

Care Coordination Policy

The Community Mental Health Framework (2019) proposed replacing the Care Programme Approach (CPA) and in July 2021, a position statement was developed by NHS E&I to support mental health providers to implement new models in line with the framework. This policy replaces the Trust's CPA policy with a new service user led, recovery-based approach for mental health and learning disability services.

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
One	11 th May 2022	First working draft
Two	22 nd July 2022	Second working draft – section added on reviews and extended section on discharge with flowchart added

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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 promotes 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, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

Definitions that apply to this Policy

Care Programme Approach (CPA)	The Care Programme Approach (CPA) was “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
Care coordination	Care coordination synchronizes the delivery of a person’s health care from multiple providers. The goals of care coordination are to improve health outcomes by ensuring that care from disparate providers is not delivered in silos.
DIALOG	DIALOG is an 11-question survey which people with a mental health problem are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment domains. The information may be used to evaluate or measure the person’s recovery journey.
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 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 regular reviews of their care plan. Review dates should be set with the service user and with carers (with the service user’s permission). Review dates must be written onto the service users care plan. Service users and carers can request a review of their care at any time.
Care Coordinator	Under the old CPA policy, the Care Coordinator had “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”.
Lead Professional	Under the old CPA Policy, 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”

Key Worker	The key worker is someone who can form a therapeutic alliance with the person, and whom the person trusts and connects with.
Advance Statement of Wishes	A Statement of Wishes (preferences) although not legally binding, must be considered 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 Integrated Care Boards (ICBs) to manage a register of people with learning disability and/or autism who are at risk of admission to a mental health inpatient user 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 Purpose of the Policy

The Community Mental Health Framework, published in September 2019, proposed replacing the Care Programme Approach (CPA) for community mental health services, and in July 2021, a position statement was developed by NHS England and NHS Improvement to support mental health providers to implement new models in line with the framework. This policy aims to provide a framework for implementation of a new service user and carer recovery led approach within LPT.

The Community Framework makes clear that one of its purposes is to enable services to shift away from an inequitable, rigid, and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare. A flexible and personalised approach following comprehensive assessment means that coordination of care can be tailored to an individual's needs, what matters to them, the views of carers and professional judgment. The new framework does not mean taking away any positive aspects of CPA and the new system of care will pull up the standard for all.

2.0 Summary and scope of policy

The term CPA is now no longer being used and will be replaced with care coordination for all service users who receiving services from LPT.

This policy includes feedback from service users about what they want to see as part of their care and provides guidance to staff about working in a more flexible and service user recovery focused way.

3.0 Introduction

CPA has had a central role in the planning and delivery of secondary care mental health services for almost 30 years, and it was originally introduced to provide greater shape and coherence to local services' approaches to supporting people with severe mental illnesses and or complex presentation requiring a multi-agency approach, in the community; it was based on care coordination, care planning, regular review, and case management. The principles underlying CPA are sound and there has been some excellent work over the years in implementing and improving it, however, it has not been updated for almost 15 years and community mental health policy and practice have evolved significantly.

From early on, doubts were raised about CPA – principally, that it attempted to unite a model of resource allocation with one for clinical care delivery and planning, and that it created a two-tier system in which a person is either 'on' or 'off' CPA. Its role has been further complicated by its close association with risk management. Several attempts have been made to evaluate its impact but have failed to provide convincing evidence for its effectiveness. This is perhaps not surprising as it is as much a policy document as an intervention that could be subject to formal evaluation.

Considerable debate has centred around who is eligible or not for the CPA, which usually focuses on diagnostic, cluster or complexity-based tools and it has also become viewed as a bureaucratic, time-consuming process that diverts staff attention away from the delivery of care to the organisation and review of care. The Care Quality Commission recently reported that there is a large variation in the proportion of people on the CPA between trusts, with figures that ranged from 3% to 73% of service users from different mental health trusts who responded to the annual community mental health survey (CQC, 2018).

The Community Framework makes clear that one of its purposes is to enable services to shift away from an inequitable, rigid, and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare. The Framework proposed “replacing the care programme approach (CPA) for community mental health services, while retaining its sound theoretical principles based on good care coordination and high-quality care planning”.

Care coordination is important work and has often been under-appreciated as a function which should provide high quality care to service users, often within an outmoded and historically resource-constrained system. While many service users find care co-ordination valuable – and while care co-ordination may form a significant part of the overall support that someone with a severe and complex mental health problem receives – care coordination is not a meaningful intervention in and of itself.

A flexible, responsive, and personalised approach following a high-quality and comprehensive assessment means that the level of planning and co-ordination of care can be tailored and amended, depending on:

- the complexity of an individual’s needs and circumstances at any given time.
- what matters to them and the choices they make.
- the views of carers and family members.
- professional judgment.
-

The new framework does not mean taking away any positive aspects of CPA and given the CQC’s (now Integrated Care Boards (ICS) regular findings from community mental health surveys that people on CPA report better experiences of care, the new system of care should be pulling up the standard for all.

The aim of care coordination is to provide high quality care planning, support and ensuring that the care plans and interventions are delivered and are effective.

Fully involving the service and family/carer as well as other key individuals in decision making and using evidence based best practice to guide/aid recovery with a view to either discharging from services or transferring to other appropriate services as when required.

The new approach is based on the following five broad principles:

1. A shift from generic care co-ordination to **meaningful intervention-based care** and delivery of high-quality, safe, and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care.
2. **A named key worker for all service users with a clearer multidisciplinary team** (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care coordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.
3. **High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community:** a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (e.g. section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.
4. **Better support for and involvement of carers** as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.
5. **A much more accessible, responsive and flexible system** in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.

3.1 National metrics and related guidance

The position statement clarifies that specific reference to CPA from the 2021/22 Contract has been removed. This follows amendment in 2020/21 of a key Standard Contract mental health metric on 7-day follow-up from people on the CPA discharged from inpatient user care to 72-hour follow-up for all service users discharged from inpatient user care. NHS England and NHS Improvement is working with NHS Digital to amend the data currently collected in the Mental Health Services Data Set (MHSDS).

