Leicestershire Partnership NHS Trust

Care Programme Approach Policy

This document describes the process and framework for the clinical application of the Care Programme Approach

Key Words:	Policy, CPA, Care Programme Approach
Version:	9
Adopted by:	Trust Policy Committee
Date this version was adopted:	10 November 2021
Name of Author:	Claire Armitage
Name of responsible committee:	Care Programme Approach Standards Group
Please state if there is a reason for not publishing on website:	N/A
Date issued for publication:	November 2021
Review date:	April 2024
Expiry date:	1 November 2024
Target audience:	Trust wide
Type of Policy	Clinical
Which Relevant CQC Standards?	Outcome 1, 4.16

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	December 2015	Discussed in CPA Standards Meeting to include Appendix in detail.
2	March 2016	Discussed in CPA Standards Meeting to review contents in detail.
3	June 2016	Incorporated comments following consultation and CPA standards Group meeting.
4	November 2017	Inputted an update on Section 4.2.7 Inpatient Areas.
5	April	Whole Policy Review
8	December 2019	Policy review following consultation in CPA Standards & Practice Group. Policy contents and format reviewed. Appendices 4, 5, 8, 9, 10a, 10b, 11a, 11b, 12, 13, 14, 15, 15a, 16, 17, 18, 19, 20, 23, 25 removed. CPA review frequency changed to every 10 months.
9	June 2021	Addition of three sections: 4.5.1 - CPA and the process for patients a waiting list 4.6 - Process for out of area patients 10.1 - Care and Treatment Reviews for people with learning disabilities and autism Additions to definitions and abbreviations to reflect 10.1 Section 3.0 Categories of CPA – amendments to terminology to reflect the new approach to collaborative care planning and safety planning.

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself?

Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up- to-date version.

For further information contact:

CPA Lead – Leicestershire Partnership NHS Trust

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development, review and implementation.

Equality and Diversity

This policy should be read in conjunction with the Trusts Equality Diversity and Human Rights policy which promotes dignity, fairness, and respect in relation to the treatment And care of service users and carer's – and subsequent support for staff.

Delivering equality and diversity is also about ensuring the needs of protected characteristics and equality groups are upheld at all times and assessed appropriately on entry to the service. This includes the needs of peopled based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief and sexual orientation. In some circumstances it will also be necessary to take account of specific needs re: pregnancy and maternity.

The Trust is opposed to all forms of discrimination and works to ensure a culture where service users can flourish and be fully involved in their care and where staff and carer's receive appropriate support. Where situations of inappropriate behaviour occur, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

A minimum requirement consistent with the promotion of equality of opportunity for service users and carer's is to make all reasonable efforts to ensure that an appropriate interpreter is able to facilitate communication between Trust staff and service user and carer's if their preferred spoken language is not English including ensuring availability of British Sign Language (BSL) interpreters. This includes, in particular, all ward and care co-ordination meetings, Mental Health Act assessments, Mental Health Review Tribunals and Managers Reviews.

Embedding a culture of dignity and respect

All staff must be aware of issues relating to equality, diversity and respect for service user and carer's including:

- Understanding how to ask questions about culture, religion and ethnic background

- Arranging interpreters where necessary

Due Regard

This policy has been screened in relation to paying due regard to the Public Sector Equality Duty of the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

The policy has specific sections on equality of access and equality and diversity; as well as emphasis throughout on placing the individual service user at the centre of their care, and taking into account at all stages the particular needs of the individual and any difficulties or disadvantages being faced.

Equality monitoring of all relevant protected characteristics to which the policy applies will be undertaken. This will help identify any specific adverse or positive trends in respect of any relevant equality group and contribute to providing lesson learnt outcomes to improve service delivery.

This policy will be continually reviewed to ensure any inequality of opportunity for service users, service users, carer's and staff is eliminated (Appendix 1)

ABBREVIATIONS USED

CPA	Care Programme Approach
LPT	Leicestershire Partnership NHS Trust
CCA	Care Co-ordination Association
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment
MAPPA	Multi-Agency Public Protection Arrangements
HoNOS	Health of the Nation Outcome Scales
STR Workers	Support Time and Recovery Workers
FYPC	Families, Young People and Children's
MHSOP	Mental Health Services for Older Persons
CAMHS	Child and Adolescent Mental Health Services
CQC	Care Quality Commission
LD	Learning Disability
CLDT	Community Learning Disability Team
AO	Assertive Outreach
WFA	Whole Family Approach
CTR	Care & Treatment Review
CTO	Community Treatment Order
HD	Huntington's Disease
EPR	Electronic Patient Record
CMHAF	Core Mental Health Assessment Form
MAPPA	Multi Agency Public Protection Arrangements
CEG	Clinical Effectiveness Group
ROAR	Risk of Admission Register
MAM	Multi-agency meeting
CTRs	Care and Treatment Reviews

DEFINITIONS THAT APPLY

Care Programme Approach	The Care Programme Approach (CPA) is "the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics" – Department of Health 2008
Non CPA	The term used, where following assessment, service users are identified to require care and support from secondary care specialist mental health services, but do not meet the characteristics that would instigate care under the formal CPA process.
Assessment	All service users are entitled to a core / full initial assessment. Those with complex needs will require a more comprehensive holistic assessment which must include clinical risk assessment.
Care Plan	The CPA Care Plan is a record of needs, actions and associated responsibilities arising out of the assessment process. The actions within the Care Plan should be outcome focused with the aim to address the identified needs and to optimise the mental & physical health of the service user.
Review	All service users are entitled to minimum review at least annually whilst those on CPA will often require more frequent CPA reviews. In this Trust, the standard minimum requirement is within 10 months or as agreed in the Care Plan.
Care Coordinator	The CPA Care Coordinator has "responsibility for co-ordinating care, keeping in touch with the service user, ensuring the care plan is delivered and ensuring that the plan is reviewed as required"- CPA Handbook.
Lead Professional	The lead professional has "the responsibility for facilitating the delivery of care to the service user who has been identified as having straightforward needs and has contact with only one agency; this will be the person identified as being most appropriate from that agency" - CPA Handbook
Community Mental Health Team (CMHT)	This title refers to all mental health teams working in the community including specialties.
Advance Statement of Wishes	A Statement of Wishes (preferences) although not legally binding, must be taken into account by those making best interests decisions on a person's behalf at a time when the person may be acutely unwell and temporarily lacks capacity (having been made when they had capacity).

Advance Decision	An 'advanced decision' is a statement of instructions about what medical treatment a person wants to refuse in case of losing the capacity to make those decisions in the future.
Due Regard	Having **due regard** for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Risk of Admission Register	The Risk of Admission Register (ROAR) is a mandate from NHSE for Clinical Commissioning Groups (CCG) to manage a register of people with learning disability and/or autism who are considered to be at risk of admission to a mental health inpatient setting.
Care and Treatment Reviews	Care and Treatment Reviews (CTRs) are part of NHS England's commitment to transforming services for people with learning disabilities, autism or both.

1.0 Introduction

This Policy is intended to serve as a framework for staff to follow in order to deliver high quality care and support for people who use mental health services provided by the Leicestershire Partnership NHS Trust (LPT). Though the use of CPA is re focused on those with most complex needs, the standards and emphasis on providing people and their families with clear information about the range of services available and choice in how their support is provided are applicable to all people who use our services. The service user must be central to the whole process, with support provided by the practitioner and services, in order for the service user to achieve his / her identified outcomes.

Within this Policy, services are asked to focus upon:

- Values and principles of CPA for all Service user to be central to care delivery
- A whole system approach to personalised, collaborative care planning and delivery
- Assessment and Care Planning standards
- Support for the workforce
- Measuring and Improving Quality
- Safeguarding issues: Vulnerable groups and individuals are protected by ensuring best practice in the area of Safeguarding - utilising national and local policies and guidance.
- Embedding culture of equality diversity and human rights

This Policy covers the main elements of CPA and the role of the Care Co-ordinator that has long been recognised as the linchpin of the whole process. It is vital that CPA Care Co-ordinators are given the guidance and support to enable them to successfully undertake their responsibilities.

A copy of the handbook produced by the CPA Association is provided to every CPA Care Co-ordinator within LPT. The information within the handbook provides additional guidance to support the LPT Policy.

The key standards statements from each of the sections of this policy are listed together in the introduction to the Policy.

The aspiration for a more personalised approach to service provision is now public policy and transforming adult social care services as described in the concordant putting People First (2007). The Care Programme Approach is at the centre of this personalisation focus, supporting individuals with complex characteristics to ensure that their needs and choices remain central in what are often complex systems of care.

The aim of the national review of CPA in 2008 was to ensure a renewed focus on people who use mental health and learning disability services having greater choice and control over their care and support.

