TRUST WIDE CARE PROGRAMME APPROACH POLICY
(INCLUDING ARRANGEMENTS FOR STANDARD CARE PLAN)

Date effective from: 1st May 2014
Review date: 28th April 2016
Version number: 3.0

See Document Summary Sheet for full details
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Care Programme Approach Development Manager (seconded) |
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(List, by title, the people this procedural document is essential for) | Responsible Clinicians, Approved Clinicians, Clinical Service Managers, Clinical Team Managers, Care Co-ordinators, Clinical Staff, Health Records Staff, Administration Staff working with Care Co-ordinators and Mental Health Act Managers  
Local Authority managers  
Partner organisations managers  
Trust Wide mental health workforce |
| **Responsible for dissemination**: | Care Programme Approach Development Manager |
**DOCUMENT AMENDMENT SHEET**

Please record what changes you have made to the procedural document since the last version.

This is a summary of changes to the document and is designed to show people exactly what has changed. The version number recorded below should correspond to the ratified version number shown on the Document Summary Sheet.

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Comments from consultation
To reflect use of different assessments across LYPFT
Comments from Social Care
Comments received from consultation
Comments from consultation with social care
Comments received from consultation
Comments received from consultation
Comments received from consultation
Comments received from consultation
Comments received from consultation
Comments received from consultation

Comments received from consultation
To reflect this may not be someone with a mental health background.

Following comments by Means Goal 1 & 2
|  | person/people/individuals to replace 'service user(s)'.
|-----------------------------------------------|
| Appendix A 117 guidelines –logos inserted; strengthened wording from Code of Practice
| Updated consultation matrix
| Feedback from York County Council
| To enhance clarity of consultation/involvement in progression of Policy

| 2.8 | ‘Key Principles of Effective Risk Management and CPA’ wording amended to reflect emphasis on co-production of safety plans.
| Amends to circumstances when a sec 117 planning meeting would be held.
| In response to feedback from Effective Care meeting 16th Jan 2014 |
1 Executive Summary

This Trust Wide policy is intended to describe how the organisation will implement the national standards regarding Care Programme Approach. CPA comprises collaboration with the individual in assessment, care planning, review and care coordination; it supports the individual’s wellbeing and recovery journey.

People can be referred for assessment and possible treatment within LYPFT from a variety of sources. Once the referral has been received by the appropriate team, there is a clear procedure to follow. It begins with a comprehensive assessment of needs which includes a risk assessment. Information must be obtained from the individual, and from other sources, which may be from carers or others the service user is close to, and from statutory or voluntary sector. There are issues about consent to share information regarding collating information, but the assessment would appear to be the best place to initiate this important conversation (subject to individuals’ capacity to consent to this).

Following assessment, and identification of needs (including risk issues), a range of interventions needs to be drawn up collaboratively with the person. The interventions may range from what services can offer, to what the service user can do for themselves. It is important that the person is central to this process, as are any carers (subject to consent of the person), as this engenders a partnership arrangement between individual (and carers) and staff, as opposed to staff imposing interventions on the individual. There may be cases where this isn’t possible due to acute presentation, but once a person is more amenable to staff help, efforts must be made to make the ‘planning’ of interventions collaborative.

After a range of interventions appropriate to need has been agreed with the person and where appropriate carers, they need to be implemented. Interventions must have a goal/outcome conducive to recovery, and must give an approximate time scale for completion. It is vital that everyone knows who will provide what intervention, when, and where.

A review of the interventions and progress towards wellbeing needs to be reviewed, at least annually, but other stages of the person’s route through services would indicate a review should be held (e.g. moving from one service to the next; deterioration in mental state; reduction of impact of illness). Anyone involved in the delivery of support or interventions can call a review, however, not everyone involved has to attend a meeting, as long as information is available to inform decisions about future interventions.

The appointment of a Care Co-ordinator or Lead professional must be done at the earliest opportunity, usually after assessment and multi-disciplinary discussion. The responsibility to carry out the other aspects of the process then falls to this nominated person.
2. THE PROCEDURE

2.1 Description of Procedure/Process

.01 Values and Principles

This policy has been developed to take account of the following values and principles that underpin the policy:

- Provision of Choice and Personalised Care.
- People should be at the centre of everything we do
- Promoting a safe and supportive framework
- Enabling a socially inclusive recovery and well-being approach
- Is person-centred in the way it operates and people with mental health problems who have a learning disability are empowered by the process
- Clear and accessible care plans are developed, agreed and shared with people
- Ensuring that care plans value and reflect individuals’ needs, preferences, diversity and their own wishes
- Ensuring the well being of children or other vulnerable people associated with the individual
- A recognition of the role of carer’s and their rights to an assessment
- A recognition of the role of advocacy and statutory required advocacy
- Supporting integrated health, social care and third sector services.
- Best practice involving all agencies, including the identification of care pathways
- Ensuring comprehensive assessment and identification of any unmet needs
- Supporting assessment and care planning that provides a central focus for information about the individual and about their immediate and longer term needs
- Supporting people to improve their lives and improve their health.
- Enabling prevention and early detection of health needs and healthy living choices.
- Ensuring risk assessment, risk management and crisis and contingency planning is undertaken. Facilitating regular care plan reviews
- Ensuring continuity in care, treatment and support. Providing documentation that is appropriate to need and function
- Supporting the workforce to deliver high quality care
- Measuring and improving quality
- Supporting use of outcome measurement tools as agreed within each service

CPA is an involving process; at its core is the partnership between the individual and Care Co-ordinator. The qualitative value of this partnership cannot be overstated in its contribution to the success or otherwise of the process. Wherever possible all care should be agreed and arrived at via a
process of open discussion and agreement within the context of the recovery approach.

This approach to individuals’ care and support puts them at the centre and promotes social inclusion, recovery and well-being. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. When carrying out assessments and devising care plans, staff should always consider the individual within the context of their family and social circumstances.

Carers and significant others should be encouraged to be involved in the care planning process where this is relevant and acceptable to the individual.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care. CPA offers a clear signal that people accessing support will be able to take an active part in agreeing the outcomes they want through producing their own care plan, advance statement and developing their own recovery strategies.

As carers form a vital part of the support required in aiding a person’s recovery and well-being; their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships, engagement and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between the person and the Care Co-ordinator is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews (DH 2008).

Individuals will know the names and roles of those providing their care, treatment and support and have contact details and telephone numbers.

CPA will promote assisted assessment, self-directed support and the development of personalised budgets through the assessment, care planning and review process. The role of the Care Co-ordinator is crucial in promoting personalised budgets, supporting the individual and assisting in the navigation of services available.

People will be supported to make informed decisions about the services on offer and have sufficient information to enable them to exercise this choice.
Any children in the family will have their needs and possible caring responsibilities considered and their welfare safeguarded, this must be through a joined up working approach with relevant children’s services in accordance with the LYPFT Child Protection policy and local interagency procedures. Any CPA meetings will include a multiagency approach to ensure the needs of children are adequately assessed. The care coordinator is responsible for coordinating this.

.02 Mental Capacity Act

The principles of the act must be taken into account when incorporating this policy into practice

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise

- The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions

- That individual’s must retain the right to make what might be seen as eccentric or unwise decisions so long as they have capacity to make that decision.

- Best interests – anything done for or on behalf of people without capacity must be in their best interests; and

- Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms

.03 Human Rights Act

The Human Rights Act came into effect in October 2000 which means that the Trust and its workforce, along with its partner agencies, are seen as a public authority that has an obligation to respect the convention rights. That means that those rights must be understood and taken into account when implementing the content of this policy into practice.

.04 All Carers

Under the Carers (Recognition and Services) Act 1995 the Local Authority has a responsibility to offer an assessment of the carer’s ability to provide care if that person (the carer) provides or intends to provide a substantial amount of care on a regular basis. If an assessment is requested, the local authority shall carry out such an assessment and shall take into account the results of that assessment in making any decision regarding the relevant person. Note: the local authority may delegate this to another service provider (1990 NHS Community Care Act).
Carers often make a major and valued contribution to the support received by many people, with a mental health problem being treated in the community. The foundation of CPA is built on such a contribution. It should be agreed in advance with the carer who (taking into account usual guidance regarding confidentiality) should be properly advised both about such aspects of the patient’s condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day to day basis.

To involve carers, Care Co-ordinators and Lead Professionals should:

- Be aware of who the main carers are and their contact details.
- Ensure that the carer has the Care Co-ordinators/Lead Professionals contact details and that these are offered in writing (or in an acceptable format for the carer).
- Communicate with carers.
- Address issues of confidentiality and consent; these should not, however, pose an automatic barrier to carer involvement, offering generic information about mental health does not depend upon the individuals consent
- Ascertained and document if carers have statutory responsibilities under the Mental Health Act and/or the Mental Capacity Act such as being a person’s Nearest Relative or acting as an attorney under a Lasting Power of Attorney, a court appointed deputy or a relevant persons representative under the Deprivation of Liberty Safeguards (refer to CM0019 Deprivation of Liberty Safeguards Protocol)
- Offer and conduct (or facilitate) a full carer’s assessment when required.
- Produce an individual support plan for the carer if indicated, following assessment.
- Ensure that where safeguarding concerns regarding carers are identified, this is acted upon in line with the relevant Adult Safeguarding Policy and local procedures.

Assessing the needs of carers:

Carers of people, including young carers, should be involved in their own assessment and care planning process, considering their own mental and physical health needs, and ability to continue to care. The assessment should include:-

- Current support provided by the carer
- Current support for the carer (formal and informal)
- Carers views
- Carers needs

.05 Young Carers

In relation to mental health, young carers are young people under the age of 18 whose lives are restricted by the need to take responsibility for the care of a person who is affected by a mental health problem
Where children and young people care for people with a severe mental health problem, they should receive adequate support to protect them from any adverse effects of having caring responsibilities and to allow them opportunities for education, leisure and friendship. The care coordinator/Lead professional should recognise and contribute to the assessment of children in need, as well as children in need of protection.

Where a young carer is involved in the care of an adult with mental health problems, the care coordinator has a responsibility to make an assessment of the family circumstances and the needs of the child/young person. If it was identified that there was risk of harm they should ensure referral is made to the Children’s social work services. Support services can be provided for a child carer to enable them to maintain their usual activities outside of the caring role. Consideration should be made to referring to the young carer’s service and undertaking a common assessment framework (CAF) to address unmet need via a multiagency approach.

The care coordinator needs to be aware of children’s needs for access to a range of information, both regarding the nature of the mental health problem and what services and support are available to them. The child or young person if mature enough should be given written information about this and the name of a person within LYPFT they can contact if needed. Where possible the child/young person should be given the opportunity to discuss their parent with the LYPFT staff involved and be allowed to ask questions or share concerns.

See Appendix B, guidance for CPA coordinators: keeping children safe; supporting parents.

.06 Confidentiality, Information Sharing and Communication

Effective communication between all those involved in the delivery of care is a key element of the care coordination process. However, the privilege of access to confidential information carries with it fundamental duties and responsibilities.

All relevant information regarding the care, treatment and protection of individuals and others must be shared with all of those involved on a need-to-know basis. Staff should be conversant with the relevant confidentiality policies and Information Sharing Agreements in force in their respective organisations. When practitioners are in doubt, direction should be sought from their line manager.

Relevant and appropriate reasons for sharing information with other professionals/agencies involved in the care of the individual that need to know for the direct care of the individual user may include:

- To ensure that the views and wishes of the person are known and accessible to all staff
For assessment, discharge and review purposes

To enable professionals to give/gain clear advice on specific problems

To avoid duplication or omission of necessary care.

To facilitate joint working between agencies and disciplines engaged with the same service user

To assess the relevance of referrals and subsequent allocation

To ensure that staff, individuals and carers are aware of situations of risk

To promote positive outcomes for the individuals and carers in a particular area of work

To comply with legislative requirements

Information is confidential when it appears reasonable to assume that the provider of the information believed that this would be the case. However, where care is provided by health and social care professionals working in different agencies the sharing of information is essential to support the planning, scheduling, delivery and monitoring of care. When sharing information the following principles should be followed:

- Information to be shared must be purposeful and justified
- Information should be specifically geared to the task it is intended to serve
- The information should be sufficient and sharing should exclude unnecessary material

Information should normally only be shared with the informed consent of the subject (some exceptions may apply to people subject to the Mental Health Act 1983, the Mental Capacity Act 2005 and safeguarding adult and children risk. Care Co-coordinators must check with the relevant codes of practice and policies and seek further advice where necessary). Consent to share information may be given orally or in writing but must be recorded in the persons continuous record including the date and any special conditions that apply.

Any request for information to be shared with anyone other than those professionals engaged in the direct care of the person, should be referred to the relevant Health or Social Care records manager or line manager in partner organisations.

There are certain limited circumstances where it may be necessary to share information without the persons consent and which is not for the purposes of direct service user care. Reference should be made to the relevant Confidentiality Policy in these circumstances or the relevant Child/adults safeguarding policy where the safety of a child or adult may be at risk.
For detailed guidance refer to the Data Protection Act 1998; further guidance is available in: Information Sharing and Mental Health, guidance to support information sharing by mental health services.

.07 Referral

Leeds and York Partnerships NHS Foundation Trust and partner agencies receive referrals from a wide range of sources, including self-referrals. All referrals will be screened to determine need. A decision will be made as to whether the person should receive a service, or be referred back to the referrer with recommendations for their care. All people who have a need for services will be allocated a Care Co-ordinator or Lead Professional and will receive care via CPA or Standard Care Plan.