There are no national requirements for providers to use the CPA, nor are there any remaining metrics within national datasets relating to the CPA that are reported on or

used for any purpose, including in the NHS Oversight Framework. The position statement requires Provider Boards, ICBs and other local governance groups including ICSs to review the metrics they report relating to the CPA with a view to stopping their collection and reporting, thereby reducing the unnecessary administrative burden on provider staff.

Within LPT Directorate of Mental Health Services, monitoring of reviews of 72-hour contacts will continue but 7 day follow ups will cease. The Directorate of FYPC/LD will continue to monitor both 72-hour contacts and 7 day follow ups. These will report directly to both the Care Coordination Standards Group and the Clinical Effectiveness Group.

3.2 Feedback from service users and carers

As a fundamental element of the development of the policy, feedback was obtained from service users and carers through discussions at the LPT recovery cafes in March and April 2022 where there was a focus on care planning and CPA/care coordination.

The main headlines of the feedback were as follows:

- the need for greater personalisation in the care process
- the benefits of a named contact person
- the need for a more friendly and proactive response to managing 'did not attends' (DNAs)
- a question about the resources available to us for this work
- the suggestion of a central hub to signpost to services
- consideration of the care navigator role and how this could further support service users
- the need to put more resources into social prescribing, rather than the quick fix of medication

Service users were asked the following:

What is your experience of CPA?

Feels like everything has already been decided for me.

Lack of understanding on what care plan reviews are

Should be holistic, looking at a persons physical/mental and social circumstance needs

Links to the neighbourhood and community settings

Should include everyone involved/friends and family members who know you when you are well

What is your knowledge of CPA?

Not present/people don't know me

I do not feel part of the process

Didn't know I was on it until I had been sectioned

You don't have a voice

Feels like the wheels fall off from the start

What is your experience of care planning?

I have never seen mine

Not been mentioned for a long time

I have asked, but its all about time (lack of time)

Clinicians are overworked and overloaded

Feeling like discussions have already been had without you

How should care be reviewed?

To have discussions and feel part of the decisions made

Clinicians' workload does not dictate how the care is delivered

Give patients a voice and to be listened to

Know the full picture and make it meaningful

Permission and choice

3.3 High-quality co-produced, holistic, personalised care and support planning.

There is little evidence to suggest that the implementation of the CPA has led to high quality care planning when it is used, and in general there is a need for services across the country to significantly improve the quality and relevance of care planning for people with moderate to severe mental health problems. While the type of plan and the level of support needed will depend on the person and their individual needs, ensuring that all care and support plans are genuinely co-produced, personalised, and Care Act compliant and integrated with Mental Health Act section 117 plans where necessary should be a key aim.

This should help to ensure efficiency and minimise the administrative burden on all health and social care staff, as well as improve care.

In line with the NHS comprehensive model of personalised care, service users should be encouraged to be owners of the information within their care plan, be familiar with its content and feel confident to request reviews and amendments should circumstances change.

Care plans should include the actions that the service user undertake, that carers and/or family members might undertake, and the actions services will undertake to support them. They should include flexible and revisable timescales for review depending on agreement between the MDT, service user and carer/family where appropriate, as opposed to within a long and arbitrary timeframe (currently six or 12 months).

Care plans should reflect the service user's individual needs rather than generic service policies or processes. There should be brief, clear documentation and follow-up of agreed actions, given the centrality of trust to any positive therapeutic relationship.

In digitised form they should be live, easily available and accessible both in terms of language and format (to service users, carers, family members and all agencies involved in someone's care) and updated regularly as agreed with the service user.

The care planning process and its outputs should be viewed as fundamental parts of the meaningful care that services seek to provide, rather than a box-ticking exercise, and should be linked to routine outcome measurement (DIALOG) or a suitable alternative.

NICE (2021) published guidance on shared decision making stated that "shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example, through advance care planning. It involves choosing tests and treatments based both on evidence and on the persons individual preferences, beliefs and values/ It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing/ This joint process empowers people to make decisions about the care that is right for them at that time (with the options of choosing to have no treatment or not change what they are currently doing always included).

3.4 Care coordination and the process for service users on a waiting list.

The Trust is committed to regular review of the safety of service users 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 service users being entered onto a waiting list:

- Robust prospective clinical triage
- Regular reviews of the waiting list by service management and clinicians through Service user Tracking Lists
- Clear process for reprioritisation or reallocation if clinical presentation changes or is escalated.

- Clear information to ensure that service users are fully aware and understand their rights, what to do if their situation deteriorates and how to access supportive resources whilst waiting.

For adult mental health services once the assessment has been completed and if the service user has been accepted and immediate allocation is not possible, a safety plan will be co-produced by the service user and the assessing clinician, and the service user will be supported through the waiting list process.

For older person mental health services, the service user is allocated at the point of assessment and intervention commenced and they are taken off the waiting list.

If a service user is open to another service within the Trust, their key worker will remain the same.

If a service is not known to any other service within the Trust and it is not possible to allocate a key worker straight away, they will have an open team referral but no named lead key worker. 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.

3.5 Lead Professional/Care Coordinator and Key Worker

The term Lead Professional and Care Coordinator will no longer be used.

All service users will have a named key worker.

Continuity of care is something that professionals and service users all want to achieve in mental health services. Service users and carers should therefore have clarity as to who they can contact via having a named key worker; in most cases we expect this would be the existing care coordinator for people already under their care of services.

All parties should share clear expectations around communication and best practice would be a key worker who can form a therapeutic alliance with the service user, and whom the service user trusts and connects with.

At the same time, services need to adopt clearer MDT-based approaches by ensuring that named key workers and patients are supported by a robust MDT integrated with social care and the VCSE, which helps to address people's social needs as well as their clinical needs, rather than the system of care relying on a single care coordinator coping with an overwhelming workload. The move away from a generic care coordinator role is also an important step in supporting all staff to perform the roles they qualified in and went into their professions to undertake, allowing them to apply their unique skills in supporting individuals as part of an MDT, such as in nursing, social work, or occupational therapy.