Personalisation supports recovery by focusing far more on what the person finds valuable and meaningful and sees a new relationship between citizens and the publicly funded services they use. It involves all public services working together around the individual, rather than individuals navigating their way through a maze of publicly-funded services. It sees resources being used in new ways so that individuals have support that fits their life rather than their life being shaped by the support available to them.

This local updated CPA policy emphasises the importance of personalisation and of different professionals and agencies coming together to provide a range of services coordinated by the framework of CPA.

Whilst adhering to National guidance, this policy has been developed, through collaboration between health and social care agencies in Leicester and Leicestershire and Rutland and with organisations representing the views and needs of people and their families who use our services.

Values & Principles

LPT is committed to the values and principles of the CPA process and a service delivery aimed at a recovery based approach that supports people in living independent and valued lives.

Recovery is the diagnosis, treatment and support considered in terms of the extent to which they help the person to do the things they want to do and live the life they wish to lead. It is not just about services but also about what people experience and how they are empowered to manage their own lives. Recovery can be described as

"a process of changing one's orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life." [1]

Recovery and Independent living are key outcomes for mental health service and central to the both the Care Programme Approach and Personalisation agenda.

An outcomes approach challenges us to focus the consequences of support received and the 'right' results rather than the 'right' way of getting there.

Recovery is … *'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even without the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'* Slade, 2013) Slade, M (2013), 100 ways to support recovery, Rethink Mental Illness

Recovery is … *'being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.'* (Scottish Recovery Network, 2009) Scottish Recovery Network (accessed 2018) www.scottishrecovery.net/chime-diagram

It recognises that services in themselves do not produce outcomes and that

people do. As such people are recognised and supported as active assessors and co-producers of their own outcomes.

The CPA is central to supporting people to achieve their outcomes by:

- Promoting recovery
- Seeing the individual as a person first, service user second
- Putting the person at the centre of the process
- Seeing the person and their carer's as having strength, skills and expertise that can help
- Supporting meaningful involvement
- Working together in partnership
- Creating open relationships, trust, honesty and respect
- Being optimistic and building confidence
- Safeguarding the person and supporting positive risk management
- Promoting social inclusion and involvement
- Challenge inequality

CPA provides a framework to get the right balance in managing risk and respecting people's rights. Enabling choice and control requires a positive approach to risk-taking where people have the right to live their lives to the full as long as they do not stop others from doing the same. CPA assists this by promoting person-centred thinking to positive risk taking and assisting people to have choice and control over their lives.

LPT aims to ensure that all services provided conform to laws and guidance under- pinning the NHS equality agenda (Appendix 1). As such, service delivery will be periodically audited to ensure conformity to related policy procedure.

LPT has clear legal requirements in relation to race, gender, disability, age, religion or belief and sexual orientation. To this end, all Trust Policies will be impact assessed.

LPT CPA Policy supports care services' aims to ensure that services provided are in accordance with an assessment of need and are allocated on an equitable basis across all authorities, without discrimination of any kind.

Criteria for deciding upon the level of support required under CPA should **not** be used as indicators of eligibility **for** secondary services **or** for entitlement to receive any other services or benefits [2]

All service users will be involved in every aspect of their assessment, care planning, implementation and review process. They will be encouraged to include any carer's / relative / representative / friend they choose in that process.

Service users who have been assessed as having less complex needs which require low level support will not require the more formal CPA process. The person to facilitate or take the lead in care delivery for such individuals will be identified as the lead professional.

The rationale for determining non CPA must be recorded in service user's electronic patient record (EPR).

[2] Refocusing the Care Programme Approach 2008

2.0 Purpose of the Policy

- Provide direction and guidance for implementation of the Care Programme Approach.
- Provide high quality and robust care to the service users who are on CPA by effective care co-ordination with all services within and outside Leicestershire Partnership NHS Trust. Those not on CPA will be managed utilizing the CPA framework taking into account individual needs and risk of the individual.
- Provide choice to service user and carer's the different options available in their case and to fully involve them in developing a personalized care plan.
- Improve the physical health and well-being of mental health and learning disability service user and reduce health inequalities through a consistent approach in care delivery.
- Provide a holistic approach to providing care to service user to ensure that the care delivered covers both mental and physical well -being.
- Offering adaptations for people with disabilities for example hearing loop, downstairs meeting rooms, accessible information, local agencies information leaflets.
- Provide the opportunity to discuss relationships and issues relating to sexual orientation.
- Ensure that people do not suffer disadvantage due to age and are dealt with appropriately within services
- Ensure that the needs of both men and women are represented equally – including the needs of transgender service users.
- Highlight that staff have a responsibility to challenge discrimination they may witness and report back in accordance with risk management and complaints and incidents processes.
- Staff must also be aware of issues relating Human Rights including how they apply to staff and service users.

3.0 Categories of CPA

The Best Practice Guidelines for CPA (2008) removed the category of standard CPA, so now service users will either be on CPA or non CPA. Key principles will apply for all service users accessing LPT, regardless whether on CPA or non CPA, including:

- All service users in LPT will receive a full assessment (including risk assessment), a collaborative care plan including a crisis and contingency plan and a personal safety plan for service users who may pose a risk re self-harm and suicide (as per the Risk Assessment Policy), the name of the person facilitating their care and regular review of that care plan and progress.
- The assessment will address any capacity issues.
- The care plan will be written in collaboration with the service user and carer (as appropriate) detailing how assessed needs will be met and by whom; all care plans should promote recovery, social inclusion and choice.
- The care plan will be explained to the service user in an accessible manner taking into account issues of equality and diversity.
- The service user should be given information about their diagnosis and treatment.
- The service user should be encouraged to sign and keep a copy of their care plan.

3.1 **CPA**

Service users who have complex needs require CPA; the guiding principles for a service user requiring CPA are those with complex characteristics, whose needs are met from a number of services or who are most at risk and who need a higher level of engagement, co-ordination and support.

3.2 Criteria for a Service User being on CPA

Severe mental disorder (including personality disorder) with a high degree of clinical complexity

Current or potential risk (s) including:

- Suicide, self harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self neglect / non concordance with treatment plan
- Vulnerable adult; for example adult / child protection
  Exploitation for example financial / sexual
  Financial difficulties related to mental illness
  Disinhibition
  Physical / emotional abuse
  Cognitive impairment
  Child protection issues
- Current or significant history of severe distress / instability or disengagement
- Presence of non – physical co – morbidity for example substance / alcohol / prescription drug misuse / learning disability
- Multiple service provision from different agencies including housing / physical care / employment / criminal justice / voluntary agencies
- Currently / recently detained under the Mental Health Act or referred to crisis / home treatment team
- Significant reliance on carer (s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of:
  Parenting responsibilities
  Physical health needs / disability
  Unsettled accommodation / housing issues
  Employment issues when mentally ill
  Significant impairment of function due to mental illness
  Ethnicity; for example immigration status / race, cultural issues / language difficulties / religious practices / sexuality / gender

Key groups who would normally need the support of CPA are service users who:

- Have parenting responsibilities
- Have significant caring responsibility
- Have a dual diagnosis (substance misuse)
- Have a history of violence or self harm
- Are in unsettled accommodation
- Are subject to Supervised Community Treatment (SCT) or Guardianship (s.7) under the Mental Health Act (1983)

If these service users are not supported through CPA, the reasons must be clearly documented in the service users EPR.

3.3 Documentation for Service User on CPA

It is the responsibility of the care coordinator to ensure the following documentation is completed after each CPA review:

- CPA review form
- Care Plan
- Risk assessment tool and Therapeutic risk taking tool (if applicable)
- Personal Safety Plan (if applicable)

3.4 Non CPA Service Users

Those service users with more straightforward needs: one agency or no problems with access to other agencies / support. At every review, it should be considered whether the support provided by CPA will be needed. As a service users needs change or the need for co- ordination support is minimised, moving towards self directed support will be the natural progression.

3.5 Documentation for service user not on CPA

For service users placed on non CPA, thorough documentation is essential; it is the responsibility of the Lead Professional to ensure that these service users are reviewed as a minimum every 10 months (can be within Out Patients Appointment) and the following documentation is completed:

- CPA review form **OR** the Out Patient Care Plan **OR** non CPA clinic letter
- Care Plan
- Risk assessment tool

4.0 Duties within the Organisation

4.1 **Trust Board Committees** have the legal responsibility for adopting
policies and strategies and ensuring that they are carried out effectively

4.2 **Divisional Directors and Heads of Service** are responsible for:

- Ensuring that comprehensive arrangements are in place regarding adherence to this policy and how CPA procedures are managed within their own Department or Service in line with the guidelines in this policy

- Ensuring that team managers and other management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction. These arrangements will include:

  - Receiving policies / procedures from the Policy Administrator
  - Distributing information about new procedures in a timely manner throughout the Division or service to a distribution list will be agreed in advance with local managers.

- Ensuring that all staff have access to up to this policy, either through the Intranet or if policy manuals are maintained that the resources are in place to ensure these are updated as required.