Anyone accepted for CPA by LYPFT should be recognised as experiencing symptoms and circumstances which may lead to ongoing mental health difficulties.

.08 Fair Access To Care Services (FACS)

In May 2002 the Department of Health issued statutory guidance to Councils called “Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care”. Under this guidance, all Councils were required to revise their eligibility criteria for adult community care services by April 7th 2003. This revision required the review of resources against the likely demand and need, and then setting a threshold that determines the eligibility of an individual.

Thresholds of eligibility criteria are up to local discretion and set within resources Councils can afford. Once the threshold is set all needs which fall above this threshold must be met. All Councils have been required to use the same framework and to apply it equally to all groups of people with needs for care.

The purpose of FACS is to ensure consistency and equity of access for all adults within each local authority and to ensure that all adults receive the appropriate services to meet all eligible needs.

Section 47 (1) of the National Health Service and Community Care Act 1990 requires local authorities, where they are providing (or arranging provision of) community services to recognise they have a duty:

– To carry out an assessment of the individual’s needs for those services

(And)

– Having regard to the results of that assessment, then to decide whether his/her needs call for the provision by them of any such services
During initial contact with a person, all staff should be aware of the local authority responsibility with regard to FACS and the local eligibility criteria. To avoid unnecessary confusion, the CPA and care management systems should ideally be integrated in mental health services to ensure that health and social care needs are assessed through one assessment process. The mental health social care support plan needs to be incorporated into the CPA plan or the CPA plan be consistent with it.

Currently however two separate systems exist and staff should be aware that Adult Social Care has its own criteria for determining eligibility and this needs to be taken into account to ensure an appropriate assessment of need. A care plan can then be drawn up to address those needs. Access to those services is gained by the Care Co-ordinator via the Adult Social Care care plan.)

Assessment identifying the need to be on CPA is not an eligibility criterion to enable receipt of social care. Individuals who are FACS eligible will receive support either from CPA or Care Plan following assessment processes including assisted assessment.

Eligibility can only be determined after an assessment. However, this is not a commitment to the provision of services. Good professional judgement remains central to the assessment process.

The eligibility framework identifies and describes a catalogue of needs, which must all be assessed and recorded; this is most likely to take place following a Community Care Act assessment.

Although FACS does not directly dovetail with CPA, it does not contradict it. FACS is based within the long established principle of needs-based assessment.

Self Directed support means providing the right level of services and support to enable people to achieve maximum independence and control over their lives. Social Care assessment will indicate what these needs are and the level of resources needed.

Support and services follow an assessment of the persons needs and can include support at home, respite and day care and, for those with very high support needs, residential and nursing

.09 Application of CPA

Characteristics to consider when deciding if the support of CPA (as opposed to Standard Care Plan) is needed:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity
- Current or potential risk(s), including:
– Suicide, self harm, harm to others (including history of offending)
– Relapse history requiring urgent response
– Self neglect/non concordance with treatment plan

• Vulnerable adult; adult/child protection issues such as:

  – Exploitation (financial/sexual)
  – Financial difficulties related to mental health
  – Disinhibition
  – Physical/emotional abuse
  – Cognitive impairment
  – Child protection issues

• Current or significant history of severe distress/instability or disengagement.

• Presence of non-physical co-morbidity such as substance/alcohol/prescription drugs misuse, learning disability

• Multiple service provision from different agencies, including; housing, physical care, employment, criminal justice, voluntary agencies

• Currently/recently detained under the Mental Health Act or referred to Crisis and Home Treatment Team or Acute Community Service

• Significant reliance on carer(s) or has own significant caring responsibilities

• Experiencing disadvantages or difficulty as a result of;
  – Parenting responsibilities
  – Physical health care
  – Unsettled accommodation/housing issues
  – Employment issues when mentally unwell
  – Significant impairment of function due to mental illness
  – Ethnicity (includes immigration status; race/cultural issues: language difficulties: religious practices); sexual or gender issues.

Those individuals who are placed on Community Treatment Orders will be on CPA with care planning and review processes meeting the statutory requirements.

Staff should remember that key groups to consider are people:

• who have parenting responsibilities
• who have significant caring responsibilities
• with a dual diagnosis (substance misuse)
• with a history of violence or self harm
• who are in unsettled accommodation
Where an individual is identified within a key group, then CPA should be applied unless justified otherwise by the assessment. This should be clearly documented in the continuous record.

**Standard Care Plan**

Where the above criteria do not apply so as to require CPA to be invoked, Standard Care Plan will be offered. It is recognised that not everyone receiving care from LYPFT services has been referred for a mental health need, for example people with learning disability who are referred for a physical health need. The principles outlined for people not on CPA will however, be relevant. The process of applying Standard Care Plan is similar in nature to that of CPA, i.e., a comprehensive assessment, collaboratively agreeing a treatment/support plan (which tends to be more self-directed); communication with all those involved in the plan (subject to appropriate consent being obtained); identification of a ‘Lead Professional’; review of the care plan at least annually, a central record of actions taken and progress made. Refocused CPA 2008, states that “using the term CPA to describe the system of care provided to those with less complex, more straightforward needs, has often led to more attention being paid to the system (with ensuing needless bureaucracy) rather than focus on good professional care” so, Standard Care Plan offers quality care and treatment, to those who’s needs are less complex, in a less bureaucratic way.

.10 **Assessment**

Everyone referred to LYPFT should have an initial assessment of their needs. This initial assessment, which aims to identify the needs and where they may be met, may have alternative names such as screening or triage. The outcome of the initial assessment should be communicated to the individual in a way that they will understand and also to the referrer promptly.

If it is agreed that the person’s needs are best met by LYPFT a care plan (either CPA or Standard Care Plan) should be negotiated and agreed with the service user and (where appropriate) their carer.

An individual’s CPA care plan should be based upon a thorough assessment of their health and social care needs. This assessment will place the person, and carer where appropriate, at the centre of the process and they will, as far as possible, be able to determine themselves how their needs will be met. The assessment should identify the individual’s strengths, hopes and aspirations for the future; it is often referred to as a holistic assessment.

Advocates and interpreters should be offered and involved to support and facilitate this process when the person wants.

To reduce documentation and cut down on duplication, services should aim to develop one assessment and care plan (CPA or Standard Care Plan) that will follow the person through a variety of care settings to enable the correct and necessary information going with them.
The persons assessment will be held on the relevant electronic records system PARIS, CPD/IMHER and/or Electronic Social Care Records (ESCR/Framework i).

The persons assessment will inform the use of relevant care pathways and mental health clustering.

In “Refocusing the Care Programme Approach” it was identified that there were additional areas to be included in assessment. According to the Care Programme Approach Association (CPAA 2008), a holistic assessment of need should include:

- Persons strengths, aims and aspirations
- Carers involvement
- Mental Health and psychological functioning
- Needs arising from co-morbidity and co-existing problems such as substance use, personality disorder. Past and current substance use should be identified and detailed
- Social functioning, social needs and social circumstances
- Physical health needs including dietary requirements
- Personal circumstances including family and carers, family and welfare circumstances
- Child care issues, child safeguarding and caring responsibilities
- Needs of the parent and family
- Experience of violence and/or abuse
- Housing status and needs
- Financial circumstances and capability
- Employment, education and training needs
- Risk to the individual and/or others, including violence and criminal record
- Opportunity for positive risk taking
- Need for medication management
- Level of support and intervention required
- Opportunity for self-management including identification of informal support network
- Potential for engagement with services
- Religious and spiritual needs
- Communication, cultural, gender and access needs
- Advocacy and legal advice requirements and needs

11 People with Learning Disability and Mental Health Problems

It is widely recognised that the existence of two service systems, (the Mental Health system and the Learning Disability system) can cause difficulties for adults with Mental Health problems and Learning Disabilities. Not all clinicians from each discipline are competent in the recognition, assessment and treatment of Mental Health problems and Learning Disability. Adults who have both Mental Health problems and Learning Disabilities can experience being shunted from one service to another without receiving effective treatment from either.
It is the role of the Care Co-ordinator/Lead Professional to support individuals to receive the best quality care, the role of the Care Co-ordinator/Lead Professional has to be effective and responsive in order to work with the individual and their person centred plan to ensure access to both services.

Procedures to support Care coordinators/Lead Professionals is available on Staffnet: CM0027 Procedure for the management of adult service users with a diagnosis of both mental health and learning disabilities

.12 Outcomes and their measurement

Assessments and care plans should routinely include arrangements for setting out, measuring and reviewing specific outcomes. An outcomes focus can help to improve understanding of the impact of services on the lives of people who use them; give assurance that treatments and care provided are producing results; and ensure that outcomes related to treatment, care and support are monitored on an on-going basis.

The desired outcomes should be explicitly agreed with the individual and carer(s) at the beginning of the care process so that the plan is personalised to the service user. The use of HoNOS is mandated in LYPFT adult and older people services and some specialist services.

It is expected that clinical services will apply relevant outcome measures in their respective service areas which are in line with nationally approved outcome tools.

Outcome scales will be completed at significant points of change within the care pathway and at any event, at least once a year.

.13 Safeguarding Concerns

If, at any time during the needs assessment, or at any point of contact with the person, there are concerns about:

- A child’s welfare – the organisation’s Safeguarding Children Policy should be followed in these cases.

- Potential adult abuse (safeguarding) - the Trust procedure must be instigated. Local Authorities require notification direct to their points of access.

It is expected that partner agencies adhere to and apply safeguarding processes in line with local policies.

- The safeguarding section on PARIS for services which use this form of recording should be used to record a chronology of significant safeguarding events.
.14 Recording Identified Unmet Needs

Need assessment must focus on the person’s needs, rather than the services available. Any needs identified within the assessment but which cannot be met for any reason must be recorded on the care plan (CPA or Standard Care Plan).

.15 Risk Assessment

Key Principles of Effective Risk Management and CPA

- All individuals accepted into Leeds and York Partnerships NHS Foundation Trust should have an appropriate risk assessment completed as agreed within that service and as part of an initial or subsequent assessment of health and social care needs; a risk assessment tool may aid this process.

- Risk assessment and management should balance safety and effectiveness with the individual’s rights to make choices and their right to take informed risks.

- Clear recording on PARIS or CPD/IMHER of information, risk assessment and subsequent action plan is essential to communicating the management risk.

- Risk assessment should be reviewed at least annually and following any risk incident / potential increase in risk and be clearly signed and dated.

- Risk assessment and co-producing a risk/safety management plan should be a collaborative process involving face-to-face contact.

- Risk assessment and risk/safety management are a connected process and integral to CPA and Standard Care Plan.

- The Care Co-ordinator/Lead Professional will ensure that the risk assessment and risk/safety management plan is reviewed and updated at each CPA or Standard Care Plan review meeting.

- In order to undertake a comprehensive risk assessment, all clinical and practice notes, paper and electronic, must be consulted before reaching any conclusions regarding risk. This includes records from other mental health service providers. If the records are unavailable at the time of the assessment or review, this must be recorded and followed up.

- The period around discharge from hospital is a time of particularly high risk of suicide. It is therefore imperative to have arrangements in place for follow-up no more than 7-days after discharge from hospital for all individuals. For further guidance see Procedure for the Discharge and Transfer of People using the services of Leeds and York Partnerships NHS Trust CM0013 and Clinical Risk Assessment and Management Procedure CM0011.
.16 Crisis and Contingency Planning

The contingency plan forms an integral part of the care plan and aims to detail alternative short term arrangements in circumstances where an element or elements of the care plan cannot be put in place.

Crisis planning aims to generate an explicit plan of action in the event of a crisis situation developing for people. Crisis plans should set out the action to be taken in the early stages of a potential crisis, with stepped responses aimed at alleviating the crisis early.

Crisis plans should include the following information:

- Triggers
- Early warning signs and relapse indicators
- The actions the service user themselves can take
- Identification of the role of carer’s and informal supporters
- Coping strategies and service action
- Contact numbers – including out of hours numbers
- Emergency action plan
- Crisis and contingency plans may be supported through advance decisions.

Crisis/contingency plans should be informed by the process of risk assessment and must be incorporated into the care plan. The relevant service risk assessment profile will inform the crisis/contingency plan. This must be completed and shared with the service user and, if appropriate, their carer, the multi-disciplinary team and services involved in the delivery of care.

Care Planning

.17 Promoting rights, choice and involvement

In providing care it is expected that people using services:

- Have their care, treatment and support options identified and the alternatives, risks and benefits of each are explained to them in a way that they can understand

- Have sufficient information to enable them, wherever possible, to make an informed choice

- Who lack capacity to make an informed decision are supported by their nominated representatives being provided with the information they need to make a decision on behalf of the person under the authority of the Mental Capacity Act 2005.

- People on CPA are offered information about what CPA is and what they can expect.
It is important to balance the need for preference and choice against safety and effectiveness, while respecting the right of people to make informed choices.

18 Care Plan Production (CPA)

The purpose of assessment is to identify the strengths and needs of an individual and then to identify how these strengths and needs can be facilitated through delivery of services. This clearly links the process of assessment with care planning.

The care plan must be produced, with the Care Co-ordinator working collaboratively with the person and, where appropriate, their carer. It must be tailored to the individual needs of the person based upon a thorough health and social care assessment, the person’s views, wishes, aspirations and goals; and those of their carer, where appropriate.

The care plan should identify the person’s goals; the actions agreed; who is involved and the time scale or frequency.

