Leicestershire Partnership NHS Trust



Care Coordination Policy

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Policy on a page

Summary and aim

Add details – what is this policy for?

Target audience

This policy is for all staff working in DMH and FYPC/LDA however, the following services are excluded from working to this policy as they will continue to work to the CPA framework. The services are Forensic services (inpatients and community). Adult Eating Disorders and Perinatal Mental Health Services.

Training

All staff must familiarise themselves with this policy during their induction period which should include a discussion with their line manager about how this policy is implemented into the service. DIALOG+ training will be provided to all services across DMH. CAMHS and LDA services will provide training relevant to the outcome measures used in the service.

This policy should be part of any starters induction.

Key requirements

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1.0 Introduction

The Mental Health Personalised Care Framework: The Modern Care Programme Approach (2026) is NHS England's updated approach to coordinating care for adults and older people with severe mental health problems. It replaces the more process-driven aspects of the traditional Care Programme Approach (CPA) with a stronger emphasis on personalised, relationship-based care that focuses on "what matters" to the individual.

1.1 Purpose and Scope

The framework aims to ensure that people receiving secondary mental health services have:

- Greater choice and control over their care and treatment.
- Consistent, coordinated support across services.
- Strong therapeutic relationships with staff.
- Timely reviews and access to help when their needs change.
- Care that is based on their strengths, goals, preferences and lived experience.

2.0 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 (Amendment) Regulations 2023 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, gender reassignment, ace, religion or belief, marriage and civil partnership, pregnancy and maternity, sexual orientation and sex.

3.0 Abbreviations and definitions that apply to this Policy.

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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
DIALOG+	DIALOG+ is an intervention specifically designed to make routine patient-clinician meetings therapeutically effective. The intervention is based on quality-of-life research, concepts of patient-centred communication and principles of solution-focused therapy. It seeks to ensure that the patient-clinician communication is effective in facilitating and promoting positive change. DIALOG+ consists first of an assessment of the patient’s satisfaction with eight life domains and three treatment aspects and an indication of their wishes for more help in each area.
Assessment	All patients 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 patient.
Review	All patients are entitled to regular reviews of their care plan. Review dates should be set with the

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	patient and with carers (with the patient's permission). Review dates must be written onto the patients care plan. Patients and carers can request a review of their care at any time.
Key worker	The key worker is someone who can form a therapeutic alliance with the person, and whom the person trusts and connects with, they are responsible for ensuring the person has a care plan and is regularly reviewed. It can be any registered member of staff involved in the patients care.
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.
PCREF	The Patient and Carer Race Equality Framework (PCREF) is NHS England's mandatory anti-racism and accountability framework designed to eliminate racial inequalities in mental health services.

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4.0 Purpose and Introduction

The Mental Health Personalised Care Framework: The Modern Care Programme Approach (2026) is NHS England's updated approach to coordinating care for adults and older people with severe mental health problems. It replaces the more process-driven aspects of the traditional Care Programme Approach (CPA) with a stronger emphasis on personalised, relationship-based care that focuses on "what matters" to the individual.

CPA is now no longer being used for the majority of services and will be replaced with care coordination for all patients who receiving services from LPT. There will be some services that will continue to work under the CPA Framework, and this are listed in this below.

The CPA will continue to be used in the following services:

- Adult Eating Disorders
- Perinatal Mental Health
* Forensic Mental Health Services

This policy supports delivery of the NHS England Patient and Carer Race Equality Framework (PCREF) by promoting culturally responsive, person-centred care coordination and reducing inequalities in access, experience and outcomes for people using mental health services.

5.0 Duties and responsibilities

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

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

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

4. Divisional Directorate Directors, Heads of Service, Head of Nursing are responsible for ensuring that comprehensive arrangements are in place

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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. Managers, Deputy Heads of Nursing, Matrons 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.

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.

Responsibility of Clinical Staff – Consent

Clinical staff must ensure that 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 patient'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.

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.

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- Communicate the decision. Best interests' decisions may need to be made if a patient is not able to consent.

National metrics and related guidance

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/LDA will continue to monitor both 72-hour contacts and 7 day follow ups. These will report directly to the Clinical Effectiveness Group.

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

The NHS England Mental Health Personalised Care Framework (2026) has four core principles.

1. Every person has a personalised care and support plan

The plan should:

- Reflect the person's current needs, strengths, goals and preferences.
- Be developed collaboratively with the individual and, where appropriate, their carers or family.
- Include physical health, mental health, social needs, recovery goals and crisis planning.

2. Every person has a named professional responsible for coordinating care

The framework emphasises the importance of:

- A clearly identified key worker who takes lead responsibility for coordinating care.
- Building a trusted and continuous therapeutic relationship.
- Acting as a key point of contact for the person and professionals involved in their care.