- Maintaining a system for recording that policies and procedures have been distributed to and received by staff within the Department / Service and for having these records available for inspection upon request for audit purposes.

4.3 **Managers and Team leaders** will be responsible for:

Ensuring that the CPA Policy and guidance is followed and understood as

appropriate to each staff member's role and function.

This information must be given to all new staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes policies and procedures.

Ensuring that staff understand how and where to access current policies and procedures;
via Intranet.

Ensuring that a system is in place for their area of responsibility that keeps staff up to date with the CPA Policy and any recommended training related to it.

4.4 **All Staff**

All staff (including seconded staff) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:

- Know where to locate the CPA Policy or procedures when necessary
- Adhere to all Trust Policies and Procedure
- Attend core mandatory safeguarding training
- Complete CPA training on U Learn every 3 years (Appendix 2)

All staff should be aware of how policies and procedures impact on their practice and be able to follow the specified requirements set out.

4.5 **Care Co-ordinator**

The CPA Care Co-ordinator is a competent, trained, registered clinician experienced in assessing complex characteristics and be the person "best placed" to oversee CPA care planning.

They are responsible for co-ordinating the assessment, planning, implementation, monitoring and review of the CPA care plan for the service user whether in hospital or community, and ensuring that all records, including the Trust EPR are maintained and updated accordingly.

The Care Co-ordinator can be of any discipline depending on capability and capacity and the following will not usually be identified into the role:

- Support Treatment and Recovery Workers
- General Practitioners
- Unqualified / unregistered health or social care workers

Care Co-ordination should form part of the job description with co-ordination support recognised as a significant part of the caseload. Best practice is that Care Co-ordinator competencies should be completed and recognised as part of job specifications (see Appendix 4).

No qualified member of a service, organisation or discipline is exempt from being

allocated the role of CPA Care Co-ordinator.

Following the assessment outcome where the service user is placed on CPA, a CPA Care Co-ordinator must be agreed and assigned immediately and registered on service user EPR. Service users assessed to have the greatest level of need should be assigned a CPA Care Co-ordinator with the most skill and experience.

A choice of CPA Care Co-ordinator gender should be offered to service users who are known to have encountered sexual abuse or violence.

Change of Care Co-ordinator will be by agreement of the care team and will follow a CPA review, if possible, and full handover of care between the two Care Coordinators or the Care Co-ordinator and lead professional or vice versa.

Practitioners working as CPA Care Co-ordinators will act within their own professional code of conduct and within LPT operational requirements and will hold professional accountability for their actions.

Medical accountability does not rest with the service user's Care Coordinator, unless the role is assigned to the Consultant.

Any dispute relating to the allocation of a CPA Care Co-ordinator, must be raised with the appropriate management as a matter of urgency.

Pro-active planning should occur to cover periods of annual leave or sickness: Care Co- ordinators must arrange for crisis and contingency plans to be amended to include details of the person to be contacted in the Care Co-ordinators absence.

4.5.1 CPA and the process for patients on a waiting list

The Trust is committed to regular review of the safety of patients who are on waiting lists and community services have monitoring processes in place.

The following key principles must be met to provide assurance of the process for patients being entered onto a waiting list:

1. Robust prospective clinical triage
2. Regular reviews of the waiting list by service management and clinicians through Patient Tracking Lists
3. Clear process for reprioritisation or reallocation if clinical presentation changes or is escalated
4. Clear information to ensure that patients are fully aware and understand their rights, what to do if their situation deteriorates and how to access supportive resources whilst waiting

Following assessment, if accepted and immediate allocation is not possible, an interim care plan will be co-produced by the service user the assessing clinician and the patient will be managed through the waiting list process.

If a patient is open to another service within the Trust, their lead professional, or care coordinator if on CPA, will remain the same.

If a patient is not known to any other service within the Trust, they will have an open team referral but no named lead professional. It is acceptable for the service to hold the lead professional role rather than any specific individual clinicians, however, the team would need to ensure access to a clinical duty worker (or similar system) within office

hours to respond to queries from anyone who rings up for support. The non-CPA level will not be logged on the electronic patient record until the patient is allocated; an entry should be made on the progress notes to state that the patient has an open team referral.

4.6 **Lead Professional**

Lead professional is the professional who has lead responsibility for a service user's treatment and care for service user on non CPA.

Process for out of area patients - Patients who are cared for 'out of area' (for example, in a specialist residential or inpatient placement such as locked rehab etc. – note that this would not apply to an acutely ill patient who is temporarily accommodated out of area in a private facility on a short term basis) can be recorded as on CPA but exempt from the need for LPT to identify a care coordinator or undertake CPA reviews etc. In such cases, it must be documented that another agency has the lead. There is no expectation for the named worker to contact the out of area provider other than if, or when, plans are put in place to repatriate the patient back to LPT services. At this point, a named worker will re-establish this role to support a smooth transition. Patients in this situation are exempt from data collection relating to CPA performance. *[note that performance team and SystmOne processes for this are being explored]*

5.0 Carers

A key element of CPA is that it recognises the importance of service user's wider social relationships to their well-being and recovery. A key aspect of the Care Co-coordinator's role is therefore to consider these with the service user and, where possible, to ensure that the right people are involved in the assessment and care planning process. Service users have a right to the involvement and support of other people where they wish it.

A carer is someone who supports a person with a mental health problem, learning and / or physical disability or illness. They do not get paid for this or do it as voluntary work. Carer's are often family or friends but they do not have to be. The support they provide might be physical care or practical support but it can also include emotional support or supervision. It is quite common for people not to see themselves as carer's because they see what they do as a normal part of being a partner or friend. Recognition should be given to the role of the carer as being a valued member of the Care Team network.

LPT and Local Authorities recognise that caring for a person with mental health problems may have a significant effect on the life of that carer and this can affect the carer's own health, well-being and life chances. All staff in the partner agencies have responsibilities to support or signpost carer's as required.

Local Authorities have a legal duty to offer carer's who provide or intend to provide "care" an assessment of their own needs. Following an assessment, support and services may be provided to help the carer in that role. This can be directly to the carer or through additional support to the service user. Staff undertaking these assessments should be familiar with the law, the National Guidance [3] and the local authority's policies.

Staff must actively seek to identify and support carer's at all times, staff must also record on EPR any people identified that service user's do not want involved in their care. Clinicians may, at times, be working with individuals and have no direct contact with carer's but become aware of them through the service user. The service user may not want their carer to be contacted. In these situations staff are advised to explore the service users concerns and encourage him / her to weigh the possible benefits of the carer receiving support against the issues giving concern. Information about what the carer's assessment involves and reassurance that confidentiality will be maintained may

help.

The Service user's consent must be sought before any information relating to their mental health is shared with their carer, unless risk / safety factors or lack of capacity, justify breaking such confidence. The rationale for this breaking of confidence must be recorded in EPR.

If a service user still refuses to give their consent, and there is no overriding responsibility in terms of risks then the service user's wishes must be respected. The rationale for refusing consent must be recorded in the service user's EPR. In these situations carer's can still be signposted to carer's organisations and / or the Local Authority for support to them.

Additional to family or friends who care "about" the service user and who the service user may wish to be involved in the CPA process, there will be others who care "for" the service user. The partner agencies all recognise the importance of supporting carer's – those who care **for** people.

The carer should be informed that records will be kept including their personal details. Consent for this should be obtained from the carer and recorded in the relevant section of the assessment form or the review form.

In order to enable carer's to make an informed decision, whether to share information or not, it must be made clear how any information they provide will be used. They should also be made aware of their right to access records about them.

Where carer's are under 18, their needs require particular consideration. Staff should always consider if children are present in the service user's life and ask if they are involved in providing any care.

The aim should be to provide the right support to the service user so that the caring role does not impact adversely on their life. This support can include help with their parenting role. Some young people do wish to continue in a caring role and this can be appropriate and specific support is available to them. Information regarding children acting as carer's must be shared.

The carer can share his / her own view and any other information he / she feel is necessary with the care team, regardless of whether the service user has given permission or not.