People should be offered information on the use of advocacy services and, where used, advocates must be involved in the care planning process.

The preparation of the care plan will involve discussion with all members of the multi-disciplinary/ multi-agency team providing care to the individual. The CPA care plan should include:

- an overarching care plan
- consideration of section 117 (see Section 117 aftercare guidelines appendix A)
- identified and recorded goals and the interventions and outcomes relating to those needs
- the use of self directed support in delivering interventions and outcomes where FACS eligible and appropriate
- any disagreements and the reasons for them
- estimated time-scale by which the goals will be achieved or reviewed
- details of the contribution of all agencies involved in the care
- agreed contingency and crisis plans
- name and telephone number of the Care Co-ordinator and any other relevant persons
- identify professionals/persons involved (named)
- contact details of services and support mechanisms in place 24/7
- any known advance statement or advanced decision

The CPA plan and all related information must be recorded using the formal CPA documentation on PARIS or CPD/IMHER and in line with partner organisations record keeping policy. Copies of the care plan must be shared with the person and all those involved in the care provided, including carers.
and any other relevant parties agreed at the review, with the consent of the person.

It is the responsibility of the CPA Care Co-ordinator to explain the CPA care plan and provide a copy to the individual and carer (if appropriate). The care plan should be formulated by the Care Co-ordinator, signed and dated on completion by the Care Co-ordinator and a copy provided to the individual. Should the person prefer to write their own care plan then this should be accommodated. Any amendments should be signed and dated also.

The CPA care plan should:

- focus on the persons strengths and aspirations as well as needs, and seek to promote recovery, choice and independence (recognising, reinforcing and promoting strengths at an individual, family and social level should be an explicit aspect of the care plan).

- be written using clear, unambiguous language, reflecting the persons own way of describing their health and social needs; acronyms should be avoided. Writing in the first person should be considered.

- recognise the diverse needs of the person, reflecting cultural and ethnic background, as well as gender, sexuality and any disability

- include goals, action and outcomes in all assessed and agreed areas of need

- clearly identify the details of any package of support arising from the health and social needs assessment

.19 Care Plan Production (for people under Standard Care Plan)

The production of a Standard Care Plan, is the same as a CPA care plan, in that it is formulated after comprehensive assessment, includes all concerned in delivering care (statutory, voluntary and carers). Emphasis should be on the persons strengths and abilities, and should incorporate support that can be accessed outside statutory services, however, the outcomes/goals need to be time framed, and explicit in who does what when and where. A review of the care plan must occur at least annually, but circumstances may dictate that reviews occur as and when necessary. The plan of care can be set out in a letter or an agreed template. The option remains for using Paris/CPD/IMHERr templates, with any letter cross referenced.

.20 Mental Capacity Act

The underlying philosophy of the Mental Capacity Act 2005 is to support individuals in making decisions for themselves and to ensure that an individual who lacks capacity is the focus of any decisions being made, or actions taken on his/her behalf. It prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person.
The inability to make a decision can be caused by a range of problems, such as; a mental health problem, dementia, learning disability, and physical problems such as toxic confusion, a stroke, brain injury or the effects of drugs or alcohol.

It is important to remember that where a person lacks capacity to make a particular decision, he can neither consent to it nor refuse it. Any person acting on behalf of a person who lacks capacity must act in that person’s best interests.

Where significant decisions need to be taken, an assessment of mental capacity in relation to that decision needs to be undertaken following the Mental Capacity Act Code of Practice. All those involved in the care and treatment of a person who may lack capacity should keep a record of long term or significant decisions made about capacity. The record should be made in the place where details about a person are regularly made, such as the case notes or care plan records. The record should show:

- The decision
- Why the decision was made
- How the decision was made
- Who was involved
- What information was used
- Who the decision maker was

Recording decisions in this way will help staff to demonstrate why they had a reasonable belief in the person’s lack of capacity and that they were acting in the person’s best interests.

It is important to note that where a person lacks capacity to make a particular decision, e.g. for treatment, or sharing information, then he/she cannot sign a consent form or any other document relating to consent or refusal. In these cases, those acting on his/her behalf must act in the person’s best interests and records should reflect this.

People should be fully informed of their treatment and/or care and support, regardless of their capacity.

Where children are able to take part in decision making, they should be asked if they are happy for their parents to be involved in decisions they need to make.

Further information is available in The Mental Capacity Act 2005, Code of Practice (DoH 2007) or from the Mental Health Legislation office.
.21 Care Planning and Mental Capacity issues (CPA and Standard Care Plan)

When a person lacks capacity to accept or understand a care plan the clinician delivering the care plan needs to act in the person’s best interests and records should reflect this.

We have a duty to offer an individual a copy of their care plan. In situations where they lack capacity, the care plan should be offered to the main carer (if available) unless there are safeguarding issues (which would then require Safeguarding policies and procedures to be followed) and so long as this is in their best interests.

In situations where there is no carer then an Independent Mental Capacity Advocate (IMCA) may be required but this will depend on the treatment recommended and the ‘best interests’ decisions. Some specific decisions place a statutory requirement on instructing an IMCA; refer to The Mental Capacity Act, 2005, Code of Practice for information.

Any decisions regarding the provision of copies of the care plan under the above circumstances should be recorded on the care plan.

.22 Advanced Decisions to Refuse Treatment

An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision. This has been a fundamental principle of the common law for many years and it is now set out in the Mental Capacity Act. Sections 24–26 of the Act set out the when a person can make an advance decision to refuse treatment. This applies if:

- the person is 18 or older, and
- they have the capacity to make an advance decision about treatment.

Any advanced decision should be documented within the care plan. Detention under the Mental Health Act may override this.

.23 Advance statements

An advance statement can set out which treatments an individual feels they would or wouldn’t like to receive should they lose mental capacity in the future. This should be included within the care plan.

Advance statements are not legally binding, but health professionals do have to take them into account when deciding on a course of action. Family and friends can also use them as evidence of the person’s wishes.
People can also make their views known verbally (for example when discussing treatment with their Care Co-ordinator) but having it written down may make things clearer for everyone.

The Trust has a separate Procedure for Advance Decisions (Living Wills) CM0037, which staff should refer to for further information.

24 Medication and Care Plans

It is important that any prescribed medication is subject to regular review. Medication management can be a vital element in supporting people in managing their mental health problems. People should be involved in the choice of medicines and information should be available to individuals and if appropriate, their carers to improve concordance with an appropriate treatment plan.

Prescribing should be in line with NICE guidance and the Trust prescribing guidance. People should always be made aware of the risks and benefits of individual medication regimens and should be given the opportunity to discuss these. Response to treatment with medicines should always be discussed in the review meeting. Regular physical health monitoring should be carried out in line with the Physical Health Improvement Procedure (CM0005); arrangements for this should be identified within the care plan.

The CPA care plan should identify plans to address the following where the individual is prescribed psychotropic medication:

- Reasons for the prescription
- Information on medicines prescribed
- Risks of the prescribed medicines and any potential for drug interaction
- Potential side effects and arrangements for side effect management
- Arrangements for the management of adherence to treatment
- Arrangements for the collection, dispensing and administration of medication
- Issues affecting adherence with treatment

CPA review meetings may be an appropriate place to discuss medication issues; to plan for changes, for planned discontinuation, and for exploration of alternative treatment options in the absence of a scheduled clinic/outpatient appointment. The CPA care plan provides an overview of the intended care, support and treatment and as such may not always be best placed to document discrete changes to the prescription. It is imperative that care co-coordinators accurately signpost within the care plan where the most up to date record of the prescription is located, for example, the most recent clinic letter (this must be on PARIS/CPD/IMHER), to prevent confusion or errors from occurring, particularly with individuals, GPs and out of hours mental health services.

People that use the service and carers will go to a variety of sources to access information about their medicines; direction to appropriate resources
should be encouraged, such as choice and medication information for people who use services, carers and professionals: http://www.choiceandmedication.org/leedsandyorkpft/

.25 End of Life Care

People using services who are at the end of their life will have their care, treatment and support needs met because wherever possible:

- They are involved in the assessment and planning for their end of life care and are able to make choices and decisions about their preferred options.
- They will have further assessments by specialist palliative care services and other specialists made available
- They will have information relating to death and dying available to them, their families or those close to them.
- They will be able to have those people important to them, with them at the end of their life.
- They will have arrangements to ensure the least possible unnecessary disruption to the person's care and accommodation and to their family and those close to them.
- They have a dignified death.
- The care plan (CPA or Standard Care Plan) records their wishes with regards to how their body and possessions are handled after their death and staff respect their cultural rites.

.26 Review

A review is a continuous and dynamic process that involves working in partnership. The purpose of a review is:-

- To hear the person and their carers’ views of the plan and services provided
- To evaluate the progress towards identified goals and the services provided.
- To review the plan in place taking into account any change in circumstances and eligibility for services.
- To renegotiate and amend any existing plan.
- To communicate with all involved including other agencies.

The Care Co-ordinator/Lead Professional and care team should tailor reviews to the wishes and preference of the individual. When deciding which review option is agreeable, staff should consider factors such as risk, the engagement of the person and the complexity of the care plan. The following review options should be considered:
1. A meeting between the person, their carer and Care Co-ordinator to review the key elements of the care plan i.e. integrated with a routine, planned contact.

2. A meeting between the person and their Care Co-ordinator, with others involved contributing by separate 1:1 meetings, post, phone or other communication media.

In both instances above; the review may take place over a stated period of time allowing for consultation with all involved to feed into the review process.

3. A full multi-disciplinary review with the person, carer, advocate and other agencies involved in care and support.

N.B.: It should be noted that for people living with children, where there is an allocated children’s worker, the worker should be routinely involved in CPA reviews. Further guidance is available in keeping children safe; supporting parents, guidance for CPA coordinators (appendix B). Also, where an advocate is engaged they too should routinely be involved.

Frequency of review

- The national minimum requirement is a twelve monthly review however it is likely that a review will be required more frequent than this. Specific care areas may have agreed standards for frequency of review. If there are changes to the persons need or risk, either as a planned or unplanned event, e.g. hospital admission, change to social circumstances, then a review should be considered, arranged and facilitated by the Care Co-ordinator/Lead Professional.

- Anyone involved in the care of the person, or the person them self, can request a review of the care plan. If the care team and the individual decides that it is not necessary or appropriate to hold a review then the reasons for the decision must be communicated and documented in the clinical or practice notes.

Planning the review

- Where a full multi-agency review is to take place it must be planned in advance, with sufficient notice of at least one week given to everyone who needs to be invited, and an agenda, chair and minute taker agreed if required.

- The person should be made aware of the purpose of the review, be offered information about what to expect, be given the opportunity to invite a friend or advocate for support and be encouraged to consider the issues they wish to raise in the review.
The Care Co-ordinator must discuss with the person regarding an attendance list of those involved in the persons care that are to be invited to take part in the review this should include the carer and advocate. Consent should be sought from the person regarding invitees.

The review process will act as a checking point for accuracy of information regarding contact details of invitees.

Ensure the remit of the review is clear to everyone involved, agreed in advance and appropriate, clarify that it is actually a CPA review rather than a safeguarding/care planning meeting or clinical review/ward round. Multiple meetings for the individual should not routinely be needed; one meeting can often address needs.

Any services involved with the child/children, such as school nurse or health visitor should be invited. It may be appropriate to combine this with a CAF meeting where a CAF is in place, to avoid duplication.

Consider inviting a member of the safeguarding team where there are complex safeguarding issues or uncertainties.

The review should be held at a venue agreed by the individual.

In order to ensure that there is adequate time for discussion, genuine involvement and for the person to raise anything that they want to discuss and receive a satisfactory response then sufficient time must be allowed. It is recommended that at least forty five minutes is allocated for a full multidisciplinary review. Those individuals unable to attend a formal meeting must be given the opportunity to have a pre and post review meeting with the Care Co-ordinator.

**During the review**

- The review should be facilitated. This may be done by the person but otherwise the Care Co-ordinator or Lead Professional are well placed to do this. The facilitation may be delegated to another professional with negotiation – for example, the primary nurse may be well placed to facilitate a review when the person is in hospital.

- A further review by date must be agreed.

- The current situation regarding each area identified within the CPA documentation should be outlined. Where a need is identified then goals should be agreed with the individual and care plan formulated.

- The current care plan including goals, outcomes, contingency and crisis plan should be evaluated and negotiated with the person. The risk management plan should be reviewed and updated.

- The need for continued support of CPA should be considered.
The holistic assessment should be updated as informed at review.

The results of outcome measures should be taken into account.

A review of any ongoing section 117 entitlement (see guidelines in appendix A) should be undertaken.

The CPA framework should be used for planning, review and extending Community Treatment Orders for those individuals subject to Supervised Community Treatment (See the Supervised Community Treatment Protocol).

Eligibility for NHS funded Continuing Care must be reviewed and recorded on an annual basis; the CPA review offers an opportunity for this.

The needs of the carer must be considered at each review, including updating information on offering the carer their own assessment; this should be done annually at least.

The needs of the children should also be routinely considered and discussed.

It is important that Care Co-ordinators regularly review social care provision to ensure the needs of the individual are being met appropriately, that the person remains FACS eligible and that the service provider is delivering the service as contracted. Review of social care provision should take place at the CPA review; this includes personalisation/self directed support.

Following the review

A record of attendance; non-attendance; and information forwarded for the review will be documented.