3. Care plans are reviewed when needed

Reviews should:

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- Occur routinely and whenever circumstances change.
- Support rapid re-entry into services if a person's mental health deteriorates.
- Ensure care remains relevant and responsive.

4. Experience and outcomes matter

A new addition to traditional principles is the focus on:

- Understanding the person's experience of care.
- Measuring outcomes that matter to the individual.
- Using feedback to improve care and services.
- Ensuring the patient's voice is central to decision-making.

3.4 Implications for Mental Health Services.

Services are expected to:

- Deliver trauma-informed, recovery-focused care.
- Work in partnership with people, carers and communities.
- Integrate support across NHS, social care and voluntary sector providers.
- Ensure assessment, safety planning and risk management are personalised and proportionate.
- Promote continuity of care and therapeutic relationships.

3.5 What This Means for Patients

People using mental health services should be able to expect:

- A personalised care and support plan.
- A named professional who knows them and coordinates their care.
- Regular reviews and quick access to support when needed.
- A genuine opportunity to influence decisions about their care and have their experience listened to.

In line with the Patient and Carer Race Equality Framework (PCREF), care planning and care coordination should actively consider the impact of ethnicity, culture, faith, language, migration experience and experiences of discrimination or racism on an individual's mental health, access to services, experience of care and recovery outcomes. Care plans should reflect the person's cultural identity, strengths, preferences and support networks where relevant.

3.6 Care plans.

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In line with the NHS comprehensive model of personalised care, patients 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 circumstance change.

Care plans should include the actions that the patient undertakes, 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, patient and carer/family where appropriate however, all care plans must be reviewed annually if they have not been reviewed previously.

Care plans should reflect the patient'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 patients, carers, family members and all agencies involved in someone's care) and updated regularly as agreed with the patient.

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).

All patients should be given a copy of their care plan. Carers/family members and anyone else involved in the patient's care can be given a copy of the patients care plan (with the consent of the patient) or if deemed to be in the persons best interests.

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Care coordination 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:

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

For adult mental health services once the assessment has been completed and if the patient has been accepted and immediate allocation is not possible, they will receive an action plan which will be co-produced by the patient and the clinician, and the patient will be supported through the waiting list process. For NMHTs the action plan will be co-produced with the Community Connector.

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

If a patient 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 that the patient, carer or family member can access the clinical duty worker (or similar system) within office hours to respond to queries from anyone who rings up for support.

Team Managers will hold overall responsibility for monitoring waiting lists. Patients must be made aware of the safe whilst waiting resources on the Trust website.

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Lead professional/care coordinator and key worker

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

NHSE Care Programme Approach position statement (March 2022) stated that all patients will have a named key worker with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators 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.

Continuity of care is something that professionals and patients all want to achieve in mental health services. Patients and carers should therefore have clarity as to who they can contact via having a named key worker.

All parties should share clear expectations around communication and best practice would be a key worker who can form a therapeutic alliance with the patient, and whom the patient 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 clinician 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 patient can build a consistent, trusted relationship with an individual who understands their history and who can support the patient to engage with the care and support available through a therapeutic alliance. A key worker can be any registered clinician who is working with the patient.

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

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(e.g.: nursing, social care, occupational therapy, employment/vocational support, housing, substance use, VCSE).

In line with the Patient and Carer Race Equality Framework (PCREF), named key workers and multidisciplinary teams must consider how racism, discrimination, cultural identity, language, faith, migration experience and wider social and economic inequalities may influence a person's experience of mental health, access to support, therapeutic relationships and outcomes. Services should work collaboratively with patients, carers and communities to identify and address barriers to equitable care and improve experiences and outcomes for people from racialised communities.

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.

Out of area patients

Patients 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 patient who is temporarily accommodated out of area in a private facility on a short-term basis) will not need to continue to have an allocated key worker from LPT (Learning Disability and Autism services now have an allocated TCP Case Manager for this role).

If the patient requires repatriate back to LPT services, the OOA placement will be required to make a referral into the relevant service. At this point, a key worker will re-establish this role to support a smooth transition. Patients 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.

Care and Treatment Reviews for people with learning disabilities and autism

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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. A CTR can be triggered if a patient is nursed in long term segregation and seclusion.

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.

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

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Service Interface and Discharge

High quality care coordination and planning is the underlying principle regarding transfers and discharges for patients 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.

Transfers

Timely and effective management of care transfers is a key part of patients 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 patient. 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 patient moving to another area either permanently or temporarily.

Unless the patient 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/Transition of Patients from In-Patient Services and Discharge/Transfer/ Transition SOP's appropriate to the service involved in the process at that time.

