for children and young people at a local level (further guidance can be found in Refocusing the Care Programme Approach; Policy and Positive Practice Guidance, March 2008).

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 rationale 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 (CPA) or lead clinician (Care Support) must be identified and recorded on RIO. If there is a delay in allocation of a care co-ordinator, this should be escalated via the line management structure.

3.1.9 The outcome of the assessment should be communicated to the service user, family / carer (unless exceptional circumstances dictate otherwise) 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 3.

3.2.1 In addition, clinicians should always give consideration for inclusion on CPA where there is a complexity of need and risk present or high level multiple agency working is involved. Where CPA is not deemed as required then this needs to be clearly documented on Rio in the most appropriate place relating to how the decision was made and who was included. For example, if the decision was made in MDT then this would be recorded in the MDT review form however if the decision was made at the point of assessment then this would be recorded in the assessment summary.

3.2.2 Service users who are under the care of acute inpatients or Home Treatment should be assessed as to whether on-going CPA is required. In the first instance, a member of the inpatient or Home Treatment staff (where the service user is not already on CPA or has not been referred directly to HT from CMHT) will act as a temporary care co-ordinator whilst this assessment takes place. At the end of this assessment period, if it has been determined that a care co-ordinator is required from the local CMHT then a referral should be made to the local team for further consideration. If upon screening the CMHT feel that CPA is not required then the rationale for this should be clearly documented in the CPA review form. If the inpatient / Home Treatment Team decide that CPA is not warranted post-discharge then they are to undertake a CPA review which clearly documents the rationale for this decision.

3.2.3 As part of the handover from acute inpatients to Home Treatment, a discussion should be had where HT are informed as to whether a CPA review has taken place and what the outcome was. If CPA is not indicated then the service user is to remain on care support, unless the HTT determine that the needs / complexity / risk has changed and CPA is now clinically appropriate. HT will continue to complete the CPA care plan for the duration of the episode of care, irrespective of the care level of the service user.

3.2.4 Service users under the care of Assertive Outreach, Early Intervention Service, Steps to Recovery or Secure Services will require CPA and allocation of a care co-ordinator.

3.2.5 Service users who have been identified as experiencing a first episode psychosis (FEP) require CPA and allocation of a care co-ordinator.

3.2.6 All service users who are subject to a Community Treatment Order (CTO) must be on CPA and allocated a care co-ordinator.

3.2.7 The Mental Health Act Code of Practice (2015) states that service users who are entitled to section 117 after-care or are subject to Guardianship will most likely require CPA and allocation of a care co-ordinator. Therefore, all service users who are under this criteria must be assessed for their suitability under CPA. If, following this assessment, it is determined that CPA is not required then a CPA review must be completed which explicitly states the rationale for this decision.

3.2.8 Significant consideration needs to be given to the role of family carers and every possible opportunity needs to be provided to allow carers to be involved in the decision making. Carers will be routinely engaged in the assessment, care planning and risk assessment process unless exceptional circumstances dictate otherwise.

3.3 **Care Planning**

3.3.1 <u>All</u> service users receiving care and treatment from secondary and tertiary 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 following assessment or review. This should be given at the earliest opportunity and any barriers to this should be clearly recorded on the signatures section of the care plan.

3.3.4 Once the care plan is agreed any changes must be completed in collaboration with the service user and others involved, including carers and families (unless exceptional circumstances dictate otherwise), 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 they should be given the opportunity to comment. This discussion should be documented.

3.3.8 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 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 and family involvement (unless exceptional circumstances dictate otherwise) in decisions about care.

3.3.11 Care plans will 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 crisis intervention / urgent care team 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. Family and carers will be offered a copy of the Care Plan and Risk Management Plan unless exceptional circumstances dictate otherwise.

3.3.12 Where the service user may be at risk of a restrictive practice, a positive behavioural support (PBS) 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.

3.3.13 Care plans may include as appropriate information to be used to assist in identifying and responding to crises.

3.3.14 In line with the 'Mental Health Units (Use of Force) Act 2018', service users, their families, carers, and independent advocates should be involved in care planning to set out the preventative strategies relevant to the individual for preventing the use of force. This might be done through advance statements or other similar measure. They should also be involved in debriefs following the use of force to further inform care planning.