The Care Co-ordinator is responsible for ensuring that the minutes and outcomes of a review are recorded (on the care plan) and that any proposed changes to the CPA care plan result in a revised CPA care plan being prepared and circulated to the individual, carer, relevant individuals and professionals. This must be sent within 10 working days or sooner if risk assessment indicates a more immediate response is required.

The agreed CPA care plan will be recorded, identifying goals, actions against individuals and timeframes.

Where ongoing section 117 entitlement was reviewed, this should be documented appropriately.

CPA reviews must be recorded on PARIS/CPD/IMHER.
Best Practice in review

- The person and carer should be involved throughout; the persons experience is paramount; immediate feedback should be sought.

- Ensure that the person is not excluded from any part of their review; should a professionals meeting be required, then this must be held entirely separately from the CPA review. Feedback from people is that sitting outside a room whilst being talked about is disconcerting.

- Listening to the person is paramount; this should be reflected through acknowledging wishes and preferences. Documentation should reflect this, with the persons own words/phrases used where appropriate.

- Where the individual is admitted to hospital, then a CPA review should be arranged promptly to ensure sufficient notice is given to attend and that discharge plans are put in place at an early stage. This ensures the admission is not prolonged unnecessarily and engages the person in discharge planning.

.27 Progress Notes and Records of Intervention

- A record of contact with the individual will be kept. This is supported through PARIS/ESCR/CPD/IMHER, medical notes and any partner organisation’s record keeping systems.

- This record needs to give the detail of the delivery of service and intervention as per the care plan and will provide the evidence of monitoring and support the evaluation of care.

- Information will be recorded on the record as soon as possible and certainly within a maximum 24 hours. Information pertaining to risk should be prioritised and communicated immediately. This will include information received from external agencies and members of the multi-disciplinary team, including carers.

- It is the responsibility of the individual receiving the information to record it on the record and to inform the Care Co-ordinator/Lead Professional directly of any significant information relating for example to risk issues.

The guidance above also applies to Care Plan.

.28 Care Co-ordination

Definition

Within this policy the term Care Co-ordinator refers to the CPA Care Co-ordinator, supporting and working with those individuals registered on CPA. The term Lead Professional describes the role within Standard Care Plan.
The Care Co-ordinator takes a proactive and co-ordinated approach in identifying the most complex and vulnerable people with mental health problems, and then co-ordinating and managing their care in partnership with the individual, their carers and other professionals involved.

29 Care Co-ordinator - Values and Principles

The Care Co-ordinator should be demonstrating, and actively ensuring that the service’s values and principles are adhered to, both with and through how s/he works, the relationships s/he develops and sustains, and the outcomes sought with and on behalf of people who use services and people who support them. These values and principles are set out in the Ten Essential Shared Capabilities (DoH 2004):

- Working in partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying people’s needs and strengths
- Providing person centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

These values and principles are embedded in the National Occupational Standards associated with the key functions of the Care Co-ordinator.

30 Care Co-ordinator - Principles of Practice

Care co-ordination is predicated on the principle that people, however vulnerable, should share in decision-making; that they are knowledgeable about themselves and the effect their conditions may have on their lives; and that they should be empowered and enabled to inform their own recovery.

The Care Co-ordinator:

- works in partnership with people who have complex mental health and social care needs, and those supporting them
- strives to empower people using services to have choices and make decisions to determine their wellbeing and recovery
- integrates and co-ordinates a person’s journey through all parts of the health and social care system
- enables each person to have a personalised care plan based on his/her needs, preferences and choices
- ensures that the person receives the least restrictive care in the setting most appropriate for that person
- supports the person to attain wellbeing and recovery in its broadest sense
ensures that the needs of carers/families are addressed
brokers partnerships and co-production with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems
ensures that the persons care is reviewed on a regular basis as appropriate
encourages the prevention and early detection of ill health, wherever there are real factors that present a risk to their health and welfare, such as taking part in vaccination and screening programmes
enables the person to make healthy living choices concerning exercise, diet and lifestyle.

.31 Care Co-ordinator Core Functions

To perform in the care co-ordination role, and to work within the identified principles, the Care Co-ordinator’s core functions are to carry out:

i. Comprehensive needs assessment
ii. Risk assessment and management
iii. Crisis planning and management
iv. Assessing and responding to carers’ needs
v. Care planning and review
vi. Transfer of care or discharge

.32 CPA Care Co-ordinator competencies

The member of staff identified to co-ordinate an individual’s care must be competent, suitably qualified and skilled in delivering mental health care to fulfil the role identified within their job description. Therefore the CPA Care Co-ordinator may be an approved mental health professional, mental health nurse, occupational therapist, psychiatrist, psychologist or other mental health worker who, through clinical supervision and self-assessment has the identified core competences to undertake care co-ordination.

The role of the CPA Care Co-ordinator incorporates Community Care Act Care Management functions such as financial assessment which may include reports for commissioning and allocation of resources including personalisation/self directed support and the formulation of social circumstances reports for First Tier Tribunals and Hospital Managers’ hearings.

In most instances individuals subject to Community Treatment Orders will have their care co-ordinated by a Trust or local authority worker because of the legislative responsibilities associated with the application of the CTO to the individual.

It is critical that the CPA Care Co-ordinator has authority to ensure the delivery of the care plan and that this is respected by all professionals and agencies involved.
The CPA Care Co-ordinator:

- should remain involved in any Mental Health Act assessments and be involved in decisions throughout the process including any subsequent actions or requirements

- is the most appropriate member of the care team who is best placed to meet the individual’s needs and to oversee care planning and resource allocation for an individual requiring CPA

- will identify any carers and ensure that they are offered an assessment and identify any young carers and ensure referral to the most appropriate service

- will also be responsible for co-ordinating the care plan of the carer, unless a decision is taken to appoint another practitioner to undertake this role

- will be proactive in identifying all people involved in an individual’s care, this may be within the organisation, partner agencies, third sector, or informal arrangements. Communication should be initiated and maintained during the episode of care and documented.

- will ensure that detailed integrated professional records are maintained to document the assessment, care planning and review processes within the CPA policy framework

- will ensure consideration of child protection, adult protection and public protection issues as guided by local and national policies

- will arrange cover for planned absence and ensuring that contingencies are in place for the care team to cover any unplanned absences

- will liaise with the appropriate authority to ensure that immediate action is taken when the care plan no longer meets the person’s needs due to a crisis.

- In circumstances where a person requests a change to their identified Care Co-ordinator discussion needs to take place with the person, care Co-ordinator and relevant Clinical Lead/Team Manager to understand the reasons and agree a way forward which will bring about the best outcome for the person within available resources.

.33 Lead Professional

The member of staff identified to co-ordinate an individual’s care must be competent, suitably qualified and skilled in delivering mental health and/or learning disability care to fulfil the role identified within their job description. Therefore the Lead Professional may be an approved mental health professional, mental health/learning disability nurse, occupational therapist, psychiatrist, psychologist or other mental health/learning disability worker who, through clinical supervision and assessment has the identified core
competences to undertake the role. The most appropriate member of the care team who is best placed to meet the individual’s needs and to oversee the care plan will be identified as the Lead Professional. Usually only one professional is involved in the person’s care or treatment; that individual will be the Lead Professional.

The Lead Professional should:

- aim to develop a therapeutic/working relationship with the person and carer
- oversee the package of care or treatment, combining assessment, planning care, review and monitoring in conjunction with the person, their carer and any wider care team.
- identify any carers, and ensuring they are made aware of their right to receive their own assessment
- respond to requests for review from the person, carers or the care team
- produce a Care Plan with the individual, clearly identifying how care or treatment will be carried out, by whom, and when. It should contain details of the Lead Professional and contact details and should identify when a review will take place. This must be recorded on PARIS/CPD/IMHER. A copy of the Care Plan will be offered to the person and communicated to any other person involved.
- review the Care Plan as the need arises but at least annually. Consideration of the need to transfer care to CPA should be made at the review. The person should receive a copy of the review (as the Care Plan) within 10 working days of the review.
- ensure that current assessments support any clinical decisions to transfer responsibility of care and that records clearly show details of agreed transfers of responsibility
- liaise as necessary with others involved in the person’s care
- arrange cover for planned absence if required and ensuring that contingencies are in place for the care team to cover any unplanned absences

Transitions of Care

Transfers of care must be underpinned with the sharing of information covering background details, relapse signatures, risks, key interventions, medication and aims and objectives of care. Any changes to the care pathway must be clearly documented on PARIS/CPD/IMHER.
Transitions between CPA and Standard Care Plan

The review process will support a step-up and step-down process, reflecting the changes in the needs and complexities of individuals throughout their recovery journey. The Care Co-ordinator or Lead Professional through review processes will facilitate and communicate any changes to levels of care relating to Standard Care Plan and CPA, and record on PARIS/CPD/IMHER.

**Transfers to Standard Care Plan from CPA:**

- Care will continue to be provided with assessments, care planning and review processes as outlined in Standard Care Plan.
- A Lead Professional will be identified and full agreement reached before transfer takes place.
- No transfer of care should take place while an individual may be experiencing crisis or disagreements exist.
- Transfer of care will be supported through joint working by the CPA Care Co-ordinator and the Standard Care Plan Lead Professional and should occur over an agreed period of time.

When transfer is completed, this should be reflected on PARIS/CPD/IMHER through completion of the Standard Care Plan followed by discharge from CPA.

**Transfers from Standard Care Plan to CPA:**

Transfer of care from Standard Care Plan to CPA will be commenced by the Lead Professional making a referral to the appropriate team.

- This referral will need to be processed in a timely manner and a telephone referral may be appropriate.
- It is important the transfer of care involves all relevant information and documentation being provided by the referrer. This should be available on PARIS/CPD/IMHER.
- It is important to acknowledge that a request for transfer may require an immediate contact and immediate management strategies to reduce risk or deterioration in mental health. Transfer must not be delayed through administrative procedures.

When transfer is agreed the individual will require a transfer from Standard Care Plan to CPA on PARIS/CPD/IMHER. Assessment and CPA care planning should then commence facilitated by the CPA Care co-ordinator. A review date must be identified.

**Transfer of Care between teams within the Trust**

Transfers of care within the Trust should be a seamless activity with minimal disruption to the individual and their carer. Transfers of care must be agreed with the person and the receiving team and the referral accepted on the
basis of the assessment and review facilitated by the referring Care co-ordinator or Lead Professional.

This may involve transfers between service delivery groups, for example from Community Mental Health Team to Assertive Outreach Team.

- It is the responsibility of the referring team to ensure that all documentation and relevant information is provided to the accepting team prior to the person’s first appointment/contact. The Care Co-ordinator or Lead Professional retains responsibility until the person has attended an appointment with the accepting team or an agreed transfer date has been planned, allowing for a period of joint working if necessary.

- There must be a uniform system for CPA across mental health & learning disability services and a clear agreement between learning disability and mental health services about roles and responsibilities in relation to CPA.

- People within Learning Disability services are often in receipt of person-centred plans. Where a person transfers from Learning Disability Services to Mental Health Services, the mental health service needs to ensure that the persons person-centred plan is integrated into their new CPA care plan.

- A transfer of care will have been agreed at a review. Assessments and care plans will have been amended to incorporate the transfer plans. This includes risk assessment and risk management plans, this must be clearly communicated as part of the transfer process.

- Any decisions to transfer care must be agreed collaboratively with the individual and fully communicated to all those involved in the care, including the carer and GP.

.37 Transfer of Care to services outside the Trust

Any decision to transfer the care of a person to another area must be agreed at a CPA or Standard Care Plan review meeting. Until transfer arrangements are agreed, the current Care Co-ordinator or Lead Professional retains responsibility.

Prior to an out of area transfer, the Care Co-ordinator or Lead Professional must ensure the following has been agreed:

- The receiving team/agency has taken responsibility for assessing the person and, if appropriate appointing a Care Co-ordinator or Lead Professional.
- The person has been advised and where necessary supported in changing GP registration.
- Agreed to set up service within the receiving team/service to meet the persons assessed needs.
• All relevant information has been effectively communicated to the receiving team including any entitlement to Section 117 aftercare services (see Section 117 aftercare guidelines in appendix A).
• All risk information has been shared with the receiving team/service.

All decisions, throughout the process, must be agreed and communicated in writing to the person, their carer (where appropriate) and all members of the care team.

.38 Discharges

Discharge from CPA or Standard Care Plan must only occur following a review of care and where the outcome of that review is that there are no outstanding areas of need requiring intervention from services as assessed by the Care Co-ordinator or Lead Professional and agreed by the person.

The review of care must include the individual, identified carer and services involved in the delivery of care (partner agencies/teams, third sector).

Details of the review of care must be fully communicated with all agencies involved, including the GP and the carer where necessary. This information must include:

• Summary of services received
• Reason for discharge
• Crisis and contingency plans regarding re-accessing services should the need arise in a timely and expedient way, appropriate to the level of need.

This communication with individuals, carers and professional group must be timely.

Discharge will be determined by the level of risk to the individual or others in their ceasing contact with mental health services.

A person should not be discharged from LYPFT without due consideration to S117 aftercare, health & social care needs. These should be clearly documented on discharge documentation, outlining ways of meeting aftercare needs, and organisations or professionals being responsible.

In all cases where the person is discharged from CPA or Standard Care Plan the relevant documentation will be completed on PARIS/CPD/IMHER.