This means that services should not respond to this statement by simply rebadging care coordinators as key workers; the purpose of designating key workers is to ensure that a service user can build a consistent, trusted relationship with an individual who

understands their history and who can support the service user to engage with the care and support available through a therapeutic alliance.

Every member of the MDT should play a prominent role in sharing responsibility for an individual's care and it should be the Key worker as a whole plays the coordinating role across the various organisations and sectors from which its members are drawn (e.g: nursing, social care, occupational therapy, employment/vocational support, housing, substance use, VCSE).

A fully personalised approach also allows providers and ICSs to take a population health approach by determining what different care spells or care packages look like for different people with different presenting needs and circumstances at a given point in time.

3.6 Out of Area Service Users

Service users who are cared for 'out of area' (for example, in a specialist residential or inpatient user placement such as locked rehab etc. – note that this would not apply to an acutely ill service user who is temporarily accommodated out of area in a private facility on a short-term basis) will continue to be allocated to a key worker from LPT (Learning Disability and Autism services now have an allocated TCP Case Manager for this role)

There is no expectation for the key worker to contact the out of area provider other than if, or when, plans are put in place to repatriate the service user back to LPT services. At this point, the key worker will re-establish this role to support a smooth transition. Service users in this situation are exempt from data collection.

Learning Disability and Autism Services have a discharge care co-ordination pathway through the Learning Disability and Autism Collaborative and will be allocated a key worker from LPT at the point of commencing on the discharge pathway.

3.7 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 Integrated Care Board (ICBs) 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 user setting. The relevant health service needs to identify that a person is at risk of admission to a mental health inpatient user 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 ICB 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 ICB 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>

CTRs provide the following:

- 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>

3.8 Service Interface and Discharge.

High quality care coordination and planning is the underlying principle regarding transfers and discharges for service users requiring input. Communication is of vital importance; therefore, all services should offer robust and seamless input/coordination for the service during their period of care and recovery.

3.9 Transfers:

Timely and effective management of care transfers is a key part of service users care and continuity of care, particularly when transferring between services and out of area.

The transfer process is not solely the responsibility of the key worker. Discussion, and decision making should be shared both within the team and external agencies, this is dependent on good communication between key individuals and agencies involved at the time with each service user. Transfers can be considered as between services and between trusts, including out of area services or with prisons or longer stay rehab units. Transfers could also be considered as short-term input by another Trust or team (for example Intensive Home Treatment) or out of area in the event of a service user moving to another area either permanently or temporarily.

Unless the service user is being discharged the key worker responsibility for will remain with the originating team. Discharges and transfers should be managed in accordance with the Trust's Policy for the Planned Discharge/Transfer of Service users from In-Service user Services and Discharge/Transfer SOP's appropriate to the service involved in the process at that time.

In the event of an out of area admission the key worker must keep in regular weekly contact with the admitting ward.

When discharging service users from an inpatient user setting the ward must ensure that they follow the discharge process / pathway which will include liaising with the relevant community mental health team.

Likewise, the community mental health team must keep in contact with the ward to enable a smoother transition and discharge from the ward to aid continuity of care.

When transferring between services the key worker must remain involved until the transfer is complete and will have responsibility for overseeing the service user's care.

3.10 Rehabilitation Services:

For those service users being admitted to an LPT rehabilitation unit for an agreed time scale (which is over 3 months) the service user will be discharged from the community team and their key worker will remain with the inpatient/rehab setting.

Upon discharge if community input is required the rehab ward/unit will make a referral back to the appropriate team with a minimum of 3 months' notice.

3.11 Both transfer and discharge:

On discharge and transfer – it is the responsibility of the discharging team and allocated key worker to ensure all services attached to the service users care are informed of any transfers out of the team and correspondence with the GP must be carried out with a full account of the service users progress and needs.

If at the point of discharge from inpatient settings, no key worker has been identified, this role defaults to the manager of the receiving team. Under all circumstances, the receiving team should be involved in the discharge planning.

3.12 Leave (inpatient LPT)

For service users going on leave from in-patient care,

For either short term or long-term extended leave, a plan of care for that period of leave should be in place, this plan must outline a clear rationale and timescale as well as include a crisis and contingency plan.

The responsible clinician or their deputy should be immediately informed of any significant deterioration or breakdown of the plan whilst the patient is on leave.

Regular contact should be maintained with service users on leave. This responsibility rests with the inpatient team, however it may be delegated to the community team, or the Crisis team (following discussion and agreement). Consideration should be given to informing the GP if the service user is going on extended leave, this can be achieved through sending information electronically through System one to the service users registered GP.

Where it is not possible to contact service users on leave the consultant psychiatrist and care team must consider and document what action to take based on their knowledge of the service user and any risks. The Responsible Clinician should consider formally requesting the service user return to hospital if required.

If a service user is open to a community team and going on leave, the ward must ensure that this is communicated to the community team, and that any additional such as depot administration is handed over.

3.13 Discharge from services;

The overall aim of input from mental health services whether this is admission or input from crisis services or community teams is recovery for the individual, it is not expected that service users will remain under the care of mental health services indefinitely, when their needs can be met in primary care, therefore discharge from mental health services should always be a goal for those admitted either into inpatient settings or community teams and care planned at the point of admission.

At each review, it should be considered whether the service user needs FURTHER INPUT or a key worker upon discharge from an inpatient setting, the automatic default should not be yes as the aim of admission and input from the community team should be recovery

During the service users' recovery, the level or complexity of a service users' needs will possibly reduce and while the clinical process of care planning and review does not change. However, if a high level of input continues to be required to maintain the service user's health and wellbeing needs then a key worker and input from community services will be required.

Recovery means different things to different people. For some people recovery means aiming to be symptom free. Or others it might mean managing their mental health to be able to live a meaningful life. Recovery can be short-term or long-term thing.

If the service user is discharged from a service and no longer requires a key worker, there should be a comprehensive discharge summary with all relevant information to

the service users registered GP. A crisis and contingency plan should be in place for the service user in the event of a relapse in their mental health.

