Livewell Southwest

Care Programme Approach Policy

Version No.1.3
Review: February 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **CPA Lead**

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Reader Information

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	Multi-Agency Public Protection Arrangements 2015 AWOL and Missing Inpatients v1:8 Section 17 Leave of Absence Policy v1:6 (Mental Health Act 1983) Section 17a Community Treatment Orders v2:4 The CPA and Care Standards Handbook, CPAA 3rd edition August 2008 MH Foundation Recovery Definition.
	Line Management and Appraisal Policy Record Management Policy and Adoption Statement Clinical Record and Note Keeping Policy MARAC Guidance Vulnerable Adults Guidance Mental Health Act Policies Mental Capacity Act Policy Clinical Risk Assessment & Management Meetings Guidance Child protection Policies / Documents on Healthnet Adult Protection Policies and Information on Healthnet Caseload Discussion Guidance
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New policy	January 2015	CPA Lead	New policy
0.2	Review following final consultation	Dec 2015	Professional Lead	Minor changes pre ratification
1	Ratified	January 2016	Policy Ratification Group	Ratified.
1.1	Minor amendments	Oct 2016	CPA Lead	Review following CPA training feedback
1.2	Minor amendments	Nov2016	CPA Lead	Final comments and PRG
1.3	Minor amendments	Dec 2016	CPA Lead	Inclusion of 2014 care Act in Sources of Information Page 2.

Care Programme Approach Policy.

1 Introduction

1.1 Livewell Southwest (LSW) will ensure that service users experience effective, safe and appropriate care, treatment and support that meet their needs and protect their rights.

1.2 LSW will support people and their families to build a meaningful and satisfying life as defined by the person themselves, whether or not there are on-going symptoms or problems, through applying the principles of Recovery and Social Inclusion.

1.3 CPA is supported through the adoption of the processes described throughout this policy, and through completion of the Organisations approved documentation on SystmOne, the electronic record. The SystmOne User Guide and Records Management Policy outline the standards for documentation for the use with both paper and electronic forms.

2 Purpose

2.1 The purpose of the policy is to support staff in the effective implementation of the Care Programme Approach (CPA).

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3 Definitions

3.1 **Advance Decision** – a legally binding decision to refuse specified treatment made in advance by a person who has capacity to do so, to be applied at a future time.

3.2 **Advance Statement of Wishes** – a statement about the care someone would like to receive. This is not a legally binding statement however, if presented, should be recorded and consequential actions noted.

3.3 **Care Co-ordinator** – the professional who, irrespective of their professional role, has responsibility for co-ordinating care, keeping in touch with the service user, ensuring the care plan is delivered and reviewed as required where the service user is being cared for under the CPA process.

3.4 **Carer** – someone who provides voluntary or paid for care by looking after and assisting a family member, friend, neighbour or employed under direct payments who requires support because of their mental health needs, and may or may not live with the person cared for. This does not include health and social care professionals, private agencies or 3rd sector carers.

3.5 **Lead Professional** – the person who has lead responsibility for an individual's treatment and care where that person is being cared for under the Standard Care process. Where an individual is the only person involved in the service user's care then that person will be the lead professional.

3.6 **Recovery** – For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model'™ to describe this way of thinking. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is "the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. MH Foundation (online 2016).

3.7 **Care Plan Evaluation** – evaluating the current care plan (this is not a formal CPA review).

3.8 **Standard Care** – treatment and care provided for those whose needs do not require the support of CPA.

3.9 **3rd Sector** – voluntary sector agencies who are contracted to deliver a service to an individual or groups of individuals.

3.10 **Private sector** – private agencies who are contracted to deliver a service to an individual or groups of individuals.

3.11 **Person-centred plan** – is an individualised plan of care from the part of the 'Green Light Toolkit' for improving mental health services for people with a learning disability.

3.12 **Step-up** – when a service user requires a higher level of intervention from LSW.

3.13 **Step-down** – when a service user requires a lower level or no intervention from LSW.

3.14 **MARAC** - multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

3.15 **VARM** - multi-agency risk management process to enable professionals to come together to develop creative and assertive plans to support Adults at Risk who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or by refusing previous offers of support from services.

3.16 **MAPPA** - multi-agency public protection arrangements to aassess and manage the risks posed by sexual and violent offenders.

3.17 **MH** – Mental Health

3.18 **DNA** – Did Not Attend

3.19 **HoNOS /LD HoNOS** - Health of the Nation Outcome Scale / Learning Disabilities HoNOS - National outcome measure.

3.20 **MHSDS** - Mental Health Services Data Set

3.21 **CORC** - CAMHS Outcome Research Consortium

4 Duties & responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2 **Director of Professional Practice, Safety and Quality** is nominated by the Board as the Executive Lead for CPA.

4.3 The **CPA Lead** and the **CPA Steering Group** are responsible for the development and implementation of this policy and strategic direction of CPA.

4.4 The **Director of Operations** and **Locality Managers** are responsible for ensuring that all teams operate CPA in a way that delivers optimum care for service users.

4.5 **Team Leaders** are responsible for:-

- Ensuring that this policy is followed and understood as appropriate to each staff member's role and function.
- Ensuring that staff acting as care coordinators have the required skills and competencies to carry out the role.
- Ensuring that effective case load management is in place.
- Ensuring that cover arrangements are in place for any absence of the care coordinator and these are communicated in a timely manner to the service user.
- Ensuring that audit recommendations in relation to CPA have an action plan.

4.6 The **Role of Consultant Psychiatrists**.

- All service users cared for under the CPA process will have a Consultant Psychiatrist involved in their care.
- The Consultant Psychiatrist is not clinically responsible for decisions taken solely by the Care Co-ordinator.
- Some service users on Standard Care will have a Consultant Psychiatrist as their Lead Professional.
- Under Standard Care there will be some service users who might not need a named Consultant Psychiatrist involved in their care.
- The medical care of such service users may be undertaken by their GP.
- Consultant Psychiatrists may be consulted by a Lead Professional in relation to the care delivered to the service user, this is within Locality Teams.