If a carer requests that information they share with staff is not passed on to the service user, this request must be respected – subject to Information sharing and Consent guidance

Throughout the CPA process, staff must be mindful of the needs of the service user's family / network and where any needs or issues are identified, further reference for guidance may be obtained in other Trust policies including Adult Safeguarding Policy, Children Safeguarding Policy or Domestic Violence Policy - available via e-source

[3] Care and Support Statutory Guidance – Issued under the Care Act 2014

6.0 Legal Framework

The Care Programme Approach is guidance not statute and the Trust must work in accordance with the legislation relevant to mental health services. Relevant legislation and guidance includes:

- Mental Health Act (1983 / 2007)
- Mental Capacity Act 2005
- Refocusing the CPA: Policy & Positive Practice Guidance (2008)
- Human Rights Act (1998)
- Equality Act (2010)
- Gender Recognition Act (2004)
- Civil Partnership Act (2004)
- Data Protection Act (1998)
- Care Act (2014)
- Children Act (1989)
- UK Care Standards Act (2000)

References and Associated Documentation

- Care Standards Handbook
- Writing Good Care Plan 2015
- Safety First: National Confidential Inquiry into Suicide and Homicide by People with mental illness: DoH 2001
- Care Programme Approach; Care Co-ordination, core functions and competencies DOH 2008
- Independent Inquiry into the Care and Treatment of MN. Avon, Gloucestershire and W iltshire Strategic Health Authority, June 2006.
- Code of Conduct – Data Protection and Confidentiality of Patient and Personal Information, Leicestershire Partnership NHS Trust (2004) / Confidentiality: NHS Code of Practice, Department of Health (2003) / Information sharing protocol, Leicestershire County Council (2006)/Local Safeguarding Board Procedures – Information sharing, Local Safeguarding Children Board, Leicester, Leicestershire & Rutland / The NMC Code of Professional conduct: standards for conduct, performance and ethics, Nursing and Midwifery Council (2004) / Information Governance LPT 2012
- Think Child, Think Parent, Think Family, a Guide to Parental Mental Health and Child Welfare (2011)

7.0 Assessment

All referrals for secondary mental health services in LPT will receive a full assessment to determine the level of input required to provide appropriate care and treatment for identified needs. Agreed care pathways and processes must be followed and assignment to formal CPA process is essential. An outcome summary of the holistic assessment together with required data collection relating to accommodation, social economic factors, must be evidenced and recorded within the agreed Trust tools on EPR.

Service users requiring formal CPA process may include more than one assessor of their health and social needs; these will be recorded on the Core Mental Health Assessment Tool (or equivalent).

Assessment must involve the service user, and where appropriate, the carer, as central and active participants in the CPA process. Staff must work with the focus on “best interests” of the service user; the assessment is a focus on a service user’s needs rather than on the services available or on any diagnosis made.

Assessments must ensure that the service user’s strengths and achievements are identified.

The Assessment process must contain an assessment of risk - please refer to the LPT

Clinical Risk Assessment Policy). Attention must be given in respect to whether or not the service user fulfils the criteria for registering under the Multi Agency Public Protection Arrangements (MAPPA).

Appropriate outcome ratings / clustering will be completed at assessment, upon discharge from an inpatient setting, at six month intervals as appropriate and at significant points in the CPA process or as defined by the Care Pathways.

During assessment, detailed demographic information must be gathered regarding any children under 18 living at same address and / or in regular contact, issues or needs of family members / dependents, safeguarding, children or vulnerable adults. All information must be recorded on EPR (Whole Family Approach 2014).

The CPA Assessment should be fully completed once and thereafter updated information must be evidenced within the review process.

Clinicians should use the Core Mental Health or equivalent within their area of work (LD). If using a detailed clinical letter to document the assessment, it should be uploaded onto EPR and should be noted on the CMHAF assessment form (CMHAF).

8.0 Risk Assessment

A Risk Assessment is mandatory for all service users and is part of the assessment process. The use of clinical risk tools is encouraged by the Department of Health to support informative risk assessment.

The electronic risk assessment tool is accepted by the Trust as the main risk assessment tool and the Trust encourages all clinicians to use the tool to aid the assessment.

When the clinician is undertaking risk assessment using more sophisticated tools specific to the risk or has expert clinical skills in undertaking risk assessment, this information must be transferred to Trust risk assessment.

All staff have a responsibility in terms of acting on information they receive regarding risk, to record accurately in service user's EPR and liaise with the service user's Care Co-ordinator.

All identified risks and how they are to be managed must be recorded in a risk management plan. Risk management plans must be reviewed regularly, whether on CPA or not and any change in risk factors must trigger a full review including clustering reassessment (if applicable to service) and care pathway check.

Please refer to LPT Clinical Risk Assessment policy

9.0 Care Plan

CPA Care Plans must be collaborative, outcome focused and in an appropriate format for the service user's requirements. The responsibility of formulating the CPA Care Plan (which must include a crisis and a contingency plan) is with the Care Co-ordinator. The CPA Care Plan must be recorded on EPR.

Dependent upon assessed mental capacity, service user's should be encouraged to be fully involved, wherever possible, in the formulation of their CPA Care Plan –

they have the right to decline if they wish.

Service users must be invited to sign the final formatted version and be given a copy of the care plan – it should be clearly documented on EPR if no signature and / or does not wish to have a copy of care plan / be involved in care planning process.

It is the right of all service users and significant carer to be offered and to receive a copy of an agreed written Care Plan.

CPA Care Plan must be in an accessible format for service user / carer; it must include crisis and contingency plan, it should identify the CPA Care Co-ordinator and everyone involved in the care of the service user and it should include the actions for which the service user will take responsibility.

A copy of the CPA Care Plan will be provided to all in the identified care Team or network and, with the consent of the service user, other relevant parties.

The effectiveness of the agreed CPA Care Plan will form part of on going monitoring and discussions between the service user and their Care Coordinator.

Where there are two service user's within one household, each CPA Care Co-ordinator must be aware of the contents of each of the CPA Care Plans. In such cases, there must be regular dialogue (at least quarterly) between the Care Co-ordinators (or lead professional where one of the service user may not be on CPA).

10.0 CPA Review

CPA review may be a planned meeting or a series of conversations or a more formal meeting. The information / outcomes from the CPA review should be recorded using the CPA review template on service users EPR and this should be circulated to identified persons within 14 days.

A planned CPA review meeting should be allotted dedicated time and not be part of another meeting.

CPA review is a structured, flexible process as well as a planned periodic event. It is to discuss / update the CPA Care Plan and Risk Assessment and it also provides the opportunity to capture / update social economic factors as required by the Trust.

10.4 Frequency of Review:

ON CPA – at least every 10 months **or** as agreed by all parties involved in the care plan taking into consideration service user choice, complexity of identified needs and planned outcomes and any risk factors.

The rationale for this agreement must be recorded

Service user's admitted as an inpatient for more than 6 months will have CPA reviews at least once every 6 months (dependent on need).

Not on CPA – minimum every 10 month

A CPA review will determine how effective the CPA care plan is in assisting the service user to achieve the identified outcomes. It provides the opportunity to reassess / update clustering (where needed), care pathways, risk assessment, outcome measures, social economic factors and review Section 117 aftercare where applicable.

It provides the opportunity to formally discuss any disagreements about the care plan

which may have arisen and where there are disagreements, these must be recorded in EPR.

If the service user or any other person involved in the care team requests an earlier CPA review, immediate attention should be given to establishing the reason for the request and if necessary, review should be arranged.

Service users have the right to request a CPA review at any time. Where this request is not granted, the reason must be recorded and an explanation given to the service user and carer if appropriate. Every consideration must be given to a request from the service user or the carer to hold the CPA review at a specific venue.

The CPA review is the responsibility of the CPA Care Co-ordinator and they need to ensure that everyone involved in the service user's care, has had the opportunity to contribute.

When a social care support package is in place, the Care Co-ordinator must involve a social care worker in the CPA review. Adequate planning is required in order for the social care report / update to be prepared.

At each review the date of the next review must be set and recorded on EPR and, as appropriate, on the Local Authorities information systems.

Decisions made and agreed in a CPA review must not be changed by any individual without full consultation with all other named participants.

The CPA Care Plan must be updated to reflect any change resulting from a CPA review and a copy given to the service user.

A CPA review must take place prior to transfer of care into another team, in or out of area, to formally handover care and all relevant information. All relevant parties in the care team network should be involved in the review. The outgoing CPA Care Coordinator is responsible for updating the records before transferring the case over to the new Care Coordinator.

Section 117 aftercare is reviewed as part of the CPA Review process. CPA should be used to oversee and manage Section 117 aftercare arrangements where appropriate. It is recognized however that the support for some people who remain entitled to Section 117 Aftercare is straightforward and does not require co-ordination and planning across services. Examples of this include where primary care takes on the support or where the person is settled in social care and no longer requiring regular input from secondary mental health services. Where this is the case then this support can be overseen and managed outside of CPA.

10.1 **Care and Treatment Reviews for people with learning disabilities and autism**

Care and Treatment Reviews (CTRs) are part of NHS England's commitment to transforming services for people with learning disabilities, autism or both.

The Risk of Admission Register (ROAR) is a mandate from NHSE for Clinical Commissioning Groups (CCG) to manage a register of people with learning disability and/or autism who are considered to be at risk of admission to a mental health inpatient setting. The relevant health service needs to identify that a person is at risk of admission to a mental health inpatient setting and complete an online ROAR referral form.

A multi-agency meeting (MAM) happens prior to a person being referred to the Register. It

should include Health, Education and Social Care and should not be confused with health based multi-disciplinary teams meetings. A MAM should be called when a person has escalating risks and/or unmet needs before referral to the ROAR. It can be called by any agency involved in the person's care and paperwork exists to facilitate the meeting - standard agenda and template for recording minutes.