3.14 Carers

A key element of a person's recovery and care coordination is that it recognises the importance of service user's wider social relationships to their well-being and recovery. A key aspect of the key workers 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 may be in receipt of carers allowance or attendance allowance or do it as voluntary work. Carers 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 carers 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 carers 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 must actively seek to always identify and support carers, staff must also record on the Electronic Patient Record (SystemOne) 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 carers 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 / them 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 capacitous consent must be sought before any information relating to their mental health is shared with their carer, unless risk / safety factors or lack of mental capacity, relevant to the decision to be made, 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 capacitous 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, carers 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 care coordination process, there will be others who care "for" the service user. The partner agencies all recognise the importance of supporting carers – those who care for people.

The carer should be informed that records will be kept including their personal details. Capacious 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 carers 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 carers are under 18, their needs require 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 carers should be shared with the child.

The carer can share his / her / them, own view, and any other information he / she /they, 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 care coordination 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

3.15 Review

A review may be a planned meeting, a series of conversations or a more formal meeting that puts the service user at the centre. The method of the review can be flexible, providing it maintains the core principles of care coordination. The decision on how to review care should be led by the service user and include all individuals involved with their care/ treatment and recovery as much as is practicably possible and rationale for decisions made should be documented within the EPR.

Whereas in the previous CPA policy, CPA reviews were required be completed and shared to all identified stake holders within 14 days of taking place, this was only relevant to service users subjected to CPA, with the expectation that those subject to non-CPA would have a yearly review and correspondence usually in the form of a clinic letter from the outpatient's department would be sent.

The aim of the review is to discuss and update the care plan, risk assessment, outcome measures, social and economic factors and to review Section 117 aftercare (where applicable).

The review is a structured, yet flexible process and service users have the right to request a review at any time. However, the general requirement now is that a review should take place at regular intervals outlined on the service users care plan, taking into consideration service user choice, complexity of identified needs, planned outcomes and any risk factors. The discussion from the review should be written in the review section of the care plan.

Service users who have been admitted to hospital must have a review within the first 2 weeks of admission. If the service users is an inpatient for more than six months, they will have reviews at least every six months, dependent on need. A review must also take place prior to discharge from an inpatient setting, transfer of care into another team, in or out of area, to formally handover care and all relevant information. All attempts must be made to hold the review in a timely manner, and overdue reviews must be prioritised. The review is the responsibility of the registered staff who have written the care plan, and they need to ensure that everyone involved in the service user's care has had the opportunity to contribute. The care plan must be updated to reflect any change resulting from a review and a copy given to the service user.

Following the review, a copy of the updated care plan must be given to the service users and any other relevant others (with service users consent). A supporting letter should also be produced which highlights the changes to the care plan and the reasons why.

Section 117 after-care reviews can be reviewed within the review process. It is recognised that however that the support for some people who remain entitled to Section 117 after-care is straight forward and does not require care coordination 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. The Mental Health Act Code of Practice chapter 33 states "33.20 the duty to provide after-care services exists until both the CCG (now ICB) and the local authority are satisfied that the patient no longer requires them".

3.16 Top tips for reviews

Given the isolation and anxiety caused by the Covid-19 pandemic, it has never been more important to ensure that the needs of service users are reviewed and supported. Key Workers can start to plan this process by talking to service users to ask them how their needs can best be met at this time.

A review does not necessarily need to be a formal meeting, and it can be a series of conversations brought together in the completion of the review template. Options for participating can be shared with the service user as a starting point, and service users may wish to get involved by submitting written feedback, dialling into a meeting on their mobile phone or through a nominated advocate or carer. It is important that efforts to contact all involved are captured and that conversations are accurately documented to record if they are face-to-face or by telephone etc. It may also be helpful to document any restrictions imposed by Covid-19.

Some clinicians have had great success with video platforms, such as Attend Anywhere and Microsoft Teams, both of which are approved for use by the Trust. Attend Anywhere has an MDT function, and up to six participants can be involved in a virtual meeting; for larger groups, Microsoft Teams can be used. This platform will not be suitable for all, but for those service users who are open to the idea but lack resources or confidence, consider a safe way to offer support if possible. Clinicians will need to follow the usual procedures around confidentiality and information governance and more information and guidance can be found in the attached video consultation SOP.

3.17 DIALOG.

The chosen method of reviewing service user's treatment and recovery goals will begin with Dialog. Dialog is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas: they'd like further support with, or of concern, or that are going well. The information may also be used to evaluate or measure the person's recovery journey. The data can be used as part of the patient reported outcome measure.

The ability to understand how the care provided to a person with a mental health illness is impacting on their outcomes is a fundamental part of routine clinical practice. Intuitively clinicians and services will have a sense of this as part of the everyday care they provide. However, to support clinical practice, improve service user experience and drive quality improvement, outcomes data needs to be collected and interpreted

The Dialog survey asks service users to rate their satisfaction from 1 (totally dissatisfied) to 7 (totally satisfied) for the following 11 areas, the first 8 being about their quality of life and the remaining 3 their satisfaction with their medication and the service they are receiving from LPT:

- Mental Health
- Physical Health
- Job Situation
- Accommodation
- Leisure Activities
- Partner/ family
- Friendships
- Personal Safety
- Medication
- Practical Help
- Meetings

The Dialog Survey should be sent via a text including the link to the survey, to all service user as soon as they are accepted into service for treatment (please refer to Dialog SOP for full detail.) Opportunity for those that are digitally excluded or unable to complete this independently should be given during the appointment.

It should then be agreed collaboratively with service users and referenced within the care plan how often this should be revisited, however this should be a minimum of yearly. The appropriateness of how often will be individual based on the treatment and recovery goals and anticipated length of offered intervention from LPT.

All service users should have the opportunity to complete their Dialog survey at the beginning and end of their treatment episode and there should be evidence of at least one further for review during, where appropriate.

Review dates must be agreed and documented within the care plan, and the care plan evaluation should indicate any needs highlighted by Dialog and any changes in scores as appropriate.