4.7 **Care Coordinators & Lead Professionals** will take responsibility for all aspects of a service user's care; this includes on-going assessment, planning and reviewing interventions, liaison with carers, including identifying carer's needs and requesting an assessment where appropriate.

Completion of all documentation required by the organisation and appropriate liaison with other teams, stakeholders and people involved with the service user. All clinical information must be recorded on S1 within agreed timescales and shared where necessary e.g. with GP or other teams.

They will be responsible for the provision of reports for the Mental Health Tribunal and Hospital Managers hearings. Care Coordinators will also attend the hearings as requested as notified by the MHA office.

All professionals working with people under CPA must be familiar with the Principles of the Mental Health Act 1983 as per the Code of Practice 2015. The Principles are:

- Least restrictive and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity.

It is good practice to be able to demonstrate how the Principles are considered throughout the care plan.

5. Scope

- CPA is the principle framework for providing services to people referred to LSW Mental Health Services.
- LSW will ensure that services are also provided under Standard Care for those people that do not have 'complex' needs and/or where risk assessment indicates

a less than significant risk to self or others (DH, 2008).

- CPA is underpinned by standardised Procedures for Adult and Older Peoples Mental Health, and where co-existing problems exist for people with a Learning Disability and / or Substance Misuse.

- Any person with a person-centred plan or a standard care letter will be incorporated under this CPA Policy to ensure parity of care.

- CPA will operate in all inpatient and community settings and will require good communication with all local organisations.

- CPA underpins the delivery of care for individuals with mental health difficulties involved in the criminal justice system, in line with the recommendations of the Bradley Report.

- The delivery of CPA will be supported in LSW through adherence to clear and robust supervision arrangements as outlined in LSW's Clinical Supervision Policy, Line Management and Appraisal Policies.

- LSW is committed to the fair treatment of all, regardless of their age, disability, gender, sexual orientation, race, ethnicity and religious beliefs.

5.1 Principle of Engagement with Service Users and Carers

- LSW staff will recognise and act upon the expertise that service users and carers bring from living with the challenges of mental distress.

- LSW will adopt a shared approach to ensure that service users and their carers have the opportunity to be actively involved in how they should be treated.

- Practitioners will use a strengths based approach that embraces individual aspirations, coping strategies and resiliencies, as well as identifying needs and challenges to promote and support recovery.

- Practitioners will work in partnership with service users and carers (if appropriate) to plan and review care. We expect that this will usually involve all parties meeting together. However at times it may be beneficial for the service user and carer to meet a practitioner separately.

- Wherever possible the service user will receive a copy of their care plan.

- The Principles of the Mental Health Act 1983 (MHA'83) as included in the MHA'83 Code of Practice (revised 2015) should be considered when making all decisions in relation to care, support or treatment provided under the Act.

- Livewell Southwest is committed to working with carers using the Triangle of

Care Framework and principles.

5.2 Standards for CPA

- Contractual requirements related to CPA will be adhered to and are available through the Business Intelligence Team.

- Further CPA guidance regarding CPA are available on the CPA section of Health net, and can be accessed through hyperlinks within this document.

- Details of any service specific forms and / or assessments to be used must be ratified through the CPA Steering Group.

6. Referrals In and Triage for LSW Services

- All referrals to LSW community teams are subject to an initial triage process.

- Referrals not requiring assessment will be returned to the referrer with referral outcome decision and recommendations for further intervention.

- Following the initial triage services may undertake a further meeting to consolidate the triage process or to provide brief intervention within the community setting.

7. Assessment

- Whether CPA or Standard Care is agreed, the principles and values underpinning CPA will apply; these comprise assessment, planning, intervention and review with a named practitioner.

- In some cases assessments may be incomplete after 1 contact, in these cases a maximum of 3 contacts can be offered to complete the assessment. Following these 3 contacts a decision should be made as to whether CPA or standard care is warranted. Contacts should be recorded on S1 and within the weekly Team discussion.

- In instances, where a carer is identified they will be offered a carer's assessment and subsequent plan to meet their needs.

- All referrals that are accepted will be assessed, completing the electronic record, to determine whether a service is warranted and, if so, whether CPA or Standard Care is appropriate.

- The assessment will last for the current episode of care for example when a person is admitted to hospital from the community. When a change in consultant occurs a new episode is initiated and a new assessment is required.

- The assessment will be completed based on the practitioner's assessment, in conjunction with service users and their carer/family to address issues written in the care plan.

- The assessment process must include the assessment of past and current risk.

- The process will identify the need for more specialist assessment for both service users and carers.

- Risk Management Information regarding the person's history and current difficulties will be sought from previous assessments and family members, where possible.

- Assessments need to fully acknowledge both the current and possible effects on the family due to any mental health problems identified.

- This is particularly relevant where there are children in the family, or where there may be a significant impact on other caring responsibilities the person may have. A member of the Safeguarding Team will be consulted in all clinical decision making for service users where a risk to a child is identified.

- Where further assessments are required, they will be requested and this will be recorded on the care plan.

- All assessments will adhere to the principles of recovery, social inclusion, equality of opportunity and diversity.

- Any assessment continuing after three appointments will be accompanied by a plan of action, which may include further assessment.

- The completion of all assessments will include allocation to a PBR care cluster and a HoNOS completed.

7.1 People assessed but not requiring a service from LSW

- Where a person is assessed but a service from LSW is deemed not necessary, a letter will be sent to the referrer and person, with the referral outcome decision and recommendations for further intervention, including any sign-posting to other services and consideration of any carers needs.

- Responses to referrals, (especially those not requiring a service) back to the referrer should be with the same priority as the original referral. For example a Referrer making an urgent referrals which is assessed as not requiring a service, should receive an urgent reply as to this effect.

- The assessor will be required to complete the relevant electronic record.

- Any person felt to require a service from Improving Access to Psychological Therapies (IAPT) or brief intervention from liaison services or CMHT will be included in this category.