3.4 **Review**

3.4.1 All service users will have their care reviewed as agreed or determined by their needs and changing circumstances. This must be at least, as a minimum standard, annually, unless clinical presentation or local service standards recommend more frequent review periods or the service user or carer request an earlier or more frequent review period. For those on CPA, this will be a CPA review and should be documented on the CPA Review form. For those on Care Support, this will be a review completed by the lead clinician and will be documented in the Care Support Plan.

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. An estimated date / timeframe of the next review must always be agreed. 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 mental health service must have a review within the timeframe given in the relevant operational procedure / protocol.

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 or Care Support.

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 (where there is no significant change or it has not been updated within the last 12 months) 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 / tertiary 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 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 management standards for CPA and Care Support

3.5.1 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).

3.5.2 Care coordinators are not a substitute for other services / interventions that are not available.

3.5.3 It is the referrers' responsibility to ensure all ICR documentation is up to date prior to making a referral. This includes, care plan, diagnosis, risk assessment, assessment summary and Honos.

3.5.4 If the referrer is aware prior to making a request for a care coordinator that the service user will need a referral to a specific service, (i.e. making a safeguarding referral, referring to DBT) then this is the responsibility of the referrer and not of the care coordinator once allocated.

3.5.5 Once the need for care under CPA has been established, a care co-ordinator should be allocated within 7 days. If a care co-ordinator cannot be allocated within this time then an incident form should be completed via Eclipse and the rationale for this to be explained. It should then be escalated through the line management structure.

3.5.6 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.

3.5.7 As a minimum, it is expected that service users on CPA will have face-to-face contact with a member of their care team, or another mental health team if directly under their care, 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.

3.5.8 As a minimum, service users on CPA must have a face to face appointment with a senior Psychiatrist once every 6 months or sooner if clinically required.

3.5.9 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.

3.5.10 For care support, the service users' care will be reviewed determined by their needs and changing circumstances. It is expected that this would be at least annually unless clinical presentation or local service standards recommend more frequent review periods.

3.5.11 For service users who are subsequently identified as needing care under CPA (including referral to home treatment), the lead clinician / assessor in the referring service is responsible for ensuring that the risk assessment and assessment summary is updated to reflect the current situation and circumstances of the service user. The service user would then need to be placed onto CPA and allocated a care co-ordinator for the duration of the episode.

3.5.12 For those on care support, 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 and in consultation with the multi-disciplinary team.

3.6 **Step Down from CPA** Decisions to move a service user from CPA to Care Support 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
- Sharing of appropriate information with all concerned including family and 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

3.6.1 The clinical team who makes the decision to not allocate CPA, or request a care co-ordinator, are responsible for completing the CPA review and changing the care level status on Rio. The CPA review must clearly state the rationale for stepping down to care support.

3.7 Tertiary Services / Specialties

3.7.1 The current contractual agreement is that all service users under the care of tertiary services should be allocated a care co-ordinator by the local community team. Please refer to section 3.5.1 for further information relating to the role of the care co-ordinator.

3.7.2 Service users under the care and treatment of a tertiary service are not to be discharged from the local community team.

3.8 **Out of area placements**

3.8.1 It is expected that the care co-ordinator, or nominated delegate, 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.

3.9 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.

3.10 **External care co-ordination**

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

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

3.11.1 Where a service user engaged with secondary or tertiary mental health 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 through liaison 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.

3.11.2 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.

3.11.3 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.

3.12 The Move Away from CPA

The Community Mental Health Framework, which was co-produced with service users, carers and professionals, and published by NHS England and NHS Improvement, aims to move away from CPA toward providing the same standards of care for all service users. This means that every service user will have a named worker and a personal care plan.