In the event of an out of area admission (for patients experiencing an acute episode) the key worker must keep in regular weekly contact with the admitting ward.

When discharging patients 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. The key worker must also maintain contact with the patient whilst they are an in-patient.

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

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Rehabilitation Services

For those patients being admitted to an LPT rehabilitation unit for an agreed time scale (which is over 3 months) the patient 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.

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 patient's 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 patients progress and needs.

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

Leave (inpatient LPT)

For either short term or long-term extended leave, a pre leave risk assessment and 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 patients on leave.

This responsibility rests with the inpatient team; however, it may be delegated to the community team, or the Crisis team, LD CRIST team or CAMHS ICST (following discussion and agreement). Consideration should be given to informing the GP if the patient is going on extended leave, this can be achieved through sending information electronically through System one to the patients registered GP.

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

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If a patient 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.

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 patients 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 patient 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 form the community team should be recovery.

During the patients' recovery, the level or complexity of a patients' 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 patient'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 patient 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 patients registered GP. A crisis and contingency plan should be in pace for the patient in the event of a relapse in their mental health.

Carers

A key element of a person's recovery and care coordination is that it recognises the importance of patient'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 patient and, where possible, to ensure that the right people are involved in the assessment and

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care planning process. Patients have a right to the involvement and support of other people where they wish it.

Services should ensure that carers from diverse ethnic, cultural and faith backgrounds have equitable access to information, involvement and support. In line with PCREF, staff should recognise and respond to any barriers that may affect engagement, communication or access to carer support services.

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 patient.

Staff must actively seek to always identify and support carers, staff must also record on the Electronic Patient Record (SystmOne) any people identified that patient'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 patient. The patient may not want their carer to be contacted. In these situations, staff are advised to explore the patients 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 patient'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.

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If a patient still refuses to give their capacitous consent, and there is no overriding responsibility in terms of risks then the patient's wishes must be respected. The rationale for refusing consent must be recorded in the patient's EPR. However key workers or other staff can liaise with carers even if they do not share information and they can listen to any information the carer wants to give them.

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 patient and who the patient may wish to be involved in the care coordination process, there will be others who care "for" the patient. 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. Capacitous 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 patient's life and ask if they are involved in providing any care.

The aim should be to provide the right support to the patient 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 patient has given permission or not.

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

Throughout the episode of a patients, staff must be mindful of the needs of the patient's family / network and where any needs or issues are identified, further reference for

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guidance may be obtained in other Trust policies including Adult Safeguarding Policy, Children Safeguarding Policy or Domestic Violence Policy.

Carers may also benefit from advocacy services to help support them. Advocacy services can be found through use of the JOY website which covers LLR.

Review

A review may be a planned meeting, a series of conversations or a more formal meeting that puts the patient 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 patient 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.

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 patients 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 patients care plan, taking into consideration patient 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. Care plans should be reviewed on a regular basis, a maximum being every 12 months.

Patients who have been admitted to hospital must have a review within the first 2 weeks of admission. If the patients are 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 patient'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 patient.

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Following the review, a copy of the updated care plan must be given to the patients and any other relevant others (with patients 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”.

Top tips for review

Key workers can start to plan this process by talking to patients 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 patient as a starting point, and patients 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.

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 patients 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.

DIALOG+

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DMH has chosen DIALOG+ as the PROM for reviewing patient's treatment and recovery goals which will begin with a Dialog outcome measure. 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 patient 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 patient experience and drive quality improvement, outcomes data needs to be collected and interpreted.

The Dialog survey asks patients 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 outcome measure should be sent via a text including the link to the outcome measure, to all patient 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 patients and referenced within the care plan how often this should be revisited, however this should be a minimum of yearly.

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The appropriateness of how often individual will be based on the treatment and recovery goals and anticipated length of offered intervention from LPT.

All patients should have the opportunity to complete their Dialog outcome measure 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 patients, their carers, and all involved stake holders within 14 days of completion and subsequent reviews providing the patient 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.

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

DIALOG+ will be used as an overarching approach along with 5Ps formulation for Adult Mental Health and functional patients in Mental Health Services for Older People (MHSOP). This also supports trauma informed ways of working whereby we can acknowledge that current difficulties may be understood int eh context of what has happened to someone. Most interventions however will be focus on the present and will look to adjusting any unhelpful cycles of what is perpetuating a person's difficulties in the present time, through use of medication and psycho-social interventions.

Dementia assessments and interventions may still take aspects from DIALOG+ and the 5Ps formulation, however, other bespoke assessments and formulation approaches, can be used that fit with the need of that clinical population.