7.2 Service users assessed as needing Standard Care

7.2.1 Those likely to be allocated to Standard Care are those receiving services from:

This list is not exhaustive and a service user might be in more than one category:

- Memory Services.
- Care Homes (without a care coordinator).
- Where only one professional is involved.
- Low risk for self, others, neglect, violence non concordant, suicide, self-harm.
- Unlikely to disengage from service.
- Less florid presentation of illness.
- Presence of supportive networks.
- Able to manage own medication, concordant and no adverse reactions or sensitivity to medications.
- One agency or straightforward needs involving more than one agency / service.

7.2.2 Any service user allocated to Standard Care must still have the principles of CPA applied to their care, as outlined above.

7.2.3 All those receiving services under Standard Care will have a Lead Professional.

7.2.4 The lead professional role must be undertaken by a practitioner of Band 4 or above who has primary responsibility for delivering care and who is best placed to oversee care planning and resource allocation and who has been assessed as competent to undertake the role.

7.2.5 Competency will take into account experience, together with evidence of learning (completion of CPA competencies). Competencies should be monitored through the line management / supervision.

7.2.6 The lead professional will have responsibility to complete a yearly review. This will be demonstrated through the completion of the Statement of Care template or Questionnaire – see section 7.2.9 for the minimum information to be included.

7.2.7 A review of standard care should be carried out as indicated by the service users PBR cluster.

7.2.8 The service user and referrer will be offered a summary of the review, including

the plan of care, service users should be encouraged to sign the review.

7.2.9 Standard Care Letter / Questionnaire on SystmOne should be used detailing:-

- Risks
- Future Plans
- Crisis Contingency planning
- Review Date (Must not exceed 12 months)
- Lead Professional

Recorded at the same time as the letter being written:

- Minimum Mental Health & Learning Disability Data Set MHLDDS
- Health of the Nation Outcome Score (HoNOS) or (LDHoNOS)
- TAG Risk assessment

If creating a standard care letter as opposed to using a care plan on SystmOne then a statement of care template and TAG risk assessment needs to be completed for reporting purposes or else the patient will be reported as not having had a review. The Statement of Care template can be completed by a medical secretary on behalf of the Lead Professional.

7.3 Service users assessed as needing CPA

7.3.1 Those likely to be allocated to CPA are those that fit the criteria below. On occasion when someone appears to meet the criteria but Standard Care is deemed more appropriate, the consultation and justification for this decision needs to be documented in the individual's clinical record, for example someone who is stable on s117 aftercare and only require standard care.

- Safeguarding issues identified and LSW is the lead organisation, including requirement for referral to Multi Agency Public Protection Arrangements (MAPPA).

- Anyone requiring admission to an in-patient unit, or under the care of the Assertive Outreach Service (AOS) or Home Treatment Team (HTT). For those under the care of AOS and transfer back to the CMHT is imminent; a discharge care plan indicating they are on standard care is an acceptable exception.

- Anyone who is subject to the Mental Health Act, including a Community Treatment Order (CTO), unless they are stable on S117 requiring standard care only.

- Where the practitioner will be responsible for coordinating the involvement of more than one agency.

- Medium to high risk for self, others, neglect, violence, non-concordant, suicide,

self-harm.

- Likely to disengage from services /difficulty of engagement.
- Acute presentation of illness.
- Little or no supportive networks.
- Non-concordant with medication or adverse reactions / hyper sensitivity to medication.
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/ recently detained under Mental Health Act or referred to HTT.
- Entitled to S117 aftercare until first review post discharge from hospital/HTT (need for CPA to be determined at subsequent reviews). The S117 policy contains further information regarding the recording of aftercare needs.

7.3.2 Those service users assessed as needing CPA will have a named Care Co-ordinator who will take responsibility for coordinating all the functions of CPA. The Care Co coordinator will be a band 4 or above from any profession within the multidisciplinary team.

7.3.3 The role of the Care Co coordinator includes:-

- Lead and co-ordinate assessments required to produce a Care Plan and the plan for managing risk.
- Provide the main link between the services and the service user.
- Ensure that their records are kept up to date according to the Record Keeping Policy.
- Monitor the Care Plan and review it, this includes S117 reviews.
- Be familiar with the service user's circumstances and consult them on their wishes that may relate to their cultural, family context or ethnic background.
- Maintain close contact and develop a therapeutic/working relationship.
- Plan for their own expected absence by ensuring that:

    1. Cover is arranged in advance by a named/duty person who will meet all the minimum standards for care.

2. Unplanned absence should be covered by the clinical team who will meet all the minimum standards for care.

3. Arrange reviews for service users at discharge/transfer and at a minimum of their PbR clustering (where used, not in LD). (Note for those under MoJ requirements: 3 monthly for people subject to Ministry of Justice requirements in the community and 4 monthly for those in an inpatient setting). It is recognised that whilst a service user is undergoing a period of in-patient treatment it may be more appropriate for the named nurse to coordinate the review. With regards to the clustering, once clustered the time is set which completes the cluster node with the time of when the next review is due. Staff can also set a recall which can sit on the recall screen.

4. Recognise that any member of the team or other agencies can call an emergency review where circumstances demand. The Care Co-ordinator must always be informed.

5. Identify clearly who should be invited to attend reviews, present information about the progress at reviews and chair reviews.

6. Co-ordinate Carers Assessments

7. Take responsibility for maintaining policy standards and attending CPA training.

7.3.4 Practitioners need to be aware that systems as well as CPA may apply to particular service user groups such as MAPPA, Deprivation of Liberty Safeguards (DOLS), S117 arrangements, Mental Capacity Act (MCA) and child protection arrangements.

8. Risk Assessment:

8.1 Generic Risk Assessments:

8.1.1 The risk assessment is a living document and must be updated as additional information becomes available and reviewed at least every six months. After 6 months risks should be transferred to the risk history form.