If a person is referred on the ROAR as amber or red, the process is to arrange a community CTR, and the CCG will contact the referrer. Following the processes of MAM, ROAR referral and CETR will enable a person's needs to be met in the most prompt and appropriate way. Failing to follow the correct processes may cause unnecessary delay or admissions to hospital. Any admission to hospital without a community CTR is classed as a breach and is a reportable incident.

All admissions for a person with a learning disability and/or autism under the Mental Health Act must be reported to either Specialist Commissioning for children and young people or Secure or the CCG so that a post admission CTR can be completed.

Please utilise NHS Futures Platform for further guidance and to access the ROAR referral:https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fhome%2Fgrouphome

The Care Programme Approach (CPA), implemented consistently and effectively with high quality care management, should be the baseline process of regular review for people with learning disabilities who fulfil the criteria for CPA; those who require multi-agency support, active engagement, intense intervention, support with dual diagnoses and who are at higher risk (Refocusing the Care Programme Approach, Department of Health 2008).

CTRs are not the same as CPA, though they will cover many of the same core areas and will be able to provide supporting information for a local CPA process.

CTRs will differ in emphasis and process from CPA in:

- Providing a degree of independent scrutiny
- Challenging elements of the care and treatment plans where appropriate
- Involving independent experts by experience
- Involving independent clinical experts
- Being chaired by and directly involving the responsible commissioner
- Routinely involving local authorities in the reviews

Reference: https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

11.0 Gaps in Service

11.1 Where a deficiency in service delivery is identified which potentially could affect an outcome as identified within a service user's care plan, a Gaps in Service form should be completed and the process contained within it follows.

11.2 This must be brought to the attention of the appropriate line manager, who take the necessary action practically and reasonably possible to bridge the deficit. The Gaps in Service should be discussed at LPT CPA Standards and Practice group.

12.0 Ending the formal CPA process and discharge

"If CPA is to end, it should be a decision, not a withering away…which requires a CPA review in order that all potential players can express a view on the matter[10]

12.1 Ending the formal CPA process will be discussed within a CPA review. The service user's treatment and recovery will have progressed sufficiently and risk level reduced significantly in order to require future care to be managed by a lead professional.

12.2 If a service user (not considered to be detained under the Mental Health Act) requests not to be on CPA and refuses to have any further care under the formal CPA process, reasonable attempts must be made to explore alternative strategies for maintaining engagement (an agreement may be reached to continue to receive care from a lead professional). A risk management plan must be formulated and agreed following a CPA review, it must be recorded on EPR and GP must be informed.

12.3 Service user and carer's, as appropriate, must be given information of how to contact services at a future date if their circumstances change.

[10] Independent Inquiry into the Care and Treatment of MN. Avon, Gloucestershire and Wiltshire Strategic Health Authority, June 2006.

13.0 Inpatient Areas

13.1 All service users who are admitted to a mental health unit will be screened Onto CPA

13.2 Upon admission, any recorded CPA assessment information must follow the service user and be updated accordingly to be discussed within the initial CPA meeting.

13.3 A CPA discharge meeting will be organised by the care coordinator before the service user is discharged involving all the professionals, service user and carer's wherever possible. Clear reasons should be documented by the inpatient team if discharge CPA was not possible and a CPA review should be organised by the CPA Care Coordinator within 28 days following discharge.

13.4 At the time of discharge, service users can be regarded as non CPA if clinically appropriate and the rationale needs to be clearly documented on the EPR.

13.5 Following discharge from any adult mental health service unit, all service users, irrespective of CPA status will receive follow up within 7 days and this will be recorded in the EPR.

13.6 At the time of discharge, service users will have either a written discharge plan detailing immediate follow up care together with a crisis and contingency plan and discharge medication **OR** a copy of updated CPA Care Plan **OR** copy of e- discharge letter to the GP (where the latter is used, the service user must be informed that this copy is their discharge plan).

13.7 Discharge plans for all in-service user who have a severe mental

illness or history of self-harm are to include specific follow-up arrangements for the first week after discharge with more intensive follow up provision for at least the first three months[9] and planning for this will be the responsibility of the Care Co- ordinator.

13.8 A copy of the agreed discharge plan / information and updated e – CPA care plan must be sent to the relevant GP within 24 hours and must be given to the service user as soon as it is practical to do so.

Please refer to LPT Discharge Policy

14.0 Service Interface

14.1 Admission to inpatient services is a change in the location of the delivery of care and is not to be interpreted as the end of one episode of care and the beginning of another. CPA assessments should follow the service user from Community and vice versa.

14.2 The CPA Care Co-ordinator retains responsibility for maintaining contact with the service user and carer (where applicable), throughout the admission stay and must be involved in discharge planning.

14.3 Inpatient staff have an important role during the period of crisis which has necessitated a hospital stay. The service user's pathway should be a collaborative process with all parties working together.

14.4 Service specific requirements in Learning Disabilities Services (LD), Family &Young Persons Children (FYPC) or Mental Health Services for Older Persons (MHSOP) may determine alternative interface arrangements.

14.5 All inpatient services must inform and involve the appropriate CPA Care Coordinator when leave arrangements for a service user are being made, whether this is planned or unplanned. Specific arrangements to involve the Crisis and Home Treatment Team (CRHT) may be included in the leave plan.

14.6 The support of formal CPA will not discontinue because a service user is discharged from inpatient services. Any such decision will be as an outcome from the pre-discharge CPA review process and this will be entered onto the EPR.

14.7 The Care Coordinator is responsible for ensuring 7 day follow up is completed but will not necessarily be the person carrying out the contact.

Each change in the following must be recorded on EPR:

- CPA Care Co-ordinator / Lead Professional
- CPA determination
- Transfer between wards
- Transfer to another RMO / Responsible Clinician
- Leave – time and date of leaving ward and time and date of return
- Discharge

14.8 For those service user's who are discharged from an inpatient service through early discharge process within the Crisis Team, the Care Coordinator

role will continue temporarily within CRHT, during facilitation of early discharge and follow-up for a service user who is awaiting allocation of,and a transfer to, an identified CPA Care Coordinator from the locality CMHT / Community Learning Disability Team (CLDT). If the CRHT / CMHT / CLDT assess the service user's CPA status can be changed to non CPA, the reasons should be clearly documented, CPA status amended on EPR and service user and care team (including GP) should be informed.

14.9 Where a CRHT member is facilitating early discharge and post discharge follow- up for a service user not likely to remain on CPA in the foreseeable future, the role of Care Co-ordinator will be with the CRHT until a CPA review agrees discharge from CPA **or** transfer to a Care Co-ordinator within the CMHT/CLDT. The maximum time agreed to hold this interim role is seven working days and must be due to extraordinary circumstances rather than routine practice (CPA Standards Group March 2012).

14.10 Managers and CPA Care Co-ordinators must be aware of any staff changes that may affect continuity of care delivery, The service user must not be left without a contact in the event of transfer from inpatient to care in the community.

Safety First: National Confidential Inquiry into Suicide and Homicide by People with mental illness: DoH 2001

[9] Care Programme Approach; Care Co-ordination, core functions and competencies
DOH 2008

14.11 Discussion regarding likely post discharge requirements should commence at an early stage of the admission process. The relevant CMHT / CLDT must be informed and advised that a CPA Care Coordinator will be required to take over the role from the ward staff. This role should be identified, the service user and the ward informed – prior to an arranged discharge date. All service users on CPA should have pre discharge CPA meeting involving all the professionals and carer's and they will be reviewed prior to discharge if they should continue to be on CPA. There should be no instances where a service user is discharged from inpatient services, on CPA, without an identified CPA Care Coordinator in the community to follow on support.

15.0 Information Sharing

15.1 Information sharing should be undertaken with the agreement of the service user.

15.2 Where consent has been withdrawn, a service user's decision can be overridden when there is a concern or a risk of serious harm to either the service user or any other person. Where this is the case, an explanation must be offered to the service user (unless by doing so, this would increase risk to any dependent children or vulnerable adult).

15.3 Information may be shared in respect of Police investigations (if appropriate and dependent upon awareness of the responsible clinician or line management).

15.4 Where a service user is a carer for either a child or another vulnerable adult, the safety of those persons is vital. Staff, on a ward or any member of the care team network, may share information with the person nominated to act as a temporary carer or advocate. This should be on a "need to know" basis and the information will likely be shared during

discharge planning stages and refer to leave arrangements and any associated risks and progress reports.

15.5 Information sharing should take into account LPT responsibility in relation to Safeguarding Adults and Children. Consideration should be given to referring people who may be victims of abuse within the multi-agency procedures**.**

15.6 Shared information systems will provide data relevant to people and agencies in accordance with public protection and data protection systems. Robust CPA requires that protocols be agreed for the sharing of information with the Police, probation service, local prison (if appropriate) and court liaison, independent / voluntary sector agencies involved in the care provision.