For those individuals who successfully discharge themselves from a mental health hospital against medical advice, then an immediate plan should be formulated, considering risks, and a CPA review must be held within 2 working days of that discharge.
.39 **Section 117 After-Care Provision**

Section 117 of the Mental Health Act 1983 applies to all those who have been detained in hospital under treatment Sections 3, 37, 47 or 48 of that Act and individuals subject to Community Treatment Orders.

Section 117 After-Care places a duty on Mental Health Trusts and local Social Services Departments to provide, in co-operation with relevant voluntary agencies, after-care services.

CPA provides the framework for planned and managed care that Section 117 After-Care requires. Therefore, a normal care planning meeting and care plan will fulfil the service’s obligation under Section 117 After-Care (see appendix A Section 117 aftercare guidelines)

- All individuals who are subject to Section 117 After-Care must have this noted in their CPA care plan and all services being provided under Section 117 must be reviewed and recorded at each CPA review meeting.
- Section 117 After-Care does not need to continue indefinitely and the decision to discharge individuals from Section 117 should be done within a review meeting with the person and carer.
- Section 117 After-Care provision must be agreed jointly between the mental health service and the Social Services Department of the Local Authority
- If ending Section 117 After Care provision, social care as well as health need to be involved in the review.
- Decisions to terminate Section 117 After-Care provision must be confirmed and communicated in writing to the individual, carer (where appropriate), GP and any other professional involved in the persons care.

**Safeguarding**

.40 **Protection of Children**

Public sector organisations have an overall duty to:

- Take all reasonable measures to ensure that they minimise risk of harm to the welfare of children.
- Take appropriate action when there are child protection concerns by working to agreed local policies and procedures, in full partnership with other agencies. The West Yorkshire Consortium Multi-Agency Safeguarding Procedures are for all agencies to follow. North Yorkshire Safeguarding Children Board, and City of York Safeguarding Children’s Board have a set of procedures to follow for safeguarding children.

During all assessment, monitoring, review and discharge planning staff should consider if the individual is likely to have or resume contact with their own children or other children in their network or family friends, even when the children are not living with the person:
If the person has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children.

- Referrals should be made to children’s social work services when it is deemed a child is at risk of harm.
- Children should have their unmet need addressed via a single agency involvement or by using the Common Assessment Framework.
- Staff should pay particular attention to expressed delusional ideas towards children and/or if suicide plans may result in the harm of a child.
- With complex cases a Consultant Psychiatrist should be directly involved in all clinical decision making for all persons involved in services who may pose a risk to children.

Staff in the Trust and in partner organisations may play a role in relation to safeguarding and promoting the welfare of children in one or more of the following ways:

- Being a source of support to the child/young person through direct liaison and information provision
- Identifying where early help is needed using the framework for assessment of children in need
- Identifying children who are being, or have been abused or neglected
- Making referrals to Children’s Services if a child is in need of support or protection
- Contributing to Section 47 Child Protection enquiries and then at child protection conferences and reviews
- Providing information for other agencies and courts where necessary
- Treating children who are being, or have been abused or neglected
- Supporting parents to care for their children and keep them safe
- Advising parents about the impact of their mental health problems, learning disabilities, substance misuse on their children (including unborn)
- Identifying when the impact of a person’s mental health problems or substance misuse is impairing their child’s health and development and taking action to safeguard the child including adapting care and treatment plans for adults
- Initiating or contributing to multi-agency common assessments of children and their families
- Liaising with other community services for children
- Treating or working with adults who have been subject to child abuse. Treating or working with adults who have been convicted of abusing children.

Staff can seek advice from the Named Nurse or named Doctor for Safeguarding Children, or their line manager in the clinical area. For further information see the Trust’s Policy and Procedures on the safeguarding and promotion of the welfare of children. Guidance specific to CPA coordinators is available in appendix B keeping children safe; supporting parents.
.41 Protection of Vulnerable Adults within CPA

A vulnerable adult is defined as someone aged 18 years or over who may need help because of physical or mental illness, or may be unable to care for themselves, or unable to protect themselves from significant harm or exploitation

- All staff have a duty to protect vulnerable adults and highlight and inform their managers if abuse is suspected.
- If staff are aware of issues of abuse or potential abuse they should take action as directed in either The West Yorkshire Multi-Agency Safeguarding Procedures (2013) or N Yorkshire Safeguarding Adults in North Yorkshire Multi-Agency Policy and Procedures 2009 depending on where the person resides.

Vulnerability should be addressed in accordance with the risk assessment and management procedures and in the care plan.

.42 Those Who Lose Contact or Do Not Engage

Withdrawal from services should be discussed urgently in the relevant team’s clinical meeting. It may be appropriate to contact the relevant most senior clinician involved and Team Manager (or equivalent in other organisations) before the next scheduled clinical meeting. The Care Co-ordinator or Lead Professional, in conjunction with the team, must make an assessment in relation to risk posed by the person withdrawing from services and make plans accordingly. Consideration may be given to referring the person to their local assertive outreach team, where available.

- Once assessment of risk has been completed, it may be deemed appropriate to assess the person under the Mental Health Act 1983 with a view to compulsory admission to hospital.
- If a person has lost contact with services, a professionals meeting should be convened. The professionals meeting should establish what steps are to be taken to re-establish contact. Consideration should be given to contacting the carer/family, GP, local A&E departments, community teams in other Trusts and the police. Relevant paperwork should be made available such as the latest care plan (inclusive of contingency and crisis plans), the most recent risk assessment and a description of the person. The Care Co-ordinator/Lead Professional is responsible for co-ordinating this.
- If the person poses a risk to themselves or others then the police should be immediately informed. A decision must also be made with the clinical team as to whether to inform any carer/significant other or any person identified as at risk of harm.
- Immediate consideration needs to be given to the children of people who withdraw from services. The care team may wish to invoke the child protection procedures and contact relevant local teams.
- Each member of the team should make effort to re-establish contact and document actions taken.
If contact with the person is not re-established, they should not be removed from CPA, but designated as ‘out of contact’. This term is interpreted as meaning that the person remains nominally linked with the care team that was providing a service when they lost contact or withdrew. This ensures there is some level of continuity when the person is contacted successfully or is re-referred to the service.

Specific consideration should be given to the welfare of any child/ren in these situations as disengagement may be an indicator of heightened concern.

In all cases, details must be well documented in the person’s case notes with clear specific action plans.

.43 First Tier Tribunals and Managers’ Hearings

It is essential that a CPA review meeting is held prior to a Tribunal and/or a Mental Health Act Managers’ Hearing. This enables discharge plans to be put in place should the convening panel decide to discharge the person from hospital. These plans should be available to the Hospital Managers and the Tribunal.

.44 Admissions to Acute Services

Acute services include in-patient services and services that are identified as an alternative to hospital admission.

All individuals admitted to acute services will be on CPA.

An identified individual within acute services will undertake the coordination role until such time as the CPA Coordinator is identified.

Where a CPA Care Co-coordinator is known, it is the responsibility of the admitting nurse to make contact with the CPA Care Co-coordinator and inform of the admission.

The existing CPA Care Co-ordinator will continue to take the co-ordination role while the individual is receiving care within acute services. This may involve delegation of tasks to the acute team.

People will be allocated a CPA Care Co-ordinator within two working days of their admissions. The name of person will be communicated to the appropriate CMHT by acute services staff.

The new Care Co-ordinator will make contact with the person within three working days of allocation. The purpose of this contact will be to convene a CPA review as soon as practicable following admission.

The allocated CPA Care Co-coordinator will be responsible for ensuring the CPA process is followed as identified within this policy and procedural...
guidance. It is expected that collaborative work with the acute services staff is undertaken with clear communication and documentation of delegated tasks. This enhances the persons experience through reduced duplication and reduction of delays in the acute journey. Following admission a CPA review will be facilitated by the CPA Care Co-coordinator. This will involve:

- Formulation of needs and risk/safety
- Identification of outcomes required to facilitate discharge Care planning to support timely discharge.
- Identification and agreement of goals prior to discharge, including detailed arrangements for follow-up within 7 days of discharge (from in-patient care). This will be communicated to all involved agencies. This is the responsibility of the CPA Care Co-coordinator who may delegate actions to other involved persons.

The care plan on discharge will allow for more intensive provision of care in the first three months after discharge and will identify how community living is supported.

Any discharge planning must take into consideration the requirements of the protection of children.

For those individuals who discharge themselves from a mental health hospital against medical advice, then an immediate plan should be formulated, considering risks, and a CPA review should be held within 2 working days of that discharge.

### 4.5 Equality and Diversity

The introduction of the Equality Act in October 2010 has simplified the legislative framework and the provisions in the Equality Act will come into force over three years to allow time for organisations affected by the new laws to carefully prepare for them. The main provision of the Act is to prohibit direct and indirect discrimination, harassment and victimisation which apply to age, race, gender, disability, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity. The general duty of the legislation means that in everything we do we must have due regard to the need to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Promote good relations between people of different groups.

All assessments must ensure that the cultural, racial and religious needs of the person are taken into account at all stages; this should be reflected in the care plan. It is important to ensure that arrangements for monitoring services take account of cultural diversity. Such monitoring will allow us to ascertain how effective we are serving the needs of particular communities.

Cultural and spiritual diversity must be respected and wherever possible related needs must be discussed with the person or the persons...
relatives/carers so that information and advice can be sought and obtained. Identified cultural and spiritual needs and how these will be met must be recorded in the patient’s care plan.

Where necessary, every effort must be made to provide a trained interpreter, particularly during the initial assessment and at each formal meeting.

Children and young carers should not be used as substitutes for interpreters.

Consideration needs to be given to the sexual orientation of people. Lesbian Gay Bisexual (LGB) and Trans people may have particular health needs to be discussed and agreed. Same-sex partners should be fully integrated into the care planning process (with agreement). Same sex partners must be asked if they are performing a caring role and offered a carer’s assessment accordingly. Further information can be found at stonewall.org.uk

3. DUTIES AND RESPONSIBILITIES

Each procedural document within the Trust must include an overview of the individual, departmental and committee duties, including levels of responsibility for the procedural document development, and procedural document authors must ensure that duties of each element of the target audience is included here, using table below.

The duties within the organisation are as follows:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>The Chief Executive has overall responsibility to ensure that policies and processes are in place for the application of the Care Programme Approach.</td>
</tr>
<tr>
<td>Chief Nurse and Director of Quality and Assurance</td>
<td>The Chief Nurse/Director of Quality and Assurance is responsible for ensuring that this policy is implemented and complied with; that all professional staff understands and adhere to their requirements; that clinical staff understand the requirements of the Care Programme Approach and utilise it in the operational delivery of care.</td>
</tr>
<tr>
<td>Medical Director</td>
<td>The Medical Director is responsible for ensuring that medical staff understand and implement the policy; that medical staff participate in CPA through supporting care coordinators and where appropriate undertake the role of Lead Professional.</td>
</tr>
<tr>
<td>Executive Team</td>
<td>The Executive Team has a duty to its staff and people that use the service to ensure that Managers, Associate Medical Directors and Associate Directors as well as clinicians are aware of how this policy affects practice, what the practice issues are in their</td>
</tr>
</tbody>
</table>
areas, the impact on the service user group and any training requirements for the workforce.

<table>
<thead>
<tr>
<th>Service Managers</th>
<th>Service Managers are responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overseeing the implementation of this policy within their areas of responsibility</td>
</tr>
<tr>
<td></td>
<td>Raising awareness of this policy and its contents with any staff they manage; bringing any issues which may affect the implementation of this policy to the attention of the relevant Associate Director in the Trust or Senior Manager in partner organisations</td>
</tr>
<tr>
<td></td>
<td>Reporting any concerns that clinical staff may bring to their attention which relate to operation of this policy</td>
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<tr>
<td></td>
<td>Exploring unmet needs as brought to their attention by Care Co-ordinators/Lead Professionals, assessing the case and specifying the action or process to be followed by the service in an attempt to meet the needs of the individual</td>
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<tr>
<td></td>
<td>Participating in monitoring the implementation of this policy; ensuring regular audit is undertaken and the results acted upon</td>
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<tr>
<td></td>
<td>Making any necessary arrangements for their staff to attend any training in relation to this policy</td>
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<tr>
<td></td>
<td>Providing regular supervision</td>
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<tr>
<td></td>
<td>The role of managers includes monitoring, audit, and improvement and performance management.</td>
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<tr>
<td></td>
<td>Ensuring that Care Co-ordinators are able to combine their role with that of care manager by having:</td>
</tr>
<tr>
<td></td>
<td>– competence in delivering mental health care</td>
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<td></td>
<td>– knowledge of the individual, their carers and family</td>
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<td></td>
<td>– knowledge of community services and the role of other agencies</td>
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<td></td>
<td>– co-ordination skills</td>
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<td></td>
<td>– access to and authority to allocate resources at an appropriate level</td>
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<td></td>
<td>– training in Self Directed Support budget procedures and in the skills required to properly, meaningfully and supportively explore Self Directed Support budget alternatives with individuals.</td>
</tr>
<tr>
<td>Care Co-ordinators and Lead Professionals</td>
<td>Care Co-ordinators and Lead Professionals are responsible for:</td>
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<td>------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Adhering to this policy effectively</td>
</tr>
<tr>
<td></td>
<td>• Fulfiling their duties as outlined in this and other related policies, to the required professional standards of their particular discipline</td>
</tr>
<tr>
<td></td>
<td>• Bringing any issues which may affect adherence to the attention of their Service Manager</td>
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<tr>
<td></td>
<td>• Identifying any unmet needs as part of the process of completing the assessment and recording this within the care plan</td>
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<tr>
<td></td>
<td>• Informing the relevant Manager when an identified action or intervention cannot be delivered, for example, because of resource or availability problems</td>
</tr>
<tr>
<td></td>
<td>• Identifying learning needs and attending relevant training</td>
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<tr>
<td></td>
<td>• Undertaking and participating in regular clinical supervision</td>
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</tbody>
</table>

| All other practitioners and support staff | All other staff are responsible for adhering to this policy effectively and bringing any issues which may affect adherence to the attention of their Service Manager |

4. TRAINING

The mental health and learning disability workforce requires a range of competencies, experience and skills in order to meet the diverse and often complex needs of individuals who use the service. The Ten Essential Shared Capabilities framework (DH2004) makes explicit the capabilities and value base necessary to achieve best practice for all staff. As such, this will be integrated within all CPA training.