8.1.2 The risk assessment will last for the current episode of care.

8.1.3 When an initial risk assessment is being completed at referral / assessment into service, it is acknowledged that collecting information may for some people take some time. To ensure safety risk assessment paperwork should be completed as soon as possible; however staff have a maximum of 10 working days to “lock the final version from editing”.

If the final version is not locked immediately – clinicians must ensure known risk information must be populated within the risk assessment, and rationale clearly visible within the record detailing why the risk assessment is incomplete and expected completion date. If the document is not completed and risks identified then the clinician should ensure there is a narrative to explain the risk more fully.

8.1.4 The risk assessment is a holistic assessment and is the method of identifying both health and social care risks these should be carried over to the care plan. It should be more than a tick box – professionals are responsible for fully completing the narrative elements detailing specific risks.

8.1.5 It is expected that the professional's and carer's point of view will be taken into account and parental responsibility is established for children and young people.

8.1.6 The risk assessment process must include the assessment of past and current risk.

8.1.7 The process will identify the need for more specialist assessment for both service users and carers.

8.1.8 When should it be completed?

a) Following assessment and as a minimum for those not taken onto caseload the **Threshold Assessment Grid** should be completed, for those on CPA the **full CPA risk assessment** must be completed.
b) On Admission.
c) Prior to discharge/referral/transfer to other agencies.
d) If mental health presentation changes.
e) If patient/client presentation requires more frequent risk assessment.
f) When there is a change of Care Co-ordinator.
g) At PBR/CPA Review – including S117 review.
h) If patient/client is admitted to in-patient facility.
i) Where a more in depth risk assessment is required for those under Standard Care (this will be determined by professional judgement).
j) At least once every 6 months.
k) Prior to MHA Tribunal or Hospital Managers Hearing.
l) When there is a change in detention, or if a section is renewed.
m) When a patient is placed on a CTO.
n) For those who are awaiting allocation of a care coordinator the risk assessment template for allocation must be completed with TAG as a minimum every 2 weeks.

8.1.9 If a risk is identified then details must be recorded on the risk assessment sheet,

- All sections must be completed.
- The ` YES ` column relates to time of assessment.

- The ` NO ` column relates to the time of assessment.
- The ` History of ` column relates to any previous risk or concern that has happened in the past irrespective of when, prior to the time of assessment.
- All sections must be completed. Any other concerns may be added to these sections.
- When an X is placed in the Yes or History column information to support this must be recorded in the action/comments column. This will then inform the care planning process.
- Warnings will be put onto SystmOne when the patient/client presents a risk to others. This warning must include a date for review of the warning and the risk associated with it.
- Risks over 6 months old should be transferred to the Risk History Section.

8.1.10 **Specific Risk Assessment Guidance for Areas:**

Acute Inpatient, Plymbridge House and Cothele – Risk assessments should be updated weekly.

8.2 **Additional Risk Assessments**
(nb staff need additional training in both assessments before they should be completed).

8.2.1 A **STORM** risk assessment should be completed by a suitably trained individual when there is <u>any</u> risk of suicide and or self-harm identified, this could be at initial assessment or whilst waiting for allocation of a care coordinator. STORM worksheets should be completed and appropriate review of the individual's place on the pathway should be reviewed. In these cases STORM worksheets should sit alongside CPA assessment, any care plans and additional risk assessments.

STORM Training is available and deemed essential for most clinical staff, currently this is not part of essential training for Consultant Psychiatrists and other Medical Staff, in these cases staff should contribute to the assessment rather than completing it themselves.

8.2.2 An **HCR-20** risk assessment should be considered by the multi-disciplinary team possibly as part of a review, when there is a history of violence and or the patient/client required active risk management around their aggressive behaviour.

8.3 Risk Summary Form

8.3.1 This form is to be used to summarise risk information; that has occurred prior to the last 6 months, reference to this must be made on the risk assessment, also referencing other risk assessments such as STORM, HCR20 etc.

- Information may be summarised, making reference to dates and times.
- Information may be added to at any time. This information is used to inform any risk decision that needs to be made.

- It is intended to summarise risk history which has occurred up to a six month period prior to the current risk.
- If further detail is required reference should be made to previous risk assessments and clinical records.

8.4 Risk Management Plans:

Any risk management plans should be recorded within the electronic record using the Risk Management Plan template. Guidance can be found within the Clinical Risk Management Policy available to staff.

9. Care Planning & Care Planning evaluation

9.1 General Considerations

- All service users will have a care plan appropriate to their needs.

- The service user's care plan must be person centred and based on the thorough assessment of their health and social care needs including assessment of risk. The care plan will involve the service user and their carer where appropriate, as central participant(s) in the process.

- Contents of the care plan must include contingency plans, relapse indicators and management of any identified risks, which will be accessible to all those involved in the patient's care.

- The service user should be involved in their care plan / statement of care and be offered a copy of it. In either instance where the service user declines or where deemed clinically inappropriate, the reason should be clearly documented.

- For those on Standard Care, the care plan must be in letter format as a minimum standard and a statement of care template complete on SystmOne.

- For those on CPA the care plan must be completed on the CPA Care Plan assessment as a minimum standard.

- Care plans will clearly set out the type of intervention required, the responsibilities of those involved, and the desired outcome.

- The care plan will be structured to record those needs that the person can address for themselves and those where support is necessary from LSW, other organisations and family or carers.

- The care plan should identify and build on strengths based approaches consistent with the recovery approach, and should reflect the aim of personalised care and social inclusion.

- Potential risks and any actions to be taken should be included in the care plan. Positive risk management should underpin any plan of care.

- If disengagement or non-attendance happens it will always be discussed and recorded within the care plan, as well as the agreed actions to be taken.

- All care plans will include crisis, relapse and contingency plans, and any advanced wishes (or decisions). The plan will include action to be taken with regard to any disengagement or non-attendance for appointments.

- Regular evaluation of care plans / statement of care must take place in accordance with agreed protocols for each individual service area / team. The minimum standard for those outside of inpatient areas is 6 monthly or more regularly if needs change. Those areas below will review care plans as below.