The current available details of this proposed approach is set out in Appendix 4 Summary Document.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	Responsible for adhering to the procedures as laid out in this policy.	
Team / Ward / Hub Mangers, Senior Medical Staff, Service Managers, Clinical 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	November 2022
Number of versions produced for consultation	1
Committees or meetings where this policy was formally discussed	

Where else presented	Summary of feedback	Actions / Response

6 REFERENCE DOCUMENTS

- Refocusing the Care Programme Approach (DOH March 2008)
- Mental Health Act 1983: Code of Practice (DOH April 2015)

7 BIBLIOGRAPHY

- Best practice in managing risk
- Suicide prevention strategy
- Offender Mental Health Care Pathway (DOH January 2005)

8 GLOSSARY

Definition of terms
For the purpose of clarity, the following definitions will apply

Care Programme Approach (CPA)	An enhanced package of care that is determined by the complexity of needs and safety concerns of a service user. Typically service users who are on CPA will have complex treatment plans, increased safety concerns and will require support from different services in order to meet their needs.
Care Support	An enhanced package of care that is determined by the complexity of needs and safety concerns of a service user. Typically service users who are on Care Support require treatment and/or intervention but are formally assessed as having a low level of safety concerns or complexity. There are no anticipated concerns or problems with engagement, or concordance with treatment and care plans and no problems with accessing other agencies.
Multidisciplinary Team (MDT)	A group of healthcare workers who are members of different disciplines (e.g. Psychiatrists, Mental Health Nurses, Psychologists, Occupational Therapists, etc.) and provide specific interventions to the service user.
CPA Review	Only applicable to service user's who are currently on CPA. A formal review of the recovery goals contained within the care plan and the current needs of the service user. 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. The views of the service user and family / carer, where appropriate, are central to this review.
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.

Care Plan	A document that details the current needs of the service user, the treatment plan and clearly defined recovery goals. BSMHFT currently has three care plans; CPA Care Plan, Care Support Plan and Inpatient Care Plan.
Care Co-Ordinator	A professional member of staff (who is registered as such with their appropriate governing body) who oversees and monitors the care of the service user whilst under CPA.
Lead Clinician	A professional member of staff (who is registered as such with their appropriate governing body) who oversees and monitors the care of the service user whilst under Care Support.
Advance Statement	An Advance Statement is a general term for a written statement whereby a person, when they have capacity, specifically indicates the arrangements that they would like put in place about their future treatment and care should they lose capacity or become unable to do this in future. It is a statement of views that should be taken into account by health/social care professionals and carers in the decision-making process at a time when the service user does not have capacity. An Advance Statement is not legally binding.

9 AUDIT & ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Committee
Compliance	CGC	ICR completeness CPA/Care support	Monthly	Clinical governance Committee
Quality	CGC	CPA quality audit Care support quality audit	Annual	Clinical effectiveness
CPA review	CGC	KPI	Weekly	Operations brief

10 APPENDICES

Appendix 1: Equality Impact Assessment

Appendix 2: Key Roles and Responsibilities

Appendix 3: Care Co-ordinator Criteria

Appendix 4: Moving Away from the Care Programme Approach- Summary Document (2022).

Appendix 1: Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	**Care Management and CPA / Care Support Policy**		
Person Completing this policy	Dr Sadira Teeluckdharry	**Role or title**	Clinical Director
Division	Medical Directorate	**Service Area**	Applicable to all Service areas
Date Started	30 November 2022	**Date completed**	26 April 2023
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy will ensure that all people using secondary and tertiary mental health services will be supported in accordance with the care management standards identified within this policy under either CPA or Care Support. Adhering to this policy will improve patient experience.			
Who will benefit from the policy?			
All staff employed by BSMHFT and service users			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
All staff employed by BSMHFT, Service users and their families and carers are affected. The CPA Policy aims to improve access to the necessary clinical interventions required by service users, families and carers and thereby reducing inequalities. The way it does so is supporting the identification of a care need level appropriate for each service user and to support the appropriate package of care to be delivered by the appropriate clinicians.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
As above			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
It will ensure delivery of the clinically required interventions for service users, carers and families, whilst providing a framework for staff to follow thereby reducing inequalities.			
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)			

As above				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			X	
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships			X	
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			X	

Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			X	
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			X	
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			X	
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
			x	

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
Not applicable
How will any impact or planned actions be monitored and reviewed?
Not applicable
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Not applicable
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2 - 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, which will promote recovery, choice and hope.