Care plans should then be shared with service users, their carers, and all involved stake holders within 14 days of completion and subsequent reviews providing the service user has consented.

Risk assessments should also be updated to reflect any information captured on the review process, in line with the Trust Risk Assessment policy.
Wrap around care.

When service users have been shown Dialog Training and Information Videos initial feedback was very positive with the below points made:

- Contacts will be more focussed
- The results will help to foster conversations between service users, and all involved with their care about their treatment and recovery goals
- Highlights what is the most important to the service user so that goals can be set accordingly and in a manageable way.
- Provides a voice to service users
- An easy and visual tool (can be hard to find words to explain sometimes)
- Can be positive for service users to visually see the improvement
- Holistic
- Gives the service user ownership of their care
- Will be beneficial for service users returning to services to provide a comparison.
- Inclusive and accessible to all.

DIALOG will only be used for those services users who have a functional mental health problem or have the capacity to understand the tool.

Risk Assessment – refer to Clinical Risk Assessment Policy

Care Planning – refer to Care Planning Policy (currently being written)

Information sharing - refer reader to relevant policy.

4.0 Flowchart/process chart

Please see appendix 1 for the flow chart to support discharges from inpatient settings. There are also details of team/ward contact emails and telephone numbers.

5.0 Duties within the Organisation

5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2 The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies.

5.3 The Clinical Effectiveness Group is the committee that has the responsibility for this policy.

5.4 Divisional Directorate Directors and Heads of Service are responsible for ensuring that comprehensive arrangements are in place regarding adherence to this policy within their own service in line with the guidelines in this policy and maintaining a system for recording those policies and procedures have been distributed to and received by staff.

5.5 Managers and Team leaders are responsible for ensuring that the 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; and ensuring that a system is in place for that keeps staff up to date with the policy and any recommended related training.

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

5.7 Responsibility of Clinical Staff - Consent

- Clinical staff must ensure that capacitous consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Such consent can be given verbally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

- If the service user's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following.
 - o Understand information about the decision
 - o Remember that information
 - o Use the information to make the decision
 - o Communicate the decision.

Best interests' decisions may need to be made if a service user is not able to consent.

6.0 Training

Care co-ordination will replace the CPA training and will incorporate DIALOG implementation. This will be role essential training and will be every 3 years.

7.0 Monitoring Compliance and Effectiveness

There will be regular DIALOG and care planning audits to monitor compliance and ensure this policy is embedded into practice.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
3	All service users will have a key worker assigned to them	All team managers, Clinical leads to monitor monthly	Via team performance S1 reports	Quality and Safety meetings or equivalent	Bi-Monthly
3.16	All service users will be offered DIALOG (excluding organic service users)	Managers and individual professionals	Via team and individual staff S1 reports performance reports	Quality and Safety meetings or equivalent	Bi-Monthly
3	All service users will have a care plan	Managers and individual professionals	Via individual staff S1 performance reports from S1 and AMaT audits for review of the quality-of-care plans.	Quality and Safety meetings or equivalent	Bi-Monthly
3.1	All service users will have regular reviews	Managers and individual professionals	Via individual staff S1	Quality and Safety	Bi-Monthly

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	of their care plan		performance reports	meetings or equivalent	

8.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
NICE Shared Decision Making NG197	

9.0 References and Bibliography

The policy was drafted with reference to the following:

Care Programme Approach (CPA) Health Service Circular/Local Authority Circular HC (90)23/ LASSL (90)11

Care Programme Approach. NHS England and NHS Improvement position statement. PAR 526 (2021)

Care Quality Commission (2018) Community Mental Health Survey. Statistical Release. Newcastle upon Tyne: Care Quality Commission; 2018

CPPA (1999) Effective Care Coordination in Mental Health Services - Modernising the Care Programme Approach

DIALOG SOP (2022) Leicestershire Partnership NHS Trust

Leicester, Leicestershire and Rutland Step up to Great Mental Health <https://greatmentalhealthllr.nhs.uk/>

National Collaborating Centre for Mental Health (2019) The Community Mental Health Framework for Adults and Older People

Appendix 1

Discharge process from Learning Disabilities Inpatient Services

A patients discharge process must follow the NHSE 12-point discharge plan. This identifies a patients journey from admission to discharge.

In line with recommendations from the Winterbourne View and subsequently the transforming care programme, a discharge plan must be identified on admission. An estimated discharge date would be set at their admission care coordination review.

For those with a learning disability and/or autism a patient would be supported under the transforming care programme (TCP), whereby external services monitor and support a patient throughout their admission.

At all stages within a patients discharge their voice should be included and the process should be collaborative if the patient has capacity to consent. Family members or carers should also be included in this process especially in cases where a patient lacks capacity. They should be supported to understand the process and have choices offered around any new accommodation found.

Those who lack the capacity to make choices around change of accommodation and have no family or friends to support them should have the services of an IMCA.

All patients who are discharged from a learning disabilities inpatient area (i.e. the Agnes Unit) will have a key worker. All patients who are discharged from a learning disabilities short breaks home will have a key worker if this is the arrangement within the community setting.

For patients eligible for Section 117 aftercare, Community Treatment Order, Guardianship or Deprivation of Liberty implications for future placement, the implications of this will be discussed in the discharge meeting.

Provide information in an accessible format according to assessed individual needs. i.e. Care plans.

The inpatient pathway should be followed throughout the inpatient stay and links maintained with any other learning disability pathways the patient may be on.

On discharge the relevant learning disability pathways will be used according to assessed need.

The discharge care coordination review will finalise details of:

- Accommodation
- Funding agreements
- The care package.
- Key worker
- Community team involvement
- Agree the discharge care plan.
- Provide discharge pack
- PROMS
- Update the Clinical Risk Assessment on SystemOne

- Agree how 7 day follow up will be completed.
- Agree first post discharge care coordination review meeting date
- Agree first post discharge outpatient clinic appointment with psychiatrist.
- Complete discharge letters
- Complete SystemOne discharge

All relevant agencies, professionals, family/carers and the patient should be invited to attend the discharge care coordination review meeting. Those professionals unable to attend should provide a report when appropriate.