9.2 Unmet need

The Care Co-ordinator/lead professional will identify any unmet needs as part of the process of completing the assessment and record within the care plan, on an incident form and raise with line manager.

9.3. Specific Guidance for Areas:

9.3.1 **Acute Inpatient including Plymbridge House, Cothele and Edgecumbe**

- On a weekly basis, all service users will have a care plan evaluation resulting in updating the service users care plan on SystmOne.

- Care plans will be updated following any evaluation/ review and as required by service user presentation.

- Within 4 hours of admission there is a minimum care plan in place. This will then be developed into a person centred care plan.

9.3.2 **Recovery Inpatients**

- Minimum of fortnightly care plan evaluated in a Ward Round Review meeting or as required by the service user's presentation. This evaluation should be documented in the individuals SystmOne record.

9.3.3 **Home Treatment Team**

- Minimum of fortnightly care plan evaluated in a regular Review meeting or as required by the service user's presentation.

9.4 Crisis / Contingency Plans

- The plans should detail the actions a service user and/or carer would take where they feel the service user is deteriorating in their health and well-being and disengaging with services. It is important to capture a person's wishes regarding the provision of information to friends, carers etc. when they are well. By recording these details when the person is well it is more likely that conflicting issues regarding the sharing of information can be avoided.

- The Crisis plan should detail an Out of Hours Contact number. Where possible staff should support the service user to construct the crisis plan enabling it to be written in the first person.

- Contingency plans will detail the service/staff response to any deterioration in the service user's health, wellbeing and/or risks.

- Detailed specific actions to be taken in response to DNA's and non-concordance with agreed plans and treatments.

- Will include any relevant requirements of any valid Advance Statement of Wishes / Advanced Directive and rapid access plan.

10. Referral for a Care Coordinator

10.1 Community Settings

- Allocate Lead Professional / Care Coordinator within maximum of 10 working days of assessment being completed. If this is not possible the individual operational policies should be consulted for the process of managing this. Risk review and contact should be maintained as per operational policies.

- Inform patient/client of name of Lead Professional / Care Coordinator as soon as allocated.

10.2 Acute Settings – Glenbourne / HTT/ OPMH Inpatients

- Where an in-patient stay is likely to be less than 3 months and where a service user does not have a Care Coordinator the appropriate team must appoint one within 10 working days from receipt of referral by the inpatient team.

- When the patient/client is admitted to Home Treatment a request for a Care Coordinator will be made to the appropriate service within 72 hours of a decision being made that a Care Coordinator is required. The appropriate service must respond with the name of the Care Coordinator within 10 working days of the request being made.

10.3 Recovery Inpatient settings

In an in-patient recovery setting where duration of admission is expected to exceed 3 months the Care Coordination role will be undertaken by the most appropriate health professional within that team. Allocation of a Care Coordinator should take place a minimum of 1 month prior to discharge from the in-patient recovery setting.

11. Review of those on CPA and Standard Care

11. 1 CPA Review – general considerations

11.1 All Care Programme Approach (CPA) documentation must be formally reviewed in line with the patient's current PBR cluster or when the following conditions apply:-

- significant change in the patient/client's presentation.
- prior to discharge from hospital.
- prior to a Mental Health Tribunal or hospital managers meeting.
- transfer of care from one service to another.
- disengagement from services.
- discharge from secondary mental health services.
- entitlement to Section 117 aftercare.
- change of legal status.

11.2 Each review will consider the issue of whether CPA, Standard Care or step down to Primary care (GP Led) is appropriate, and the appropriate risk assessment undertaken to support any changes made.

11.3 Reviews of care should take place with the service user and others involved, in line with the review set under their PbR Cluster (where appropriate). For those clustered in cluster 7 to 13 - reviews should be 6 monthly instead of annually this in line with CPA guidance and is considered good practice. With regards to the clustering, once clustered the time is set which completes the cluster node with the time of when the next review is due. Staff can also set a recall which can sit on the recall screen.

11.4 Where face to face reviews are organised, agreement will be sought from the service user about whom it is felt needs to be present.

11.5 If step down from CPA, either to Standard Care or back to GP in Primary Care is being considered then a full assessment of risk will be undertaken, include a relapse prevention plan, and instructions on rapid access to care and / or advice.

11.6 At the point of step down to Primary Care, all relevant information will be communicated again to the GP. The GP, service user and any carers will be made aware of circumstances where access to Secondary Care may be appropriate.

11.7 Wherever possible carers will be consulted on and involved in all stages of

developing care plans and reviewing the on-going care of the service user, including the offer of a meeting alone to discuss any concerns.

11.8 A formal review will take place before any step up (to CPA) or step down (to Standard Care or Primary Care) from services, including discharge from hospital, which should be at the earliest opportunity to facilitate putting in place any relevant plans.

11.9 The care plan will reflect any specific vulnerability of services users leaving hospital and clearly document actions to be taken to provide the requisite level of care in the post discharge period.

11.10 A step down may take place where a service user is in a placement / has a care package where the only function of LSW staff is to undertake a review.

11.11 If secondary mental health services are solely providing a liaison and / or monitoring service to primary care, such as those prescribed specific medications that necessitate this specialised monitoring and prescribing , then step down could be considered.

11.12 Any on-going S117 requirements will be reviewed at each CPA meeting and will be recorded in their SystmOne record.

11.2 Standard Care Review

11.2.1 A standard care review must take place as appropriate and at least annually.

11.2.2 A review of standard care should be carried out as indicated by the service users PBR cluster.

11.2.3 The service user and referrer will be offered a summary of the review, including the plan of care.

11.2.4 Standard Care Letter / Questionnaire on SystmOne should be used detailing:-

- Risk
- Future Plan
- Crisis Contingency
- Review Date (Must not exceed 12 months)
- Lead Professional

11.2.5 Recorded at the same time as the letter being written:

- Minimum Mental Health & Learning Disability Data Set MHLDDS
- Health of the Nation Outcome Score (HoNOS)
- TAG Risk Assessment

11.2.6 If creating a standard care letter as opposed to using a care plan on SystmOne then a statement of care template and TAG Risk Assessment needs to be completed for reporting purposes or else the patient will be reported as not having had a review. The Statement of Care template can be completed by a medical secretary on behalf of the Lead Professional.