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.

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

Refocusing CPA (2008) – National Training Resource

Care co-ordination has two critical functions:

• Establishing and sustaining a professional relationship with the service user and significant others, based on regular contact.
• Co-ordinating, monitoring and recording the assessment, planning, delivery and review of care, including risk.

Appendix 3 - Care Co-ordinator Criteria

A referral for a care coordinator should be made for service users who have a severe and enduring mental health problem along 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, AND in addition, the presence of one or more of the following;

• Suicide – frequent suicidal thoughts/ recent attempt / intent & plan
• Self-harm that results in a high risk to persons physical safety
• Risk of physical safety to others due to the mental health condition
• Self-neglect that results in a high risk to persons physical safety
• Significant harm to children and whereby mental health condition impacts on ability to adequately care for the child.
• Significant risk of harm from others, abuse or exploitation from other individuals or society
• Current inpatient or subject to Supervised Community Treatment Order or Guardianship under section 7 of the mental health act.
• Toxic Trio – Mental Health Problem, Domestic Violence & Substance Misuse
• Disabling problems with thinking / behaviour that has a significant impact on person's ability to function within the community causing vulnerability and a high risk to self.

NB: The above list is not exhaustive and should not be considered as a blanket rule to allocate to either CPA or Care Support. Instead each case should be considered based on its own merits and agreed within MDT.

Appendix 4 – Moving Away From CPA

Moving Away from Care Programme Approach

Summary prepared for BSMHFT Trust Clinical Governance Committee

Prepared by	Dr Sadira Teeluckdharry Clinical Director- ICCR- CMHTs
Date	2 November 2022

Background

CPA has had a central role in the planning and delivery of secondary care mental health services for the past 30 years. There is a recognition that principles were sound when initially introduced and implemented. It was associated with resource allocation, clinical care delivery and planning whilst being closely associated with risk management.

The two main aspects of a CPA package of care involved allocation of a care coordinator and development of a care plan. It was also used as an overarching framework to join up health and social care assessments.

Community Services have held a central role in the delivery of mental health services alongside Specialist teams introduced in response to the National Service Framework and Acute and Urgent Care teams.

The Community Mental Health Framework for Adults and Older Adults, alongside the Long Term Plan sought to describe more innovative ways of working that would result in more responsive, cohesive and efficient care.

Concerns re: CPA as Drivers for Change

The Policy documents referenced above have also set out that the development of Community Services has "stagnated" for several years, with parallel processes leading to fragmentation and discontinuity of care.

In addition, the Community Mental Health Framework (2019) identified concerns about the utility of CPA, the creation of a "two-tier system" of care in which a person is either "on" or "off" CPA where being placed "on" CPA is not a meaningful intervention on its own.

Attempts to evaluate its impact has felt to have not produced convincing evidence of its effectiveness with CQC reports referencing "large variation" in the proportion of people on CPA between Trusts and systematic differences in how CPA Policies are interpreted and applied leading to large variations in standards of care of patients.

This will no doubt further reinforce the health inequalities faced by patients and their carers and families.

Summary of Key Proposed Changes and Supportive Tools

The Community Mental Health Framework (2019) proposed replacing the CPA for community mental health services while retaining the sound theoretical principles of **good care coordination and high quality care planning.**

The NHS Standard Contract 2021/22 Technical Guidance document has stated that "With the publication of the Community Mental Health Framework, the Care Programme Approach has now been superseded". Specific reference to CPA from the 2021/22 Contract has been removed with amendment of the key Standard Contract mental health metric on follow up from patients on CPA

discharged from inpatient care to the 72-hour follow up of all patients discharged from inpatient care (already in practice).

There are no national requirements for providers to use the CPA.

The Community Framework has set out its intention to enable services to move away from "rigid", "arbitrary" and "inequitable" CPA classification thereby ensuring that standards of care are brought up to a minimum standard of high-quality care for everyone in need of community mental healthcare with a flexible, responsive and personalised approach following comprehensive assessment of needs when planning and coordinating care.