A client/patient is ready for discharge when the following has been agreed:

- A clinical decision has been made that the client/patient is ready for discharge as they have met the goals/outcomes agreed.
- To be monitored and have weekly discussions with the collaborative team i.e. ICB, ASC
- The client/patient is safe to discharge.

This has been discussed with the multidisciplinary team (MDT) where MDT involved, and agreement made that the client/patient is ready for discharge.

Process for Discharge

The patient and carer facilitator will work with patients to make sure their voice is included. They will also work with their relatives and/or carers to encourage them to work in partnership with the MDT on discharge planning.

Patients should be informed of the planned discharge and a copy of the discharge care plan should be given to them. Information should also be given on what to expect following discharge to include any arrangements for reviews and follow-up appointments by others. All this information should be given verbally and followed by an appropriate written format.

Where a care company has been identified to continue with care after discharge, a patient will need to undergo a transition which would include staff becoming competent with knowing the patient through direct observations and training e.g., workshops.

A discharge summary should be sent within 14 days of the patient being discharge from hospital. A copy of this is uploaded in the patient's notes.

A patients discharge summary should be sent to:

- Patient (if they have capacity) and an accessible format should be provided (if needed)
- Registered GP
- Task using Systemone the community teams, to uploaded documents.

A patient/carer should be provided with a discharge pack prior to discharge with the following information included:

This list is not exhaustive:

- Discharge Summary: Patient details e.g. legal status, discharge information, next of kin, GP, Inpatient MDT, Community MDT, Medication, Past Medication, Allergies,
- History: Medical, Social
- Health Action Plans
- Physical Observations
- Weight, Height, BMI
- Concerns and Management
- Blood Results
- Relationships: Who is important and how to sustain those relationships
- Discharge care coordination review minutes
- Risk Assessment
- Eating and drinking recommendations
- Positive Behaviour Support Plan
- Emergency Grab Sheet
- PRN Protocol
- Crisis and Contingency Plan
- LD Annual Health Check
- Follow up arrangements by other professionals within the service

LD Outreach Involvement:

The LD Outreach will accept a referral from an inpatient unit for support with transition and on discharge. The referral should be made when a discharge date is set.

LD Outreach will attend any discharge planning meetings.

LD Outreach can support inpatient staff with planning and delivering workshops to new providers.

LD Outreach will work in partnership with the community teams to provide support to the patient once discharged. The team will visit to monitor the patient, placement and care provider post discharge.

LD Outreach will provide crisis support/intervention on the telephone or face to face if required during weekends and evenings.

LD Short Breaks:

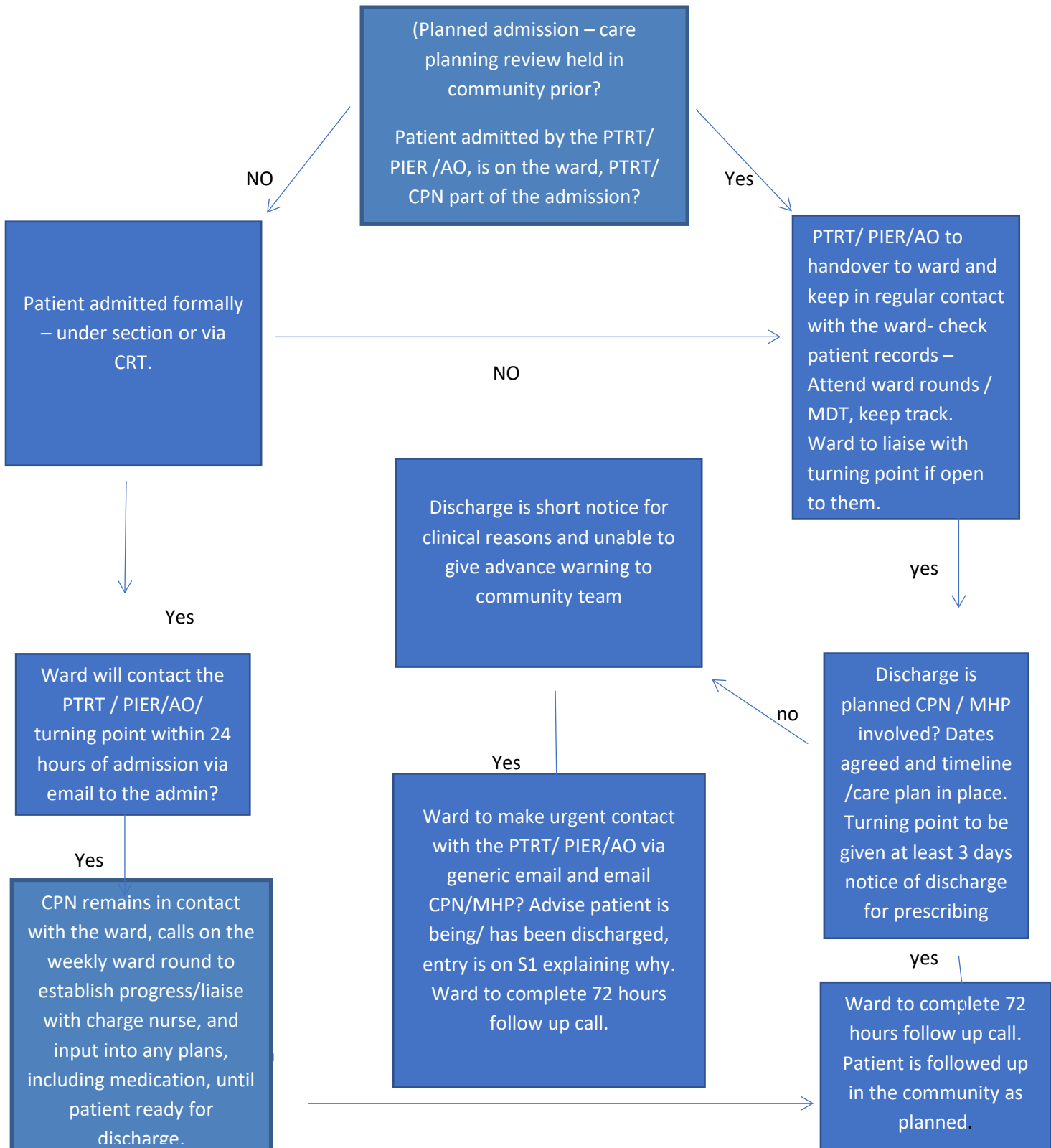
At the admission phone call, a discharge is planned, and the date is set. A referral is opened. Other things such as medication and confirmation of the length of stay is also confirmed during this phone call.