12. Step up / Step down within CPA and Transfer / Transition of Care within LSW services

- Any service user maybe stepped up (to CPA from Standard care) or stepped down (to standard care following a CPA review) at any time depending on need.

- It is good practice to discuss fully with the service user and any other key individuals and plan to step up or step down. Ideally the service user should be in agreement with the decision, if this is not the case a clear rationale should be recorded in the record.

- In any transfer or transition of care, the individual needs of the service user must remain paramount and will not be disadvantaged.

- No duplicate assessments will be undertaken to decide suitability for accepting any transfer request, as this may result in unnecessary delays.

- Care will remain with the originating team, until it has been officially transferred through a CPA review or a comprehensive handover meeting including formal transfer from the relevant medical professional involved. Copies of the CPA review, care plan and risk assessment must be available to the new team when the request for transfer / transition is made.

- Where it is felt that inappropriate transition requests are being made, the transfer will still continue to prevent unnecessary disruption to the service user, and local arbitration processes will be followed.

- Where utilising Care Clusters, transition will be determined via these Procedures.

- When transferring a patient out of area or to another provider the above would still apply. In addition, the referrer (from Livewell) must confirm receipt of the referral with the new team (external to Livewell) within 2 working days of it being sent. Local Operational policies for services may contain more detailed information on transfers external to Livewell.

13. Carers

- Carer involvement should be agreed with service users as appropriate; if necessary with negotiation to clarify any information the service user does not wish to be disclosed. Carers do not automatically have the right to a

person's care plan. Chapter 10 of the MHA'83 Code of Practice 2015 provides useful information regarding confidentiality and information sharing.

- Caring arrangements can change and should be reviewed regularly, particularly during the care plan review and care planning process.

- Within SystmOne carers should be registered. It is on the intranet under Systems> SystmOne > Useful links and Guides > How to register a Carer

  http://pchnet.derriford.phnt.swest.nhs.uk/Systems/SystmOne/UsefulLinksandDocuments.aspx

13.1 Anyone identified as a carer is entitled to:-

- The opportunity to contact or meet professionals without the service user present.
- Support to express their views and raise any concerns.
- An explanation of the role of the CPA Care Co-ordinator or lead professional.
- Be told who to contact in an emergency.
- Be given information about CPA/Standard Care.
- Be given information about 'out of hours' support.
- Continuing support in their caring role (Carers Act 2004).
- Be told that they have a legal right to an assessment of their own, repeated at least annually (Carers Act 2004).
- Their own written support plan, implemented in collaboration with them (Carers Act 2004).
- Request a review of their support at any time.

13.2 Service users may have caring responsibilities of their own. These should be identified in assessments and appropriate support should be identified in care plans with liaison from other services as necessary.

14 CPA – Discharge

14.1 Discharge from the ward and 7 day follow up

- Upon discharge from a ward, all service users with a risk of suicide at point of/during admission identified on their risk assessment will be followed up at 24hrs hours and all other service users should be followed up within 7 days of discharge.

- There is a requirement for service users discharged from in-patient services who are receiving care under the CPA process to be followed up within 7 days of discharge. This includes discharge to a nursing home.

- The follow up may be either face to face or via telephone. Contact must be

recorded on SystmOne as a minimum standard.

- There is no requirement for 7 day follow up where a service user is discharged under the Standard Care process; however this decision must be recorded on SystmOne.

- 7 day Follow Ups are monitored and reported to our Commissioners.

14.2 Discharge from secondary mental health services

- Any decision that someone no longer needs the support of secondary mental health services should be confirmed during CPA Review meeting or Standard Care review and service user discharged back to the appropriate Primary Care Services.

- At all times those using services must be fully engaged along with all those involved in their care, including carers, other members of the Team and other services if necessary both internal and external to LSW.

- Discharge Plans and the process should be recorded fully in the record, using the CPA Review, appropriate risk assessments and care plans and any instructions for re-referral if needed. Once discharge is agreed by all involved then this information should be circulated to all involved.

- If disagreement exists regarding discharge this should be carefully managed and advice sought from Team manager, Lead Consultant. Discharge should not occur until differences resolved or a plan is developed.

15. Loss of contact/refusal to maintain contact with services

- Service users have the right to refuse treatment providing that they have the capacity to understand the consequences of giving or withholding consent to treatment and are not subject to compulsory treatment under the Mental Health Act 1983.

- Services should make all reasonable attempts to ascertain the reason for non-contact and offer a second appointment

- If no immediate risks then discussion should be held in the Team Review Meeting or other appropriate forum and local protocols followed. The Care Co-ordinator/lead professional will ensure that decisions for managing the non-attendance are clearly documented in the clinical record.

- If immediate risks are identified consideration should be given to arrange an assessment under the Mental Health Act, consider a welfare check with the police or organise a risk management meeting. The Care Co-ordinator/lead

professional will ensure that decisions for managing the non-attendance are clearly documented in the clinical record.

- Local procedures should be available through operational policies for services relating to non-attendance processes.

- If a person is entitled to S117 but refuses to engage it could be appropriate to end the S117. The appropriateness of ending the S117 should be a multi-disciplinary decision which is looked at on a case by case basis. The MHA'83 Code of Practice 2015 Chapter 15 provides further guidance on ending section 117.

16. Recording Measures: MHSDS, HoNOS, CORC

- Completion of the Mental Health Services Data Set (MHSDS) is a requirement for DH. Patient registration details must be checked for accuracy at every intervention and updated as required.

- Health of the Nation Outcome Scales (HoNOS/ mental health clustering tool) are a requirement of the Department of Health (DH) for all mental health service users over the age of 18. These will be completed at assessment and every review as a minimum standard. CAMHS will adhere to CAMHS Outcome Research Consortium (CORC) requirements. Learning Disability Teams will adhere to LDHoNOS.