Key contents of this policy are covered within CPA training; the training is available to all staff with roles relevant to CPA and is available Trust wide. There is also an e-learning pack for those new to CPA or new to the care coordination role. CPA training is not compulsory but it is recommended that care coordinators should attend CPA training at least every 3 years.

The care coordinator work based assessment of competencies is a practical work based assessment document available to individual staff as a tool to support the development of care coordination skills in practice. It is of benefit to staff who want to assess/evidence their own competence; those identified as needing to focus upon care coordinator skill development and those new to care coordination. This is also useful for team use; it identifies the 6 core competencies of the care coordinator but also serves as a ‘check’ that the team has structures and resources in place to support the care coordinator role.
### GLOSSARY OF DEFINITIONS

The following definitions are of relevance to this document:

<table>
<thead>
<tr>
<th>Definition</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA</td>
<td>The term Care Programme Approach describes the approach used to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex needs.</td>
</tr>
<tr>
<td>Green Light</td>
<td>A ‘tool kit’ of assessments and resources for identifying and treating people with a mild to moderate learning difficulty who access Mental Health services.</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scales are the most widely used routine clinical outcome measure in mental health services in England.</td>
</tr>
<tr>
<td>Personalisation</td>
<td>Personalisation is a social care approach meaning that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support regardless of care settings, this includes all individuals in our communities, whatever their age, background, income or need, will have access to care and services.</td>
</tr>
<tr>
<td>Recovery</td>
<td>Recovery is the process of regaining active control over one’s life. This may involve discovering (or rediscovering) a positive sense of self, accepting and coping with the reality of any ongoing distress or disability (Faulkner and Layzell, 2000) finding meaning in experiences, resolving personal, social or relationship issues that may contribute to mental health difficulties, taking on satisfying and meaningful social roles, and calling on formal and/or informal systems of support as needed (Leibrich, 1999).</td>
</tr>
<tr>
<td>Recovery Star</td>
<td>The Recovery Star is a tool that enables care to be planned around user-defined goals and quality of life outcomes.</td>
</tr>
<tr>
<td>Risk</td>
<td>The likelihood of an event happening with potential harmful or beneficial outcomes for self and others. (Possible behaviors include suicide, self-harm, neglect, aggression and violence, with an additional range of other positive or negative service user</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>A gathering of information and analysis of the potential outcomes of identified behaviors. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstance, to anticipate future change.</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Risk Management</strong></td>
<td>A statement of plans, and an allocation of individual responsibilities. Translating collective decisions into real actions, this process should name all the relevant people involved in the treatment and support, including the individual service user and appropriate informal carers. It should clearly identify the dates for reviewing the assessment and the management plans (Morgan 2000).</td>
</tr>
<tr>
<td><strong>Self Directed Support</strong></td>
<td>Self Directed Support is a new way of providing social care to adults who have been assessed as having unmet eligible social care needs. The process involves identifying a Personal Budget, following the construction of an outcome focussed support plan, which is designed to help people take control over their lives, manage their support (with or without assistance) and identifies their own goals and needs and plans the service(s) or support that best suits them. The person is at the centre of the planning process.</td>
</tr>
<tr>
<td><strong>Standard Care Plan</strong></td>
<td>This term refers to the approach used to assess, plan, review and co-ordinate the treatment, care and support needs of people in contact within LYPFT who have straightforward needs, typically with the involvement of only one agency and an appropriate professional in that agency, who will be responsible for facilitating their care. It is recognised that some people seen within LYPFT services do not have specific mental health needs, but the principles underpinning Standard Care Plan are applicable e.g. everyone receiving services will have a care plan.</td>
</tr>
<tr>
<td><strong>Wellbeing</strong></td>
<td>Describes a state of contentedness or happiness. In mental health terms, refers to a persons’ ability to cope with their mental health problems, and maintain a balanced stable mental health.</td>
</tr>
</tbody>
</table>
Appendix A

Guidelines

Section 117 After-care

Director Responsible: LYPFT : Medical Director

<table>
<thead>
<tr>
<th>Date effective from:</th>
<th>1st May 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>28th April 2016</td>
</tr>
<tr>
<td>Version Number</td>
<td>2</td>
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</tbody>
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2. Establishing and Identifying Applicability of Section 117 4
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SECTION 117 AFTER-CARE

1. Introduction

“After-care is a vital component in patients’ overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital”


This policy recognises that aftercare should be provided for all service users but addresses specifically the statutory after-care provisions under Section 117 of the Mental Health Act 1983. Reference where appropriate will also be made to the Care Programme Approach (CPA), supervision register and supervised aftercare requirements.

The Trust and partnering local authorities: Leeds City Council Social Services Department, North Yorkshire County Council and City of York Council are jointly committed to the provision of appropriate after-care arrangements.

Statutory guidance in the form of Circulars HC(89)5 and LAC(89)7 remind health and local authorities of the need to plan jointly for after-care and of the individual responsibility of the various professionals who are involved in the process. All service users are subject to the provisions of the CPA if they are admitted to a Mental Health in-patient unit and/or are accepted by Community Mental Health Services.

Section 117 of the Mental Health Act 1983 is distinctive in the sense that it places a legal obligation on both agencies stating that it is the duty of the health authority and the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care for persons subject to specified sections of the Mental Health Act 1983. Namely persons who are detained under Section 3, or admitted to a hospital on a Hospital Order Section 37, or transferred to a hospital under a transfer direction under Section 47 or 48 of the Mental Health Act 1983 (see Code of Practice, Mental Health Act 1983, Chapter 27 “Aftercare”).

In the case of service users detained under 37/41 or 47/49, there are special considerations to be taken into account in addition to those which apply to unrestricted service users.

The Mental Health Act 2007 amended the 1983 Act by introducing the practice of Supervised Community Treatment for patients who have been subject to Section 3 detention. This group of patients are also entitled to after-care services as prescribed within the Mental Health Act 1983 and Code of Practice (2008)

2. Establishing and Identifying Applicability of Section 117

On all admissions the relevant admin staff should ensure that case notes or computerised records are checked to see if a previous entitlement to after-care has been established.

A person admitted to hospital for treatment under Section 3 or 37 or who is transferred to hospital from prison under Section 47 or 48 of the Mental Health Act 1983, and patients subject to Supervised Community Treatment comes under the auspices of Section 117. Once this requirement has been established the obligation under the Mental Health Act 1983 continues even when a service user is re-graded to informal status prior to discharge and/or following all subsequent admissions to hospital until the after-care agencies agree that after-care is no longer necessary.
3. Identifying the Responsible Authorities

The responsible authorities (health and local authority) are the ones for the area where the service user lived at the time of the detention, not the area where they are going to live on discharge.

However, if the service user has no fixed place of residence at the time of detention the responsible authorities would be those for the area they were discharged to.

If this is in dispute the relevant Local Authority legal department should be contacted.

4. What is covered?

It is held that someone cannot be charged for after-care services, which are required in order to meet their mental health needs.

If someone was also, for example, physically disabled and was receiving services that related to this need, then it would be held that these were not covered by Section 117 and would be subject to normal charging policy.

In case of any serious doubt regarding this distinction legal advice should be sought.

For service users in care homes there are three points worth noting:

- The fact that someone is ‘settled’ in a home is not in itself grounds for ending Section 117. The need can continue to exist even though it is being successfully met.
- Care services, which were provided to a service user living in the community – and charged for – prior to admission to hospital under one of the appropriate sections will be provided without charge on discharge if the provision of that service is part of the care plan to meet mental health after care needs.
- The decision to discharge from Section 117 should not be financially motivated.

5. Planning After-care

The cornerstone of effective care planning is the CPA process. The recording and organisation of section 117 meetings should be made with reference to the CPA policy. Discussion, planning and agreement of care will take place in a formal Section 117 planning meeting. Wherever possible this should take place:

- At an appropriate time prior to the patient being discharged from hospital
- Where a tribunal or hospital managers’ hearing has been arranged
- Where renewal of detention is being considered

The Responsible Clinician (RC) has specific duties and responsibilities under the Act, See Code Of Practice 2008 Chapter 27.10 and 27.11. Where these are delegated, this policy will set out to whom these duties have been delegated.

Please also refer to LYPFT Trust Wide CPA Policy 2014

5.2 Who should be Involved?

In convening a Section 117 review, participation of the following people would be deemed essential:

- the service user, if he or she wishes and/or a nominated representative
- that service user’s RC
a nurse involved in care (for the service user in hospital)
appropriate Social Services representative
Care Co-ordinator

In addition the following people should be invited to attend:

- the GP and primary care team
- a community psychiatric nurse
- a representative of relevant voluntary organisations
- in the case of a restricted service user, the probation service
- subject to the service user’s consent, any informal carer who will be involved in looking after him/her outside hospital
- subject to the service user’s consent, his/her nearest relative
- a representative of housing authorities, if accommodation is an issue
- the Clinical Commissioning Group may need to commission resources not provided by LYPFT

If any of the above people are unable to attend they should be given the opportunity to provide a verbal and/or written report.

Please also refer to LYPFT Trust Wide CPA Policy 2014

5.3 Duties of the Responsible Clinician (RC)

Ideally, planning for discharge should be initiated as soon as entitlement to after-care provision has been established. Plans for after-care should be an integral part of the service user’s stay in hospital. When a decision has been taken to discharge or grant leave to a service user, it is the responsibility of the RC to ensure that:

- a proper assessment is made of risks to the service user or other people
- in the case of offender service users, the circumstances of any victim and their families are taken into account
- consideration is given to whether the service user meets the criteria for After-care under Supervision, or under Guardianship

Delegated Responsibilities:

- a discussion (multi-disciplinary team meeting) takes place to establish a care plan to organise the management of the service user’s continuing health and social needs
- responsibility for organising the multi-disciplinary team meeting has been delegated to the service user’s CPA Care Co-ordinator, where allocated, or key nurse.

The Consultant Psychiatrist (RC) is responsible for ensuring that records of the after-care arrangements under Section 117 are sent to Medical Records at the appropriate unit. This responsibility can be delegated to the service user’s CPA Care Co-ordinator or key nurse on the in-patient unit.

5.4 Social Services Department

The local Social Services Department has a policy which requires that individuals who may be entitled to After-care under S117 must have a Community Care Act Assessment to identify any unmet Social Care needs which the local authority may be responsible for addressing; LYPFT need to refer people where this is the case.
City of York council requires that individuals who may be entitled to S117 aftercare are referred to a CYC member of the Community Mental Health Service to determine whether a social care assessment is required.

There may be cases where in due course, there will be no need for aftercare services for a patient’s mental conditions, but he or she will still need social service provision for other needs, for example physical disability. Such cases will still have to be examined individually through the assessment process via Section 47 of the NHS and Community care Act 1990.

5.5 Care Plan Principles

Care Plans will be drawn up in line with the existing CPA Policy

5.6 Commencement of After-care

For record purposes after-care will be deemed to commence from the date of discharge from in-patient care. This date should be shown on the CPA form and should correspond with the discharge date as shown on the applicable database.

6. Reviewing the Care Plan and Applicability of Section 117

- A 1st review date will be set at the Section 117 initial review not later than six months after that review.
- Subsequent reviews will take place within six monthly intervals while the service user remains subject to Section 117.
- The decision about whether Section 117 still applies will need to address the question of whether after-care is still required for the conditions which led to the detention under the Mental Health Act. The factors which will influence this decision will vary for each service user but are likely to include:
  - Views and intentions of the service user about the future
  - Passage of time
  - Risk assessment
  - Objectives of after-care and progress in reaching those objectives
  - Whether those objectives can be met by continuation of existing services or adjustment to those services
  - Continuing/new/changed needs of the service user or carer
  - If the clinical team decides that section 117 no longer applies, the reasons for this decision should be recorded on the section 117 Discharge Notice.
- Should a service user be discharged from LYPFT or local authority services without a review of whether s117 applies, LYPFT and the relevant local authority will attend a subsequent S117 review meeting called by either party to determine progress and review whether S117 still applies.

Please also refer to LYPFT Trust Wide CPA Policy 2014.

7. Service Users Discharged from Hospital to Police Custody

A service user subject to Section 117 who is discharged from hospital into police custody remains subject to after-care under Section 117. The identified Care Co-ordinator is responsible for maintaining contact as necessary with any other agencies until such time care co-ordination is handed over. The service user’s applicability of Section 117 will be notified to those resuming responsibility of care e.g. community forensic team, social services, probation services and police surgeon.
8. Termination of After-care

If a full discharge from the requirements of Section 117 is warranted the ‘Section 117 Discharge Notice’ must be completed. It should be noted at this point that both Health and Social Care services must agree that no further after-care is required. Appropriately qualified staff from both agencies will sign the ‘Section 117 Discharge Notice’ to confirm discharge. This will include a registered Medical Practitioner currently involved in the care of the individual and for Leeds Social Services this means a Social Worker.