All patients will have care plan which documents the procedure for being discharged. At the end of a patient's admission, the patient will take all their belongings home. The area is cleaned, and the discharge letter is completed. The referral is then closed.

PTRT/PIER/AO - INPATIENT ADMISSION AND DISCHARGE CONTACT AND CONTINUITY PROCESS.

Patients **open** to the PTRT/ PIER/ AO will be expected to have continued input from the PTRT / PIER / AO during their stay on the ward, this may be or include accessing S1 for information, attending MDT ward rounds or making contact with the wards for updates on progress and an estimated discharge date.

The ward will take responsibility for ensuring any unplanned discharges are managed and that the PTRT or key worker is notified, via the attached admin email addresses.



Psychology

Further Support/guidance

If a service user is already open to a psychologist in the community, the Psychologist will contact the inpatient psychology team to discuss at admission. The inpatient Psychologist will contact the service user's Psychologist in the community team at discharge."

If a service user is open to the PTRT but not working with a psychologist in the community but has been seen by the inpatient psychology team during their admission, the inpatient Psychologist will contact the CPN to handover at discharge."

Ward Point of contact is through the Charge Nurses/ Ward Sisters or via the generic email as below:

Heather ward: lpt.heatherward@nhs.net

Bosworth Ward: lpt.bosworthward@nhs.net

Beaumont Ward: lpt.beaumontward@nhs.net

Watermead Ward: lpt.watermeadward@nhs.net

Thornton Ward: lpt.thorntonward@nhs.net

Ashby Ward: lpt.ashbyward@nhs.net

Unit Matrons can be contacted via switchboard.

Community Teams

Perinatal: lpt.PerinatalReferrals@nhs.net

PIER: lpt.pierteam@nhs.net

Forensic: lpt.forensiccmht@nhs.net

ADHD: lpt.adultadhdservice@nhs.net

Charnwood CMHT: lpt.admincharnwoodcmht@nhs.net

City Central CMHT: lpt.AdminCityCentralCMHT@nhs.net

City East CMHT: lpt.AdminCityEast@nhs.net

City West CMHT: lpt.AdminCityWest@nhs.net

East Leicestershire CMHT: lpt.AdminEastLeics@nhs.net

North West CMHT: lpt.AdminNWLeicsCMHT@nhs.net

South Leicestershire CMHT: lpt.AdminSouthLeics@nhs.net

West Leicestershire CMHT: lpt.adminWLeicsCMHT@nhs.net

Assertive Outreach: lpt.assertiveoutreach@nhs.net

Forensic Community: HPC-ForensicCommunity@leics.nhs.uk

Psychology: lpt.BradgatePsychology@nhs.net

Leicestershire Partnership NHS Trust Mental Health Services for Older People CMHTs And Inpatients and Specialist Teams	
CMHT	Phone / Email
City East CMHT Merlyn Vaz Health and Social Care Centre 1 Spinney Hill Road Leicester LE5 3GH	Main Tel: 0116 225 5964 Email: mhsopcmhtcityeastgen@nhs.net
City West CMHT The Bennion Centre Glenfield Hospital Glenfield Groby Road Leicester LE3 9DZ	Main Tel: 0116 295 6036 Email: lpt.mhsop.citywestcmht@nhs.net
Memory Service East / Young Persons Memory Service The Evington Centre Gwendolen Road Leicester LE5 4QG	Main Tel: 0116 225 6143 Email: lpt.mhsopmseast@nhs.net
Memory Service West The Bennion Centre Glenfield Hospital Groby Road Leicester LE3 9DZ	Main Tel: 0116 225 2775 Email: lpt.mhsopmswest@nhs.net
Central Referral HUB and Unscheduled Care Service Neville Centre Gwendolen Road Leicester LE5 4PW	Main Tel: 0116 295 6894 Email: llr.mhsop@nhs.net Lpt.llr.mhsopucsclinicians@nhs.net
In-Reach Team Neville Centre Gwendolen Road Leicester LE5 4PW	Main Tel: 0116 295 3151 Email: mhsopcmhtinreachteam@nhs.net
Integrated Care Mental Health Springfield Road Health Centre Springfield Road Leicester LE2 3BB	Main Tel: 0116 225 6779 Email: Lpt.icmht@nhs.net
MHLS (Formally known as Fopals) Level 4, Windsor Building Leicester Royal Infirmary Infirmary Square Leicester. LE1 5WW	Main Tel: 0116 258 5587 Email: lpt.mentalhealthliaison@nhs.net
South Leicester CMHT The Neville Centre LGH Site Gwendolen Road	Main Tel: 0116 295 3154 Email: Lpt.mhsop.sleicscmht@nhs.net

Leicester LE5 4PW	
(Melton, Rutland and Harborough) CMHT Melton Mowbray Hospital St Mary's Birth Centre Thorpe Road Melton Mowbray Leicestershire LE13 1SJ	Main Tel: 01664 854950 OP Tel: 01162 957838 Email: lpt.mhsop.mrhcmht@nhs.net
Charnwood CMHT Entrance 3 Loughborough Hospital Hospital Way Off Epinal Way Loughborough Leicestershire LE11 5JY	Main Tel: 01509 568680 Email: lpt.mhsop.charnwoodcmht@nhs.net
West Leicestershire CMHT Hynca Lodge Tudor Road Hinckley Leicestershire LE10 OEW	Main Tel: 01455 443 634 Email: lpt.mhsop.westleicscmht@nhs.net