- When service users under the age of 18 are being treated by adult mental health services the adult standards will be adhered to.

17. Dual Diagnosis (co-existing mental health and alcohol and drug problems)

17.1 There are increased risks of suicide, non-engagement, non-compliance of medication, of a poorer prognosis, social exclusion and physical related harm for people with dual diagnosis therefore effective detection, support and treatment is essential.

17.2 The treatment with the strongest evidence base is an integrated approach. The primary responsibility for care planning sits within mental health services.

17.3 Current alcohol and drug use must not exclude people from a full assessment. If alcohol and drug needs are identified and interventions, including management of risk, identified in the care plan and any appropriate referrals made, this includes appropriate care coordinator.

18. Rapid Access on Step Down to Primary Care

- Any service user subject to CPA who is stepped down to Primary Care will be able to make use of a Crisis Relapse and Contingency Plan. This plan will outline the detail of the circumstances for allowing rapid access.

- The service user, carer or member of their support network will be able to contact their previous team for rapid access. Every effort will be made to ensure that the previous care coordinator is allocated.

- The timeframe for rapid access will be decided by the care coordinator and service user in collaboration with others involved in their care. The date when rapid access ceases will be identified in the initial step down crisis, relapse and contingency plan.

- For some on Standard Care a Rapid Reassessment Pathway will have been agreed, in these cases the route agreed within the plan will be followed. This allows those to be discharged safely to primary care with an appropriate reassessment plan that once activated can start a timely and clear referral pathway back into services. Eligibility Criteria apply.

- Following this period service users will be able to access LSW services through referral routes as identified above.

19. Confidentiality

- Service users have a right to understand their rights to confidentiality and the circumstances in which LSW practitioners have a duty to share otherwise confidential information with others.
- Whenever possible, it is good practice to share relevant information both within the care team and with family, carers and significant others, as detailed in the LSW Data Protection Policy and outlined in Department of Health guidance NHS Code: Confidentiality.

- The scope of information to be shared will be discussed with the service user, family, carers, and significant others in order to develop safe and beneficial therapeutic relationships between all those involved with the person.

20. Legal Considerations – Mental Health Act and Mental Capacity Act

There are separate policies and links in clinical areas available for staff covering these areas in more detail.

20. 1 CPA and Mental Health Act 1983

- All service users who are detained under the MHA in hospital, or who are subject

to Guardianship or Supervised Community Treatment will be supported under CPA.

- S117 aftercare needs and entitlement must be reviewed in line with CPA. A review must be held on 6 monthly basis minimum, more frequently if indicated. It is considered good practice for the Section 117 Aftercare planning meeting to take place prior to a patients discharge from hospital, this includes extended section 17 leave.

- It will be the responsibility of the patients care co-ordinator to ensure that S117 Aftercare review meetings are arranged in line with the S117 policy. If the care coordinator is not available the duty will fall to the clinical team manager.

- All statutory reviews of S117 must be recorded on the CPA Review form. The needs of the patient identified as part of this review will form part of the care plan for the treatment and management of their mental disorder.

- All professionals working with individuals detained under the Mental Health Act should have detailed knowledge of the MHA'83 Code of Practice (revised 2015) including its purpose, function and scope. Chapter 34 of the Code of Practice is of particular importance relating to this policy. This Chapter provides guidance on the key features of the CPA, when to use it, who should be involved, and on care planning. Where this chapter uses the term "should" departures should be documented and recorded. Where the terms "may", "can" or "could" are used the guidance is to be followed wherever possible.

  Mental Health Act Code of Practice:
  https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

20.2 CPA and Mental Capacity Act

- Service users may not always have the capacity to make decisions for themselves. Effective working requires that in line with the principles set out in the Mental Capacity Act 2005, every practicable step to help someone make a decision must be taken, and any act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

- Full guidance on capacity issues and the law affecting them is set out in the MCA Code of Practice (DCA 2005) (http://www.justice.gov.uk/protecting-thevulnerable/mental-capacity-act), the Deprivation of Liberty Safeguards Code of Practice (MoJ 2008).

  Mental Capacity Act Code of Practice:
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

20.3 Deprivation of Liberty Safeguards (DOLS)

- The DOLS Code of Practice contains guidance on the deprivation of liberty safeguards.
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- The DOLS authorisation process is organised by the Local Authority. Each part of the process has paperwork to demonstrate that the correct statutory assessments have taken place and the detention is necessary. When an authorisation has been granted the Local Authority will provide a copy of the authorisation to the detaining establishment.

- Where the person is receiving care and treatment by the mental health services a care plan will still be required as this will evidence what treatment is being provided and under which legal authority parts of the care plan are provided. It is important to remember that the DOLS authorisation does not provide authority for the treatment of an individual lacking capacity only their detention. The MCA 2005 authorises the care and treatment of an individual lacking capacity providing the principles are followed (as above). A good care plan will demonstrate what treatment is being provided and why it is in the individual's best interest to receive that treatment, what assessment of the individual's capacity took place and what measures were taken to assist the individual in making their own decisions.

- All recording of DOLS related information should be made in the relevant section on SystmOne.

21. Safeguarding and Risk

- LSW is committed to delivering effective public protection and safeguarding arrangements to manage care and risk, for service users, their families and carers, and their communities.

- Every person referred to LSW will have a risk assessment completed and recorded in SystmOne.

- Details of any significant contact with children must be recorded at assessment and details should be checked at subsequent CPA & Standard Care Review meetings. For details of what must be recorded please see practice guidance for staff.

- Where a safeguarding issue or concern has been identified of a sufficient degree to require an alert form or a referral to a partner agency, procedures on the following links will be followed:-

  Safeguarding Children.
  Domestic Abuse.
  MAPPA.
  Safeguarding Vulnerable Adults.

MARAC.
VARM.