There is also a section on the form, which allows services to record that an explanation has been given to the service user regarding the reasons for terminating Section 117. The Care Co-ordinator is responsible for ensuring that all relevant people are notified of this decision.

Where the patients progress has not been monitored by the responsible authorities, then the patient, their carer and any agencies that have been involved in providing aftercare should always be consulted to determine what progress has been made and inform the decision making process.

The duty to provide aftercare services continues until both authorities have come to a decision that the patient no longer needs any after-care services. Given the nature of aftercare services, many patients will require such services for substantial periods. A patient should not be discharged from care under this section solely on the ground that:

1) He or she has been discharged from the care of a Responsible Clinician or specialist MH services;
2) an arbitrary period has elapsed since the care was first provided;
3) the provision of care is successful in that the patient is well settled in the community or in residential care;
4) he or she is no longer subject to a Community Treatment Order or s17 leave;
5) he or she returns to hospital as an informal patient or under Section 2

or

6) The patient has had the deprivation of his or her liberty authorised under the MCA 2005.

An unwillingness to receive after-care services should not be equated with an absence of a need for such service. A patient’s continued refusal to receive after-care services should be confirmed by professional inquiry at appropriate intervals. A patient’s expressed wish to be “discharged” from this section has no legal effect if he or she continues to have need for after-care services.
SECTION 117 DISCHARGE/ TRANSFER NOTICE

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
<th>Patient No:</th>
</tr>
</thead>
</table>

*Please tick appropriate boxes*

☐ 1a. S117 after-care no longer required

Date of review meeting:  …/…/……

Staff/Agencies consulted:  

____________________________________________________

___________________________________________________________________________

____________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Reasons given for cessation of requirement:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

☐ 1b. Service user re-detained under applicable section within another authority

Name of current Health Authority/Provider: 

Name of new Health Authority/Provider: 

Contact details in new Health Authority Area: 

Name of current Local Authority/Provider: 

Name of new Local Authority/
Provider:

Contact details in new Local Authority/Provider Area:

Date service user re-detained:

Certificate of Agreement to After-care

Signed

Print Name

On behalf of the current Health Authority/ Provider

Title

Date

Signed

Print Name

On behalf of the current Local Authority/ Provider

Title

Date

Signed

Print Name

On behalf of the new Health Authority/ Provider

Title

Date

Signed

Print Name
<table>
<thead>
<tr>
<th>On behalf of the new Local Authority/Provider</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
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<table>
<thead>
<tr>
<th>1c. Death of service user</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of death:</td>
<td>...../...../......</td>
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</table>

<table>
<thead>
<tr>
<th>1d. Other reason</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify reason:</td>
<td>____________________________</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>______________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Have the reasons for cessation of Section 117 requirements been explained to the service user?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Not possible</td>
</tr>
<tr>
<td>□ Not applicable</td>
</tr>
</tbody>
</table>
If not possible, reason why:________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Certificate of Agreement to Discharge Aftercare

Signed Print Name

On behalf of the Health Authority/
Provider *Title
Date

Signed Print Name

On behalf of the Local Authority/
Provider Title
Date

* should be a registered Medical Practitioner currently involved in the care of the individual
Appendix B

Guidance for CPA Co-ordinators:

Keeping Children Safe; Supporting Parents

This guidance should be read in conjunction with the City Wide CPA policy, the Children visiting psychiatric wards policy and the Safeguarding Children Policy. It is intended as a guide to ensure that:

1. The needs of parents who use mental health services are met;
2. The wider family needs are considered;
3. Children are safeguarded.

Assessment

As part of any initial assessment or subsequent review, it should be identified whether a service user has caring responsibilities or direct contact with children. This might include:

- Their own children
- Step children
- Family and friends children e.g. nieces/nephews/grandchildren etc
- Children that they babysit for or look after
- Children in the house e.g. where the accommodation is shared
- Children they work with e.g. at a playgroup, nursery, school, voluntary group

Where children are identified, their name and date of birth and address (if different from that of the service user) should be documented. This information will be needed for any referrals, now or in the future. The National Patient Safety Alert, published on 28th May 2009, recommends that if the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children. Assessment, including risk assessment, should consider the impact of the parent’s mental illness upon the child and any support needs the service user may have in this area. This includes:
- The potential or actual impact of the service user’s behaviour, attitudes and actions on the child and on the parent and child relationship;
- The significance of the timing (is the service user prone to relapse rapidly if they discontinue medication), duration and severity of the parents mental health problems or learning difficulties. Examples of particular concern include the child’s involvement in any psychotic symptoms, parental suicide plan or exposure to episodes of deliberate self harm,
- Impacts linked to the service user’s circumstances such as domestic abuse, substance misuse, financial problems, inadequate or unstable accommodation etc;
- The persons engagement with services and compliance with treatment (including any side effects of treatment which may impact on their caring responsibilities);
- Identifying if the child is undertaking a caring role;
- The potential cumulative impacts of a range of negative factors over time;

Following assessment, the information should be evaluated and a course of action formulated. Needs may fluctuate over time and will require ongoing review:

<table>
<thead>
<tr>
<th>1. No current needs identified</th>
<th>Ongoing review of needs</th>
</tr>
</thead>
</table>
| 2. Child and family need some support | Contact the child’s health visitor or school nurse to discuss the needs (see below for contact details). Best practice is that the parent is involved in this decision and is in agreement:  

Undertaking a shared assessment of need is good practice. The health visitor or school nurse may arrange a common assessment framework (CAF) meeting for the child to provide support. It maybe appropriate for you to attend this meeting.  

If you do not have the parent’s agreement but feel that information should be shared with the health visitor or school nurse |
| 3. Child is at risk | Following the safeguarding procedures, refer immediately to Children and Young People's Social Work Services:

Leeds - 0113 376 0336
City of York – 01904 551900
North Yorks – 01609 536993

You do not have to have the parent’s agreement to do this but where possible it should be sought and parents at least informed. |

A referral to Children and Young People's Social Care **must** be made if the child is suffering or likely to suffer significant harm. Advice can be taken from the Safeguarding Children Team if this isn't clear but the following will always be considered significant harm:

a) If the person is experiencing psychotic symptoms (including both hallucinations and delusional beliefs) involving their child and/or

b) If the person might harm their child as part of a suicide plan.

The rationale for this recommendation is accepted good practice in the safeguarding children arena because of the very high risks inherent in psychotic symptoms involving children and/or homicidal thinking involving children prior to completing suicide (NPSA 2009).
The Rapid Response Report (NPSA/2009/RRR003) also recommends that a Consultant Psychiatrist should be directly involved in all clinical decision making for people who may pose a risk to children.

[Click here for examples in clinical practice of adults posing a risk to children.]

The assessment and outcome needs documenting in the PARIS/CPD record. Risks need alerting on PARIS/CPD, consider marking as ‘crucial information’.

**Care Planning**

CPA meetings should include all professionals that are involved with the family e.g. health visitors, social workers, voluntary or other agencies working with the family etc. If the service user objects to the involvement of Social Care workers in the CPA meeting; serious consideration should be given to organizing a separate professionals meeting where safeguarding issues can form part of the discussion.

CPA templates on PARIS now contain a section dedicated to family support needs and safeguarding issues. This care plan field must be completed where the service user is a parent or has contact with children. It should include a summary of the assessment and detail any action taken. Individuals working with the child and supporting the family should be identified and collaborative work outlined.

The following guidance from SCIE & DH (2008) should be considered best practice in generating a care plan that fully addresses and family support needs and safeguarding issues. The guidance recommends that:

- Involving children and young people in a review or ascertaining their views beforehand (with parents consent) will provide a unique perspective on what has
been happening with their parent; how it has been for the child; and what has worked well (see Appendix 1).

- A care plan should include how the needs of the adult, as a parent, and their child can be addressed both separately and as a family unit
- Plans should address how the views of the parent and the views of the child will be sought together with support and monitoring arrangements
- Crisis and contingency plans should include the arrangements for the child; their ages and gender should be documented
- Earlier interventions should be considered; for example respite arrangements

**Community Treatment Order (CTO)**

CTO plans should include the potential positive and negative impacts this may have on the parent-child relationship, the child and how these should be addressed and monitored during and after acute episodes.

It is essential that partner agencies, particularly Children and Young People’s Social Work Services, are not only invited to Care Planning meetings but also receive copies of both the Care Plan and an up to date risk assessment (highlighting any safeguarding issues). This is particularly important in the aftermath of acute episodes.

It is considered good practice, where children and young people’s workers are involved with the family, to discuss any major changes to the care plan with partner agencies e.g. discharge of the service user back to primary care, reduction in or discontinuation of treatment.
Frequently asked questions

How do I know if there are existing concerns about a child?

If you think there may be existing or previous concerns about a child, you can check out the list of children who are subject to a multiagency child protection plan by contacting 01132 478 652 (Leeds) or 01904 551900 (York and North Yorks). Out of hours, contact Social Care Emergency Duty Team on 0113 240 9536 (Leeds) or 0845 034 9417 (York and North Yorks.). You do not need consent from the parent but you do need a valid reason for this, this might be that

- the parent has been admitted to hospital or accessed by crisis services and there are concerns for the welfare of a child,
- there are concerns about the presentation of the child and parent,
- you are aware that there may be current or past involvement from a child and family social worker,

Asking questions about parenting scares people; they think they will have their children taken away. What can I tell them?

Reassure parents that identifying a need for support is a way of avoiding rather than precipitating child protection measures. Involve parents and children as much as possible in the screening process, explaining that the process is important for making sure families get the support they need. This should be the start of developing a supportive and therapeutic relationship in which to allay fears and reduce stigma.

I already have enough to do; I am not a child expert; shouldn’t children’s services be doing this?

Yes. Your role is to ensure that families with a parent with a mental health problem are routinely signposted or referred to other appropriate services. You need to be aware of how to access these other services. You may also need to liaise with individuals in these services where they become involved in supporting the family.

I’m not sure if the child is at risk or if the parents need more support in caring for their child?

Discuss this further with your manager; LYPFT or Selby and York safeguarding children named professionals or out of hours discuss your concerns with Social Care Emergency Duty Team. This will enable you to reach a decision regarding maintaining the safety of the child and facilitating appropriate support for the family.
The parent I am working with needs more support in caring for their child, it's not safeguarding but they need extra support. How do I make a referral?

- If the child has not started full time school yet or is unborn, you need to contact the child's health visitor – see below for contact details.
- If the child has started school and is under eighteen you need to contact the school nurse - see below for contact details.

The health visitor or school nurse will work with the family to consider the support needed and make arrangements for this. This might include accessing local resources or they might initiate a Common Assessment Framework (CAF) with the family as a way of identifying unmet needs.

I have no experience of working with children and don't know how to effectively communicate with a child.

There is some guidance in appendix 1 about speaking to children and young people. If you feel that you need some further assistance, contact the health visitor, or school nurse who will be able to discuss strategies or undertake a joint visit.

What is CAF?

This is the common assessment framework. It is a way of identifying unmet needs. It is a voluntary process and relies on agreement from and cooperation with the parent. The CAF ensures that all staff working with the family work together to support the child. The outcome of the CAF may result in a multi-agency approach plan; a lead professional from child and family services will be identified. As a Care Co-ordinator, part of your role is to work with family and carers; this will include liaising with the lead professional and including them in reviews and care planning.

What about consent; what information can I share?

You should always refer to the HM Government information sharing guidelines. If there are concerns a child may be at risk of significant harm then you should seek consent to make a referral but only if this does not place the child at greater risk. If there is no consent you will still need to share the information.

Consent should always be sought for CAF processes or other family support areas.
If you are unsure, always seek advice from LYPFT named safeguarding children professionals or utilise the on-call system out of hours if necessary. Ensure any information sharing is well documented.

**Important contacts**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindsay Britton</td>
<td>LYPFT Named Nurse for Safeguarding Children.</td>
<td><a href="mailto:ibritton@nhs.net">ibritton@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>Offers guidance, advice and support regarding safeguarding children.</td>
<td>0113 2954541</td>
</tr>
<tr>
<td></td>
<td></td>
<td>07957 378194 (Mon-Thurs)</td>
</tr>
<tr>
<td>Lorraine Fox</td>
<td>Named Nurse Safeguarding Children,</td>
<td>01904 724906/724797</td>
</tr>
<tr>
<td></td>
<td>Offers guidance, advice and support regarding safeguarding children to staff in NYY area.</td>
<td></td>
</tr>
<tr>
<td>Dr Chris Buller</td>
<td>LYPFT Named Doctor Safeguarding Children</td>
<td><a href="mailto:christopher.buller@nhs.net">christopher.buller@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>Offers guidance, advice and support regarding safeguarding children.</td>
<td>0113 2952317</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>There is a named health visitor for every child and contacts are made with the child and family from the antenatal period until the child enters reception at Primary School. Contact the clinic nearest to the family home to speak York and North York – contact your named nurse or child protection advisor.</td>
<td>York and North York – contact your named nurse or child protection advisor.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Contact</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>School Nurse</strong></td>
<td>The School Nurse will focus on meeting the health needs of school aged children, young people and their families. Contact the school nurse for the child’s school or the school nurse coordinator if the school is unknown or the child is not attending school.</td>
<td>York and North York – contact your named nurse or child protection advisor</td>
</tr>
<tr>
<td><strong>Children Leeds</strong></td>
<td>Children Leeds describes the partnership between all services that work with and for children and young people in Leeds. A useful resource for accessing local resources and for current guidance.                                                                                                                                                                                                 <a href="http://www.leedsinitiative.org/children/">http://www.leedsinitiative.org/children/</a></td>
<td></td>
</tr>
<tr>
<td><strong>Children’s Advice and Assessment Service (aka ‘Front Door’)</strong></td>
<td>The Children’s Advice and Assessment Service (CA&amp;AS) provides professionals and members of the public with advice, information and support about services for children and young people who are vulnerable and at risk in the York and North York area.</td>
<td>Children’s Advice and Assessment Service</td>
</tr>
<tr>
<td><strong>Children and Young Peoples Social Work Services</strong></td>
<td>Referral point and advice for reporting when you think a child a child is being abused                                                                                                                                                                                                                                           Practitioners number 0113 376 0336 or 0113 222 4403</td>
<td></td>
</tr>
</tbody>
</table>
If you need to contact them out of normal office hours, contact the Social Care Emergency Duty team on 0113 240 9536.