MHSOP Wards

ORGANIC WARDS	
Coleman on Wakerley The Evington Centre Gwendolen Road Leicester LE5 4QG	Tel: 0116 225 1444
Gwendolen ward The Evington Centre Gwendolen Road Leicester LE5 4QG	Tel: 0116 225 5791
FUNCTIONAL WARDS	
Kirby Ward Bennion Centre Groby Road Leicester LE3 9DZ	Tel: 0116 295 4115 / 0116 295 4145 Tel: 0116 295 4115
Welford on Ashton Bennion Centre Groby Road Leicester LE3 9DZ	Tel: 0116 295 6356/ 57/62 Tel: 0116 295 6352 Tel: 0116 295 6356

Beechwood	Rehab	Tel: 225 6140	Fax: 225 6149	SYSTEM ONE
Clarendon	Rehab	Tel: 225 1550	Fax: 225 1489	SYSTEM ONE

RECEPTIONS

BENNION	Glenfield Hospital	Tel: 225 2750	Fax: 225 2770
BRADGATE	Glenfield Hospital	Tel: 225 2650	Fax: 225 2651
EVINGTON	General Hospital	Tel: 225 1001	Fax: 225 1003

Appendix 2

Training Requirements

Training Needs Analysis

Training topic:	Care Co-ordination
Type of training: (See study leave policy)	<input type="checkbox"/> Mandatory (must be on mandatory training register) <input checked="" type="checkbox"/> Role specific <input type="checkbox"/> Personal development
Directorate (s) to which the training is applicable:	<input checked="" type="checkbox"/> Adult Mental Health & Learning Disability Services <input type="checkbox"/> Community Health Services <input type="checkbox"/> Enabling Services <input checked="" type="checkbox"/> Families Young People Children <input type="checkbox"/> Hosted Services
Staff groups who require the training:	All clinical staff
Regularity of Update requirement:	Every 3 years
Who is responsible for delivery of this training?	Clinical trainers within DMH and FYPC
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	<input checked="" type="checkbox"/> ULearn <input type="checkbox"/> Other (please specify)
How is this training going to be monitored?	Via workforce training reports

Appendix 3

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 <input type="checkbox"/>
Respond to different needs of different sectors of the population	X <input type="checkbox"/>
Work continuously to improve quality services and to minimise errors	X <input type="checkbox"/>
Support and value its staff	X <input type="checkbox"/>
Work together with others to ensure a seamless service for service users	X <input type="checkbox"/>
Help keep people healthy and work to reduce health inequalities	X <input type="checkbox"/>
Respect the confidentiality of individual service users and provide open access to information about services, treatment, and performance	X <input type="checkbox"/>

Appendix 4

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Claire Armitage	Deputy Head of Nursing
Mat Williams	Community Matron
Melanie Brown	Practice Development Nurse
Jacqui Newton	Community Matron
Haley Cocker	Patient Experience and Involvement Manager
Sandie Warden	Patient Experience and Involvement Coordinator

Circulated to the following individuals for comment

Name	Designation
Michelle Churchard-Smith	Deputy Director of Nursing and Quality and Head of Nursing MHD
Jane Martin	Deputy Head of Nursing
Simon Guild	Deputy Head of Nursing
Saskya Falope	Deputy Head of Nursing
Bernie Crawley-Nash	Deputy Head of Nursing
Dr Sam Hamer	Associate Medical Director
Dr. Ian Randall	Clinical Director
Dr. Sam Tromans	Consultant Psychiatrist - LD
Dr. Vesna Acovski	Clinical Director
Louise Short	Service Manager
Tracy Bessant	Service Manger
Helen Rutter	Service Manager
Claire Pope	LD Matron
Colin Bourne	Matron
Dawn Holding	Team Manager
Dave Hunt	Interim Team Manager
Lynn Wroe	Trainee MPAC
Vicky Noble	Trainee MPAC
Jane Capes	Matron
Rebecca Colledge	DMH Lead Allied Health Professional
Jon Crossley	Consultant Clinical Psychologist
Jenny Dolphin	Clinical & Quality Governance Lead
Tracy Ward	Head of Patient Safety
Jo Nicholls	Patient Safety Manager and Interim Serious Incident Lead for DMH
Alison Kirk	Head of Patient Experience and Involvement

Due Regard Screening Template

Section 1			
Name of activity/proposal		Care Coordination	
Date Screening commenced		25/11/2022	
Directorate / Service carrying out the assessment		Directorate of Mental Health	
Name and role of person undertaking this Due Regard (Equality Analysis)		Jacqui Newton Deputy Head of Nursing DMH	
Give an overview of the aims, objectives, and purpose of the proposal:			
AIMS: The aim of this policy is to ensure that Care Coordination is consistently applied to all areas/services who will be required to implement care coordination.			
OBJECTIVES: The document describes how the services implements care coordination via training			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	No negative impact identified		
Disability	No negative impact identified		
Gender reassignment	No negative impact identified		
Marriage & Civil Partnership	No negative impact identified		
Pregnancy & Maternity	No negative impact identified		
Race	No negative impact identified		
Religion and Belief	No negative impact identified		
Sex	No negative impact identified		
Sexual Orientation	No negative impact identified		
Other equality groups?	No negative impact identified		
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 <u>tick</u> appropriate box below.			
Yes		No <input checked="" type="checkbox"/>	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4. <input checked="" type="checkbox"/>	
Section 4			
If this proposal is low risk, please give evidence or justification for how you reached this decision:			
No negative impacts were identified with regards to protected characteristics			
Signed by reviewer/assessor	Jacqui Newton	Date	25/11/2022
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
Head of Service Signed		Date	

Appendix 6

DATA PRIVACY IMPACT ASSESSMENT SCREENING

<p>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.</p> <p>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.</p>		
Name of Document:	The Care Coordination Policy	
Completed by:	Jacqui Newton	
Job title	Deputy Head of Nursing	Date 25/11/2022
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 more than what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information more than 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 examples, health records, criminal records, or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
<p>If the answer to any of these questions is 'Yes', please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk</p> <p>In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</p>		
Data Privacy approval name:		
Date of approval		

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