15.7 Information sharing should take into account LPT responsibility in relation to Safeguarding Adults and Safeguarding Children. Consideration should be given to referring adults or children who may be victims of abuse within the local safeguarding multi-agency procedures.

When there are Safeguarding concerns in relation to children, it is important that information is also shared with the relevant children's service area. Health Visitors work with children 0 -5 years and school nurses with school age children. Staff can contact the children's safeguarding advice line on 0116 295 8977 or the adult safeguarding advice line on 0116 295 7261 for advice (Monday – Friday).

15.8 Further detailed guidance can be referenced in national and local documents.

16.0 Monitoring Compliance and Effectiveness

16.1 LPT must have an appropriate central record of all service user receiving treatment, care and the support being provided. This record will provide reports to managers and staff concerning caseload and other relevant information.

16.2 Compliance with this policy will be monitored through a dedicated assessment and care planning audit which will take place on an annual basis and will be included within LPT audit calendar. This audit will be undertaken in conjunction with LPT Clinical Audit Department. The frequency of the audit will be reviewed annually.

16.3 Additional audits may be commissioned by Divisions, service user groups or he CPA Chairs or Lead. This should also include audits to provide evidence of standards of care being given to service user's not on CPA.

16.4 CPA related audits will be reported to the Clinical Effectiveness Group (CEG). This Group will seek assurance from Divisional Directors and Service Managers (CPA Standard & Practice Group) that any necessary remedial action is taken following the audit and that clinical staff are complying with the CPA Policy. Any issue raised as non-compliance will result in the formulation of an Action Plan which will be monitored by the CPA Standards Group. Action plans will include recommendations for addressing issues raised, review dates and responsibility as well as identifying any plans for re-audit

16.5 The CPA Standards & Practice Group will support the design of appropriate audit tools. Audits will be performance managed by the CPA Standards Group (via the CPA Practice Groups).

16.6 LPT will encourage qualitative audits to be led by service user groups as well

as by clinicians.

16.7 Services must support clinicians to undertake data collection and receive finding whether Trust-wide or Service specific

16.8 In addition to the audits referred to above, Managers are expected to monitor service user electronic systems data relating to CPA within their teams, by the use of electronic reports. This information should be shared within supervision with care coordinators and also be used as part of caseload management.

17.0 Links to Standards / Performance Indicators

This CPA Policy links to Care Quality Commission (CQC) Outcomes 1, 4, 16.
An annual CPA audit will be conducted to ensure compliance with all the CPA Standards.

Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
All service user18 or over on CPA for one year or more have a CPA review yearly	Section 10	CPA Audit Integrated Quality Performance Report (IQPR) Divisional Score Cards	Managers and Individual Professionals Divisional CPA Practice Groups Trust CPA Standards Group Clinical Quality Group Directorate Quality & Safety Groups	Annual Quarterly Quarterly Quarterly Quarterly
All service users have CPA level assigned to them	Section 4.5	CPA Audit Directorate Scorecards	Divisional CPA Practice Groups Trust CPA Standards Group Manager and Individual Professional	Quarterly Monthly
All service users on CPA age 18 and over are seen by their Care Coordinator six monthly	Section 7	Directorate Scorecards	Manager and Individual Professional	Monthly
All service users on CPA aged 18 and over have a Care Coordinator assigned to them	Section 4.5	Directorate Scorecards	Manager and Individual Professional	Monthly

Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
All service users on NON CPA aged 18 and over have a lead professional assigned to them	Section 3.5	Directorate Scorecards	Manager and Individual Professional	Monthly
All service users on CPA aged 18 and over have a CPA Care Plan	Section 9	Directorate Scorecards	Manager and Individual Professional	Monthly
All service users on CPA between ages 18 and 69 have had their accommodation status recorded.	Section 7	Directorate Scorecards	Manager and Individual Professional	Monthly
All service users on CPA between ages 18 and 69 have had their employment status recorded.	Section 7	Divisional Scorecards	Manager and Individual Professional	Monthly

APPENDIX 1:

Due Regard Equality Analysis

Due Regard Screening Template

Section 1	
Name of activity/proposal	Review of LPT CPA Policy
Date Screening commenced	1st August 2016
Directorate / Service carrying out the Assessment	Adult Mental Health, Families, Young Persons and Children. Community Services
Name and role of person undertaking this Due Regard (Equality Analysis)	Heather Crozier, LPT CPA Lead
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To provide direction and guidance for implementation of the Care Programme Approach	
OBJECTIVES: To provide high quality and robust care to service user's who are on CPA by effective coordination with all services within and outside Leicestershire Partnership NHS Trust. Those not on CPA to be managed utilising the CPA framework taking into account individual needs and risk of individual	
PURPOSE: To provide choice to service user and carer's, fully involving them in developing a personalized, collaborative care plan. **PURPOSE:** To provide a holistic approach to providing care to service user's ensuring that care delivered covers both mental and physical well being.	

Section 2		
Protected Characteristic	**Could the proposal have a positive impact Yes or No (give details)**	**Could the proposal have a negative impact Yes or No (give details)**
Age	There is no bias within the policy	NO
Disability	There is no bias within the policy	NO

Gender reassignment	There is no bias within the policy	NO
Marriage & Civil Partnership	There is no bias within the policy	NO
Pregnancy & Maternity	There is no bias within the policy	NO
Race	An interpreting and translating service is available if the service users first language is not English	NO
Religion and Belief	There is no bias within the policy	NO
Sex	The policy is equally applicable to all sexes	NO
Sexual Orientation	There is no bias within the policy	NO
Other equality groups?	There is no bias within the policy	NO

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
It this proposal is low risk please give evidence or justification for how you reached this decision:			
Update of existing policy conforming to national policy and guidelines			
Signed by reviewer/assessor	Heather Crozier, LPT CPA Lead	**Date**	06/12/2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 2

Training Requirements Training Needs Analysis

Training Required	YES **X**	NO
Training topic:	CPA and Care Planning	
Type of training: (see study leave policy)	X Role specific ☐ Personal development	
Division(s) to which the training is applicable:	XAdult Mental Health & Learning Disability Services XCommunity Health Services ☐ Enabling Services XFamilies Young People Children ☐ Hosted Services	
Staff groups who require the training:	All staff undertaking the role of Care Coordinator	
Regularity of Update requirement:	3 Yearly	
Who is responsible for delivery of this training?	Clinical Trainers / Identified clinical staff	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	XULearn ☐ Other (please specify)	
How is this training going to be monitored?	Monthly record of mandatory training	

APPENDIX 3 :

Table of indicators for the support of formal CPA process

Severe mental disorder (including personality disorder) with complex health and social needs and / or a learning disability.
Current or potential high risk(s), including: • Suicide, self-harm, harm to others (including history of offending) • Relapse history requiring urgent response • Self neglect/non concordance with treatment plan • Vulnerable adult; for example adult / child protection - Exploitation for example financial / sexual - Financial difficulties related to mental illness - Dis-inhibition - Physical / emotional abuse - Cognitive impairment - Child protection issues
Previously detained under the Mental Health Act.
Subject to Supervised Community Treatment (SCT) Subject to Guardianship under the MHA (Section 7)
Current or significant history of severe distress / instability or disengagement
Presence of non-physical co-morbidity for example substance / alcohol / prescription drugs misuse.
Multiple service provision from different agencies including: housing, physical care, employment, criminal justice, voluntary agencies
Engaged with Crisis and Home Treatment Team in excess of 6 weeks
Significant reliance on carer(s) or has own significant caring responsibilities
Experiencing disadvantage or difficulty as a result of: o Parenting responsibilities o Physical health problems / disabilities o Unsettled accommodation / housing issues o Employment issues when mentally unwell

Appendix 4:

Care Coordinator competencies

These competencies may be used as part of the induction process for new care coordinators, and they will assist with the identification of further learning needs. In addition, they may also be helpful for self-assessment, reflective practice, clinical supervision or audit purposes.

	Yes	No	Comments or action
1. Comprehensive Needs Assessment a) Assess mental health b) Identify potential psychiatric and psychological functioning and mental health needs and related issues. c) Identify the physical health needs of individuals with mental health needs. d) Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes of care.			
2. Risk Assessment and Management a) Develop risk management plans to support independence and daily living within the home. b) Assess needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others. c) Assess the need for intervention and present assessments of needs and related risks.			
3. Crisis Planning and Management a) Work with families, carer's and individuals during times of crisis. b) Respond to crisis situations.			
4. Assessing and Responding to Carer's Needs a) Work in collaboration with carer's in the caring role. b) Assess the needs of carer's and families of			

	Yes	No	Comments or action
individuals with mental health needs. c) Develop, implement and review programmes of support for carer's and families. d) Empower families, carer's and others to support individuals with mental health needs.			
5. Care Planning for Recovery and Review a) Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances. b) Plan and review the effectiveness of therapeutic interventions with individuals with mental health needs. c) Implement, monitor and evaluate therapeutic interventions within an overall care programme.			
6. Transfer of Care and Discharge a) Plan and implement transfer of care and discharge with individuals who have a long term condition and their carer's. b) Work with others to facilitate the transfer of individuals between agencies or services. c) Consider the known elevated risk around discharge, particularly of self-harm, and ensure safeguards are in place.			