Access to social care will still take place via the Care Act 2014.
Responsibilities under Section 117 of the Mental Health Act will continue.

Five broad principles have been suggested as outlined below.

1. **Meaningful Intervention Based Care**

Shifting away from generic care coordination; should be planned with the service user and their care team; allowing easy "stepping up" or "stepping down" of care where needed.

2. A Named Key worker for all service users with a clearer Multidisciplinary Team Approach

Reducing reliance on care coordinators; allowing staff to make the best use of their skills and qualifications; drawing on new roles including lived experience roles. To support continuity of care; shift from Care Coordinator to Named Key worker to form therapeutic alliance; adopt clearer MDT-based approaches so that named key workers and patients are supported by robust MDT integrated with social care and VCSE.
Services should not respond to this by rebadging Care coordinators as Key workers. Every member of the MDT should have a role in shared responsibility for an individual's care and it should be the MDT as a whole acting in the coordinating role across organisations and services.
Will support the Integrated Care System to adopt a population approach to health delivery and planning of care spells and care packages.

3. High quality, co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community

Live, dynamic process; meant to be facilitated by the use of digital share care records and integration with other relevant care planning processes (eg. S117 MHA); service users actively co-producing brief and relevant care plans with staff; active input from non-NHS Partners and social care where appropriate, housing and VCSE sector.
Need for services to significantly improve the quality and relevance of care planning.
All Care and support plans to be genuinely co-produced and personalised. Care plans should include the actions that the service users will undertake, that carers/family members might undertake and actions services will undertake to support.
Include flexible and revisable timescales. Should reflect the service user's individual needs.
Brief, clear documentation with follow up of agreed actions. **Safety Planning to be included**.
Recommended that in digitised form, they should be "live", easily available and accessible in language and format; updated regularly as agreed with the service user.
Using a Dialog Plus Approach to support this
Should be linked to Routine Outcome Measurement.
Has been tried in other organisations as part of the Dialog Plus Care planning approach.
BSMHFT/BSOL Dialog Plus approach developed on RIO. For Community Transformation Teams this is currently held as workgroup with Project Initiation Document to guide implementation and roll out.

4. Better support for and involvement of carers

Improved communication; actively seeking carers' and family members' contributions; Triangle of Care framework, Patient and Carer Race Equality Framework (PCREF), NHS England Carers Toolkit can support.
5. More accessible, responsive, and flexible system
Via place based, integrated models of care to be developed as part of Community Mental Health Transformation and moving into an Integrated Care System.
Exceptions- where CPA will continue until reviewed
Custodial health and justice settings
Specialised Commissioning Mental Health, Learning Disability and Autism Services.
Adult Secure Services. Due to be reviewed in 2022/2023.
Adult Eating Disorder Services
Deaf Mental Health Services for Adults
OCD and BDD Services
Perinatal Mental Health
Additional Note
People with Learning disability and Autism accessing Mental health services remain entitled to regular Care and Treatment Reviews (CETRs) in line with existing national Policy (2017 Policy will be updated to reflect NHS England's position statement).
Points for Discussion
Where is ownership for this work held across BSMHFT?
What approach does BSMHFT want to take to progress this work?
Who needs to be involved in this work?
What timeframe do we want to work towards?
Do we have all the required tools and resources to support this work?
How do we ensure that all relevant strands of work are interlinked and included in this work?
Recommendations
Community Mental Health Transformation Dialog Plus approach to Care Planning, including Project Initiation Document, can be shared widely across services and directorates
Creation of new internal policies in line with this move away from CPA
Current CO1 Policy to be agreed as an interim until late 2023 to allow time for the above
Discussion at Provider Board/ICS, Trust and Local Governance Committees to review metrics held and reported related to CPA with a view to stopping collection and reporting
Exploration of important interfaces- Intervention Based Care via existing BSMHFT Care Packages and Care Pathways and links to Clinical Effectiveness Group; Embedding the use of Outcomes in clinical care; Dialog Plus approach to Care Planning.
Consideration for specific Working group to be set up which includes all affected services and directorates
Allocation or Identification of specific resource to help coordinate and facilitate this work
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