Goal-Based Outcomes (GBOs) are a person-centred outcome measure used within Learning Disability and Autism (LDA) Community services to assess progress towards goals that are meaningful to the individual. Goals are agreed collaboratively with the person, and where appropriate their family or carers, and are scored on a scale from 0 to 10, with higher scores indicating greater progress towards achieving the goal. GBOs support personalised care by focusing on outcomes that matter most to the individual, rather than solely on clinical symptoms, and can be used to demonstrate change over time, evaluate the effectiveness of interventions, and inform ongoing care planning.

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The Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD) is used in LDA inpatient services to assess an individual's health and social functioning. It evaluates a range of domains, including behaviour, impairment, symptoms, social relationships, activities of daily living, and environmental factors, enabling clinicians to measure clinical need and monitor change over time. HoNOS-LD scores are completed at key points during an inpatient stay.

HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents) and Goal-Based Outcomes (GBOs) are core outcome measures used across mainstream CAMHS teams to evaluate clinical progress and service effectiveness. HoNOSCA provides a clinician-rated assessment of a young person's mental health, behaviour, impairment and social functioning across a range of domains, offering a standardised measure of clinical outcomes over time. GBOs complement this by capturing progress towards personalised goals that have been collaboratively agreed with the young person and, where appropriate, their family or carers.

In addition to the core outcome measures used across services, specialist and therapy services may use additional outcome measures that are tailored to the specific needs of the population they support and the interventions they provide.

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.

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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 SystmOne
- 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 SystmOne 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:

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- 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 then 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 Systmone 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:

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- Discharge Summary: Patient details e.g. legal statue, 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.

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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 belonging's home. The area is cleaned, and the discharge letter is completed. The referral is then closed.

Appendix Two: Governance

Version control and summary of changes

Version number	Date	Description of key change
Version 1	11th May 2022	
Version 2	22nd July 2022	Section added on reviews and extended section on discharge with flowchart added
Version 3	20th July 2023	Added which teams will stay on CPA and clarified the role of CPA in inpatient areas
Version 4	14th November 2024	Changes to target audience
Version 5	9th April 2026	Added to new SOP template
Version 6	19th August 2026	Review of whole policy and update

Responsibilities

Responsibility	Title
Executive Lead	*Linda Chibuzor*
Policy Author	*Jacqui Newton*
Advisors	*Saskya Falope, Dr. Hamer.*
Policy Expert Group	*CEG*

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Key individuals involved in developing and consulting on the document

- Jacqui Newton
- Mel Brown
- Saskya Falope
- Simon Guild
- Zahra Makhany
- Jon-Paul Vivers
- Zayad Saumtally

Governance

Governance Level	Name
Level 1 Assurance Oversight	*CEG*
Level 2 Delivery Group for policy approval and compliance monitoring	*Quality Forum*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
72 hour reporting compliance	Report to CEG monthly.

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Training Requirements

Please explain what relevant training is available for staff to support the understanding and implementation of this policy.

Training is recognised as a critical control measure in minimising risks associated with healthcare delivery. Ensuring that staff possess the appropriate knowledge and skills significantly reduces the potential for errors, omissions, and unsafe practice.

Managers

- Assess the training needs of staff to ensure they are equipped to meet the expectations set out within this policy.
- Facilitate staff access to all relevant training required for safe and effective compliance with this policy.
- Ensure all staff complete mandatory and role-essential training in line with Trust policy.
- Where gaps in available training are identified, collaborate with the policy author or subject matter expert to develop and agree a training or development plan.

Staff

- Maintain compliance with all mandatory and role-essential training as required by Trust policy.
- Identify any personal learning needs necessary for the safe and effective implementation of this policy, and work with your manager to agree an appropriate training plan to meet these needs.

Relevant training currently available to equip staff to deliver the requirements of this policy

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Training topic title	Source of training e.g. ulearn, CPD

References

The policy was drafted with reference to the following:

The Mental Health Personalised Care Framework: The Modern Care Programme Approach (2026)

Monitoring arrangements should include consideration of the Patient and Carer Race Equality Framework (PCREF), including review of patient and carer experience, access, engagement and outcomes across different ethnic groups where such data is available. Findings should be used to identify and address inequalities and support continuous service improvement.

Signatures for relevant staff to sign

I confirm that I have read and consider myself to be sufficiently trained in the above Standard Operating Procedure with regards to my individual roles and responsibilities

Signature of Trainee …… Date ……

I confirm training in the above SOP was delivered as recorded above and that the trainee may be considered sufficiently trained in their roles and responsibilities.

Signature of Trainer …… Date ……

. Additional Notes & Signatures

Signature of Trainer (where appropriate)

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I confirm training in the above SOP was delivered as recorded above and that the trainee may be considered sufficiently trained in their roles and responsibilities

Signature of Trainer …… Date …….

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