Appendix 5:

CPA within Directorated

5a) CPA and Learning Disability

Services

Many referrals to the Learning Disability service do not fit the criteria for formal CPA and immediately are non CPA.

The information received via the referral process determines service response and which assessment is to be completed.

Clinical Care Pathways which have been developed will ensure that CPA and non CPA needs are addressed.

A lead professional will always be allocated to open, non CPA cases and details entered onto the service users EPR.

Those with a learning disability who will most likely benefit from the CPA process will be:

- L.D. plus severe mental illness
- L.D. plus severe challenging behaviour
- L.D / Autism associated with challenging behaviour
- L.D. plus personality disorder
- L.D. plus substance misuse
- L.D. plus vulnerability/safeguarding issues
- L.D. plus forensic issues
- or otherwise assessed, including assessment of risk that indicates suitability for CPA.

5b) CPA and Family, Young Persons and Children Services

Whilst FYPC must comply with the Trusts CPA policy, there may be certain circumstances where even in complex and high risk cases it is not appropriate to place a service user onto CPA.

Due to the age of CAMHS service users there are other formal frameworks which can be employed to ensure their protection, that the right services are being delivered, and that the process of delivery is monitored for example Child Protection Procedures, Child Assessment Framework, Multi- agency meetings and the standard CAMHS assessments address whole systems issues with families.

It is also accepted that all agencies working with this age group are commonly sharing information as normal practice.

FYPC staff must remember that age is not an exclusion criteria for CPA and the CPA determination tool for new referrals must be completed. Any decision for not placing a service user on CPA must be clearly recorded on EPR.

5c) Protocol for following CPA process for out-of-area

On Admission:

Admitting practitioner to establish if the service user is open to a CMHT and whether they are on CPA in the community. Ideally the out of area hospital will have this information at the point of referral, however if this is not the case please contact the Bed Management Team on 07826 891352 whereby the CMHT contact numbers can be provided for these details to be confirmed.

1. If the answer is yes, the out of area placement needs to inform the CMHT of the admission and provide them the ward details where the service user was admitted and who the named nurse is.

2. If on CPA, request that the CMHT send across a copy of the CPA care plan and put these on the service users EPR.

3. The out of areas assessment forms and risk assessment need to clearly identify that the service user is on CPA.

FIRST CPA / DISCHARGE REVIEW (service user / carer / relative, care co-ordinator / lead professional, GP and any other involved agency must be invited. If any unable to do so then their views must be obtained either verbally or written and documented).

1. Must take place within the first two weeks of admission.

2. Discuss the presenting and known risks and update the risk assessment, consider plan for therapeutic risk taking. Document everything. **Discuss**:

- How long is the service user likely to be in hospital for and set a planned discharge date?
- Is the service user suitable for an Early Discharge Plan with the Leicestershire Partnership Trust Crisis Team prior to discharge? To discuss their referral criteria please contact 0300 300 10 10 and select the option for the Home Treatment Team.
- Does the service user need to be on CPA upon discharge? If not, a clear rationale must be documented. A temporary Care Coordinator needs to be identified from within the team if remaining on CPA.
- Identify person to complete the 7-day follow-up upon discharge (please note that the Crisis Team can complete a 7-day follow-up for service user but this should not be the only reason for a referral to their team).
- Identify any barriers to discharge for example housing and / or benefits.
- Agree a clear post discharge plan
- Arrange next CPA / discharge review if required.

3. A copy of the completed review form to be given to all parties involved including The Bed Management Team. Document on EPR or on the CPA review form who copies have been sent too.

4. Discussion to take place about the best method of contacting the community team member regarding leave and discharge arrangements if they occur outside of the CPA review. Establish how weekly contact between the ward and CMHT is best achieved. If in doubt, please contact the Bed Management Team to explore who needs to be involved.

FIRST CPA / DISCHARGE REVIEW FOR SERVICE USERWITH NO COMMUNITY INPUT (service user / carer / relative and any other agencies involved must be invited to attend if any are unable to attend their views must be obtained in writing or verbally and documented).

1. Must take place within the first 2 weeks of admission.

2. CPA review form must be completed. Named nurse to commence CPA review form prior to meeting.

3. Identify the planned discharge date. Identify and discuss any barriers to discharge and whether the service user is suitable for Early Discharge Plan (see previous page for contact number).

4. Discuss at the review whether a referral for a community team is needed and contact the Bed Management Team for specific teams contact details. Referrals need to be completed providing a clear rationale for the referral and the service user's current presentation.

5. A copy of the completed review to be given to all parties involved and documented in the service user EPR.

DISCHARGE / CPA REVIEW

1. Practitioner to prepare relevant documentation prior to the meeting, involving all relevant persons
2. Ensure risk assessment is discussed and updated.
3. Clarify whether the service user is to be discharged on CPA and that there is a written rationale if not.
4. Ensure that a 7-day follow-up plan is in place and that it is documented who will be doing this.
5. Ensure a clear aftercare, crisis and contingency plan is in place
6. Clarify discharge address and GP details
7. Clarify discharge medication and if 14 days is required due to risk issues.
8. Discuss completing an Advance Statement of Wishes or personal safety plan with either the community worker or ward staff?
9. Document the CPA review and ensure that all parties involved receive a copy

including the GP.

10. If the CMHT are not present, ensure prior to the review that their views are documented and that they are informed of the outcome of the review either by phone.

5d) CPA and the Dynamic Psychotherapy Service

The nature of the therapeutic relationship within the treatment model in this service means that certain local adaptations to the Trust CPA Policy are necessary.

The process of both assessment and treatment in psychodynamic psychotherapy is non-directive and is focused on the service user's inner world. It would normally be assumed that referral for psychotherapy implies that a systematic and full assessment of a service user's health and social care needs has already been undertaken within primary or secondary care services. In the event of other, non-psychological needs becoming evident during the assessment, the psychotherapist will discuss with the service user how these might best be dealt with and what, if anything, might make it difficult for the service user to attend to these needs.

As the therapeutic relationship is the cornerstone of the work, psychotherapists have minimal contact with relatives and carer's, who are not included in assessment or treatment planning for psychotherapy.

Because in most instances service users within the service have an in-depth therapy with a single psychotherapist as their sole care plan, without the necessity to coordinate care between agencies, it is unusual for them to require CPA.

When other services are involved in the service user's care, it is usually appropriate for another agency to take the lead professional or care coordinator role (rationale: it is inappropriate for the psychotherapist to provide care outside of the weekly psychotherapy sessions and it is usually unhelpful for the psychotherapist to be directly concerned other aspects of the service user's care.

Similarly, since the goal of psychotherapy is first to contain the service user's disturbance within the therapeutic frame and then to move towards increasing autonomy and responsibility for their own world, it is usually inappropriate for the psychotherapist to be involved with the service user's external world or to prepare contingency plans other than the weekly provision of psychotherapy.)

Where service users are on CPA, because of complex needs or high levels of risk, they will require the input of a number of professionals. In these circumstances, psychodynamic psychotherapy may form part of the care package; however, the neutrality and preservation of therapeutic boundaries required by the therapeutic model preclude the psychotherapist from taking the role of Care Coordinator, so it is necessary that another professional involved in the care package is likely to be the "best placed" person to assume the role.

In order to safeguard the therapeutic boundary, it will not generally be appropriate for the psychotherapist to attend case conferences or be in open communication with other members of the care team, but each situation is considered in its unique

circumstances, in conjunction with the supervisor, the clinical director and/or consultant psychotherapist, as appropriate.

For service users on formal CPA, communication with the care coordinator may be helpful prior to therapy, or at the point of a change in CPA status (for example at CPA review). This will help to establish, clarify and agree the boundary between the psychotherapy service and the rest of the care team that will be in the best interests of the service users.

When agreed at a CPA Review that CPA and input from other services is no longer required, and input from the Dynamic Psychotherapy service is to continue, there must be agreement on the identification of the new lead professional. This must be recorded on service users EPR and the service user is fully informed.

In all cases, whether on CPA or not, any risk information which may affect the safety of the service user or another person, must be shared with the care coordinator or lead professional where this person is based in another service.

5e) CPA and Therapy Services for People With Personality Disorder

It is acknowledged that personality disorder is commonly associated with developmental problems with attachment issues, so consequently the way that individuals are transferred between services providing continuity of provision is essential for safe and effective transition between services.