Police Child Protection Unit

Referral point for reporting when you think a child is being abused and the situation is urgent or needs to be referred to the police directly (Leeds area).

0113 2413535

Dial 999 if the child is being harmed now

Emergency Duty Team

Leeds: 0113 240 9536

York & North Yorks: 0845 034 9417

Donna Kemp

CPA Development Manager

donna.kemp@nhs.net

07985259082

Further reading and guidance

LYPFT CPA Policy

Children Visiting Mental Health Wards Policy

Safeguarding Children Policy
CPA briefing: Parents with mental health problems and their children

Parents in Hospital: how mental health services can best promote family contact when a parent is in hospital

http://www.leedsinitiative.org/children/

Leeds Safeguarding Children Board Procedures http://www.leedslscb.org

Sources of information for parents and for children

http://www.leedsinitiative.org/children/

http://www.childline.org.uk/pages/home.aspx

http://www.privatefostering.org.uk/pfcarer


References

Robinson, B and Scott, S (2007) Parents in Hospital: how mental health services can best promote family contact when a parent is in hospital. Barnados: London


Social care Institute for Excellence (2009) at a glance 9: Think child; think parent; think family

Social care Institute for Excellence (2009) Think child, think parent, think family: a guide to parental mental health and child welfare

Appendix 1

A group of young carer’s in Merseyside (Robinson and Scott 2007) came up with following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

1. Introduce yourself. Tell us who you are. What your job is.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know, and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don’t ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU.

These 10 messages should influence care planning, interventions and review.
PART B
7. PURPOSE OF DOCUMENT

7.1 Policy Statement

The aim of this policy is to ensure that the Care Programme Approach is applied across Leeds and North Yorkshire and York in line with “Refocusing the Care Programme Approach, Policy and Positive Practice Guidance” (DH2008).

This policy should be read in conjunction with the documents listed in section 4.

All staff involved in applying the Care Programme Approach should, in addition, familiarise themselves with the referenced documents set out in Refocusing the Care Programme Approach (DH2008) and Practice Guidance.

7.2 Purpose of Document

This policy is focused on the support needed for individuals receiving LYPFT services. This includes adults, people with learning disabilities, and individuals receiving specialist services.

The policy sets out the statement of values and principles that underpin the Care Programme Approach and how these should be applied by all staff across Leeds and North Yorkshire and York involved in providing mental health care, treatment and support to people.

8. IDENTIFICATION OF STAKEHOLDERS

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Level of involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development group</td>
<td>Development/Consultation - collaborative between Leeds and York’s CPA Managers, liaison across in-patient and community services for feedback. First draft produced.</td>
</tr>
<tr>
<td>Members of the Planning Care Standing Support Group</td>
<td>Responsible for authoring the Policy and overseeing development and progression; members responsible for sharing with their directorates and teams, including service user and carers groups.</td>
</tr>
<tr>
<td>North Yorkshire County Council</td>
<td>Consultation and Involvement, face to face and via email for ASC perspective and comments; 117 guidance in detail</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>City of York Council</td>
<td>Consultation and Involvement, face to face and via email, for ASC perspective and comments, 117 guidance in detail.</td>
</tr>
<tr>
<td>Leeds County Council</td>
<td>Consultation and Involvement, face to face and via email for ASC perspective and comments on Policy and 117 guidance in detail.</td>
</tr>
<tr>
<td>People that use the service and Carers</td>
<td>Consultation and distribution to AMD’s, lead professional colleagues and service users and carers for views and comments on the Policy (via email and Tweet).</td>
</tr>
<tr>
<td></td>
<td>Liaison with Head of Engagement and Involvement; distributed to service user and carer networks/links, including SUN; comments incorporated in the Policy.</td>
</tr>
<tr>
<td>City Wide Care co-ordination Quality Group (Leeds)</td>
<td>Consultation via circulation to members for comment (June 2013); comments received and responded to.</td>
</tr>
<tr>
<td>LYPFT Clinical Governance Groups</td>
<td>Consultation via email (May 2013), LD, York and North York’s, Specialist and Adult and Older Peoples directorate; 8 week consultation; feedback incorporated in Policy. Consultation with Safeguarding Leads for their perspectives and comments – policy amended to reflect feedback.</td>
</tr>
</tbody>
</table>

9. **REFERENCES**


Leeds and York Partnership


Department of Health (2009) Information Sharing and Mental Health, guidance to support information sharing by mental health services, DH, London


Monitor; The Independent Regulator of NHS Foundation Trusts http://www.monitor-nhsft.gov.uk/


National Institute of Health and Clinical Excellence http://www.nice.org.uk/

National Patient Safety Agency http://www.npsa.nhs.uk/

10 ASSOCIATED DOCUMENTATION

CM0019 Deprivation of Liberty Safeguards

CM0027 Procedure for the management of adult service users with a diagnosis of both mental health and learning disabilities

CM0013 Procedure for the Discharge and Transfer of People using the services of Leeds and York Partnerships NHS Trust

CM0011 Procedure for Assessing and Managing Clinical Risk within the Trust
CM0037 Procedure for Advance Decisions (Living Wills)

West Yorkshire Multi-agency Safeguarding Adults Procedures 2013

Safeguarding Adults in North Yorkshire Multi-Agency Policy and Procedures 2009

LYPFT Child Protection Policy

11. EQUALITY IMPACT ASSESSMENT

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

**Title: Trust wide Care Programme Approach Policy (including arrangements for Standard Care Plan)**

**What are the intended outcomes of this work?**

**Aim:**
To ensure CPA is consistently applied across Leeds, York and North Yorkshire.

**Objective:**
To describe what the Trust and Partnership Agencies will do to implement national guidance on CPA.

**Intended Outcomes:**
To ensure that people that use the service and their carers receive appropriate care and support within LYPFT services.
To ensure that the mental health workforce are able to undertake their roles in relation to CPA.
To ensure that the Trust and partner agencies are compliant with national, regional and local guidance.

**Who will be affected?** *Individuals, carers, staff*

**Evidence**
**What evidence have you considered?**

CPA is underpinned by principles and values based upon the ten shared capabilities, as such, it endorses a service user centred approach to care. This focuses on strengths, abilities and skills, it values and respects diversity.

National guidance (Refocusing the Care Programme Approach DoH 2008) was published following extensive consultation with key stakeholders, and objectively reviewed the progress of existing CPA guidance (DoH 2006).

The policy is consistent with the organisations Improving Health, Improving Lives strategy (2010). It is concordant with the Trusts Respect strategy; CPA encourages workers to value diversity, to be responsive to individual need and to work in partnership in its broadest sense.

Information provided for people and their carers is designed in an accessible format; the Diversity Team are available to provide information in formats required for the individual.

The National Service User Survey includes questions related to CPA; this provides information on service user perspective/experience both nationally and locally.

The 2011/12 Minimum Mental Health Dataset Analysis Summary Report provides detailed information of the demographics of the people across the organisation; including CPA related information (LYPFT 2012). This includes analysis of BME access to services; an action plan is in place to further explore these issues. Reports will be generated annually.

<table>
<thead>
<tr>
<th><strong>Disability</strong></th>
<th>none Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>none Identified; see above</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Gender reassignment (including transgendered)</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Religion or belief</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>none Identified</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>none Identified</td>
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<tr>
<td><strong>Other identified groups</strong></td>
<td>none Identified</td>
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</table>
**Engagement and involvement**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How have you engaged stakeholders in gathering evidence or testing the evidence available?</td>
<td>Through the consultation process</td>
</tr>
<tr>
<td>How have you engaged stakeholders in testing the policy or programme proposals?</td>
<td>Through the consultation process</td>
</tr>
<tr>
<td>For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:</td>
<td>Consultation coordinated via the Planning Care Standing Support Group directorate representatives.</td>
</tr>
</tbody>
</table>

**Summary of Analysis**

Staff engaged in CPA activities will deliver a consistent approach in developing a care plan, implementing interventions and reviewing the care plan, staff will actively engage with the service user, carer and partner organisations. The recording of activities will comply with national standards and requirements. Policy will impact on all protected groups in a positive manner, encouraging their inclusion in the planning, delivering and reviewing of care.

**Eliminate discrimination, harassment and victimisation**

Robust CPA assessment identifies people’s needs and places responsibility on care coordinator to address them, such as advocacy, interpreters etc.

**Advance equality of opportunity**

Correct application of CPA and Standard Care Plan encourages recovery and collaborative working between all involved in the care package

**Promote good relations between groups**

Personalisation is an integral component of CPA; both actively encourage close working relationships between all groups.

**What is the overall impact?**

Overall impact of this policy will be to advance the inclusion of individuals, carers and partner organisations in planning, delivering and reviewing care. Following national guidance, that drives this policy, will help iron out regional variations and promote personalisation. Barriers to engagement are addressed under CPA, the policy dictates that care coordinators continually look for ways to build trust and rapport with all involved.
Addressing the impact on equalities

National training package for care coordinators which encourages workers to value diversity; implementing and disseminating this policy and trust strategies are aimed at reducing inequality.

Action planning for improvement

Improving access to BME groups action plan coordinated with Touchstone is in place; updates received at Planning Care Standing Support Group.

For the record

Name of person who carried out this assessment:
Initiated by Donna Kemp, CPA Development Manager, completed by Lynne Maskill, CPA Development Manager (seconded)

Date assessment completed: 1 August 2013

Name of responsible Director/Director General:
Beverley Murphy, Chief Operating Officer and Chief Nurse/Director of Quality and Assurance

Date assessment was signed: 28th April 2014

12 PLAN FOR DISSEMINATION AND IMPLEMENTATION

DETAILS OF DOCUMENT TO BE DISSEMINATED

<table>
<thead>
<tr>
<th>Title of Document</th>
<th>Trust-Wide Care Programme Approach Policy (including arrangements for Standard Care Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Ratified</td>
<td>28th April 2014</td>
</tr>
<tr>
<td>Dissemination lead name</td>
<td>Donna Kemp, CPA Development Manager</td>
</tr>
</tbody>
</table>

DETAILS OF DISSEMINATION

<table>
<thead>
<tr>
<th>Date put on Staffnet</th>
<th>1st May 2014</th>
</tr>
</thead>
</table>
Who is the document to be disseminated to | Clinical staff including: Care Co-ordinators, Lead Professionals, Service Managers, Team Managers
---|---
Disseminated to (either directly or via meetings, etc) | Format (electronic/paper) | Date disseminated | No of copies sent | Contact details/comments
LYPFT service users, cares & staff | Electronic | May 2014 | n/a | Via Trustwide email; via external website
Partner Agencies | Electronic | May 2014 | n/a | Via Volition newsletter; email to ASC mental health leads

13 Standards/key performance indicators

The CPA Policy contributes to the Trust and partner agencies compliance with the following:

- Care Quality Commission Registration:
  - Regulation 09 – Care and welfare of people who use services
  - Regulation 11 – Safeguarding people who use services from abuse
  - Regulation 13 – Management of medicines
  - Regulation 17 - Respecting and involving service users
  - Regulation 18 – Consent to care and treatment
  - Regulation 22 – Staffing
  - Regulation 23 – Supporting workers
  - Regulation 24 – Cooperating with other providers

- Contractual reporting requirements on CPA performance

- MHMDS reporting

- Monitor's compliance framework

- CQC National Priorities

- Locally agreed CQUINs
### MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THE PROCEDURAL DOCUMENT

<table>
<thead>
<tr>
<th>Topic</th>
<th>Monitoring/Audit</th>
<th>Lead Manager</th>
<th>Data Source</th>
<th>Sample</th>
<th>Data Collection Method</th>
<th>Frequency Of Activity</th>
<th>Review Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with the Trust-Wide Care Programme Approach Policy</td>
<td>Clinical Audit</td>
<td>CPA Development Manager</td>
<td>Electronic record</td>
<td>Random representative sample, generated electronically.</td>
<td>Electronic record to be interrogated by care coordinators (peer approach).</td>
<td>Full audit to be undertaken at least every 2 years with a follow up audit in-between.</td>
<td>Planning Care Work-Plan Implementation Group to oversee the audit; final report to go to Effective Care for sign off</td>
</tr>
<tr>
<td>(including arrangements for Standard Care Plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>