National guidance and the Trust CPA policy states that the CPA care co-ordinator should be the person who is “best placed” to oversee the CPA care plan.

As the therapies offered, within Therapy Services for People with Personality Disorder, vary in intensity and length and are group based it is acknowledged that staff providing therapy may not be the person “best placed” to do this. The therapeutic frame of group therapy prioritises interpersonal learning occurring, in the here and now in the group situation, which may not always uncover issues pertinent to CPA, such as housing, finances, safeguarding.

Therapists convening CPA meetings with only some individual service users in the group, can skew the therapeutic relationships with the group in an unhelpful way, for instance creating envy, creating an identification with the sick role to gain staff attention, damaging the evenly suspended attention that the therapist holds for the group as a whole.

NICE guidance for BPD states that community mental health services should be responsible for the routine assessment, treatment and management of people with

borderline personality disorder.

In those instances where the therapy service provides group therapy for an individual but does not hold CPA care co-ordination, and where it is agreed that it is appropriate, staff from this service will be part of the care network and be involved with CPA reviews.

The principle that any change in CPA care co-ordination or lead professional is by agreement requiring a full handover between them is acknowledged”

5f) CPA and Huntington's Disease Services

Whilst the HD service complies with the trusts CPA policy there are specific referrals that do not fit the criteria for screening for CPA. These include:-

- Northampton HD Advisory Service. If there is a need for CPA, this is carried out by Northampton Mental Health Services

- Service users that are pre symptomatic of HD and wish to take part in Enrol HD research

- Service users at risk of HD who require a psychiatric assessment as part of the care pathway for genetic testing. Most of these clients, although not all are one off assessments.

All other clients within the HD service will be screened for CPA.

Appendix 6:

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual service users, their families and their carers	☐x
Respond to different needs of different sectors of the population	☐x
Work continuously to improve quality services and to minimise errors	☐x
Support and value its staff	☐x
Work together with others to ensure a seamless service for service users	☐x
Help keep people healthy and work to reduce health inequalities	☐x
Respect the confidentiality of individual service user and provide open access to information about services, treatment and performance	☐x

Appendix 7:

Stakeholder and Consultation

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
Dr G Kunigiri	Consultant Psychiatrist and Chair of CPA Standards Group
Heather Crozier	CPA Lead

Circulated to the following individuals for consultation	
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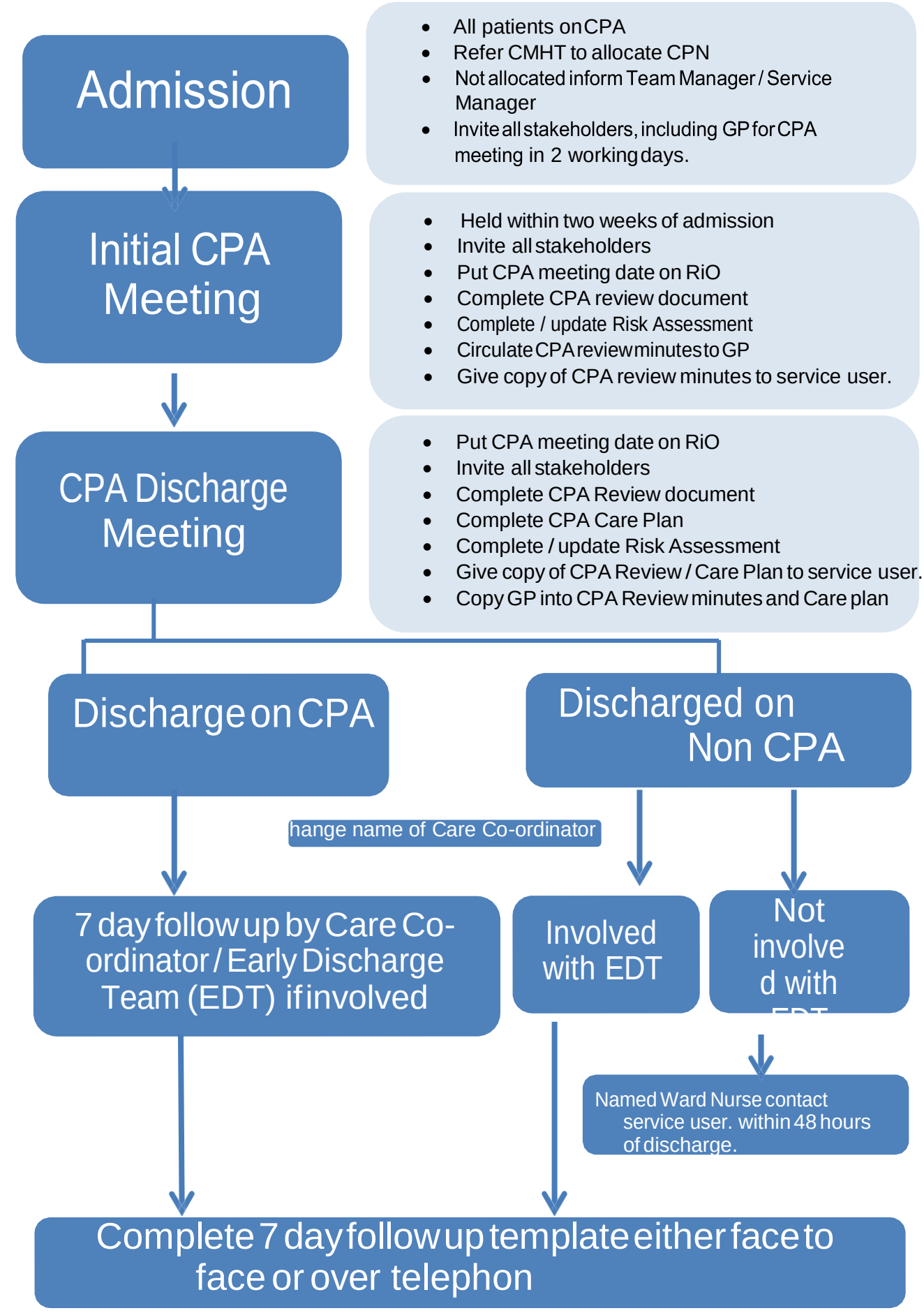
Jane Hasman	Senior Practitioner Assertive Outreach
Sandra Warden	Service user. Experience & Involvement
Sue Scarborough	Information Analyst Business Development
Michelle Churchard - Smith	Head of Nursing AMH LD
Fern Barrell	Risk Manager

Inpatient CPA Process Flow Chart



APPENDIX 9

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**CPA Policy**		
Completed by:	**Claire Armitage**		
Job title	**Deputy Head of Nursing**		**Date 08.11.21.**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	The only changes to this policy are three sections that have been added as follows: • CPA and clarification of the process for patients on a waiting list • Process for out of area patients - patients who are cared for 'out of area' are exempt from data collection relating to CPA performance • Care and Treatment Reviews (CTRs) for people with learning disabilities and autism – clarification of how CTRs will differ in emphasis and process from CPA
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For		No	

examples, health records, criminal records or other information that people would consider to be particularly private.		
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Data Privacy Impact Screening Guidance Notes

The following guidance notes should provide an explanation of the context for the screening questions and therefore assist you in determining your responses.

Question 1: Some policies will support underpinning processes and procedures. This question asks the policy author to consider whether through the implementation of the policy/procedure, will introduce the need to collect information that would not have previously been collected.

Question 2: This question asks the policy author if as part of the implementation of the policy/procedure**,** the process involves service users/staff providing information about them, over and above what we would normally collect

Question 3: This questions asks the policy author if the process or procedure underpinning the policy includes the need to share information with other organisations or groups of staff, who would not previously have received or had access to this information.

Question 4: This question asks the author to consider whether the underpinning processes and procedures involve using information that is collected and used, in ways that changes the purpose for the collection e.g. not for direct care purposes, but for research or planning

Question 5: This question asks the author to consider whether the underpinning processes or procedures involve the use of technology to either collect or use the information. This does not need to be a new technology, but whether a particular technology is being used to process the information e.g. use of email for communicating with service users as a primary means of contact

Question 6: This question asks the author to consider whether any underpinning processes or procedures outlined in the document support a decision making process that may lead to certain actions being taken in relation to the service user/staff member, which may have a significant privacy impact on them

Question 7: This question asks the author to consider whether any of the underpinning processes set out how information about service users/staff members may intrude on their privacy rights e.g. does the process involve the using specific types of special category data (previously known as sensitive personal data)

Question 8: This question asks the author to consider whether any part of the underpinning process(es) involves the need to contact service users/staff in ways that they may find intrusive e.g. using an application based communication such as WhatsApp

If you have any further questions about how to answer any specific questions on the screening tool, please contact the Data Privacy Team via
LPT-DataPrivacy@leicspart.secure.nhs.uk

7 DAY FOLLOW UP