22 Advanced Statement of Wishes and Advanced Decisions

More in depth information is available from the Mental Health Act ’83 Code of Practice 2015, Chapter 9 and the Mental Capacity Act Code of Practice. Chapter 9.

22.1 Advanced Statement of Wishes

- An advanced statement of wishes is a guide, owned by the patient. This statement is not legally binding or enforceable but if presented should be recorded and consequential actions noted. All service user’s should be informed of their right to make an advanced statement of wishes, although it must be explained to them that if might not always be possible to follow someone’s preferred wishes.

- If there is an advanced Statement of Wishes this should be noted on the care plan on SystmOne. The statement is designed to be held by the patient to ensure the most up to date copy is available.

- If there is any deviation from the advance statement of wishes, this should be documented and a rationale given.

22.2 Advanced Decision

- An Advanced Decision is intended to be a binding refusal of certain kinds of treatment as specified by the person making it.

- The Mental Health Act can override an advanced decision to refuse treatment for mental disorder with the exception of ECT unless emergency treatment is needed under section 62. To meet the criteria for urgent treatment, the ECT must be either:

    - Immediately necessary to save the patient’s life or

    - Treatment which (not being irreversible is immediately necessary to prevent a serious deterioration in the patient’s condition.

    - The MCA requirements for refusing treatment which may be life sustaining would still apply for ECT. I.e. must be in writing, signed and witnessed, clear, specific and state that “the advance decision is to apply to the specific treatment even if life is at risk”.

23. Equality and Diversity

- The values and principles that underpin CPA are applicable to all people who are offered a service, whether or not they are on CPA.

- Assessments, Care Plans and Reviews should take account of the needs of individuals irrespective of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs.

- Wherever possible service users will be offered a choice of gender of Care Coordinator/lead professional and choice of Care Co-ordinator/lead professional, that takes into account any cultural or religious needs.

24 Training implications

- It is essential that all clinical staff have the necessary skills, knowledge and competencies to undertake their role. This can be achieved through training and the ongoing competency package, which should be reviewed at line management.

- CPA training is available through Professional Training and Development – this training must provide an overview of CPA, LSW's CPA Policy but also link to SystmOne the electronic patient record for MH.

- Training must be updated at least every 3 years.

- Competencies are available for both registered and unregistered staff and are downloaded from the Intranet.

- Livewell SW is part of the CCA, training opportunities and resources are available from the CCA. LSW has nominated links to the CCA and will regularly review training and resources available.

25 Monitoring compliance

- The CPA Lead is responsible for monitoring that the standards and requirements of this policy have been met.

- Compliance with this policy will demonstrated through ongoing record review specific to individual areas, investigations where records are reviewed, competencies and training evaluations.

- National Audit findings - such as the Care Quality Commissions' inpatient / community audits

- CPA compliance is monitored through the LSW Databook and reported through the Safety, Quality and Performance Meeting. Minutes of the Learning Disability and Mental Health Records Group are available.

- Any issues arising from the review process and monitoring that will aid and inform wider learning will be communicated via the LSW's programme of thematic reviews.

- Operational managers are responsible for ensuring the quality of practice of staff, and should regularly review the skills of individuals and their ability to carry out tasks and obligations with regard to the process of CPA.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: 5th February 2016

Date: Director of Operations

Appendix 1:

When Should a CPA Episode be started by staff?

Inpatient wards

All inpatient wards start the patient on CPA if they have not already been on CPA prior to admission. The named nurse on the ward will take on the role of the care coordinator until one can be allocated. The named nurse will only open a responsibility under the ward view on S1 of named nurse; they do not open a care coordinators responsibility. A referral is made the CMHT for a care co-ordinator; the CMHT will add the referral to the awaiting care coordination waiting list.

HTT

HTT do not care coordinate but all of the patients coming through their service (as gatekeepers to the ward) would have enhanced needs and thus be commenced onto CPA. A referral to the ward and/or CMHT would be completed. The HTT would take on the role of care coordination as a team until a care coordinator is confirmed. The HTT would only open a referral allocation as a team, on discharge from their service they would decide whether the patient needs to remain on CPA, if not they would discharge from CPA and hand care back to the G.P or if needing a lead professional a referral to the CMHT to ask for this. If needing to remain on CPA the referral for care coordination would go to CMHT who would add to their awaiting care coordination waiting list.

AOS

AOS would open a referral allocation and the clinician taking on the responsibility of care coordinator would also open a responsibility of care coordinator within S1. As the patient ends their care with AOS, they may no longer meet the criteria for CPA if this is the case CPA would be closed and the AOS member of staff would end the care coordination and open a lead professional role either with the member of staff who was the care coordinator or the consultant may take on this role. The referral to the CMHT would be for a lead professional.

CMHT

The CMHT would not open CPA for a patient until there is a care coordinator available. However, they would not end CPA if someone has already been commenced on CPA and is awaiting re-allocation of a care coordinator. The team would be responsible for making sure that care was still provided within the framework of CPA until a care coordinator can be assigned, to assign a care coordinator to someone on CPA must be a high priority. If someone on standard care needs a risk assessment that is more comprehensive than a TAG, then a CPA risk assessment can be completed, as the case with a CPA care plan, however if this level of assessment is required the clinician should ask themselves whether the patient's needs could be better addressed within the framework of CPA. A discussion should take place with the Team Multi-Disciplinary Meeting and the person added to the awaiting care coordinator waiting list if requiring CPA.

Consultants

If the consultant is acting as the lead professional then they should open a referral allocation in the name of the team, add the consultants name as a member of staff under this allocation and open up a responsibility of lead professional. If they are only acting as the consultant in the care of the patient then they should only open a referral allocation in their name under the team's referral allocation.

In General:

The patient should only have **one care coordinator** if on CPA and **no** lead professional.

There should be a **referral allocation** in the teams name and the member of staff should add their name under this allocation, this is so that if they want to use mobile working they will be able to download their own case load rather than the whole team and will also be able to search under referral allocations for their own caseload too.

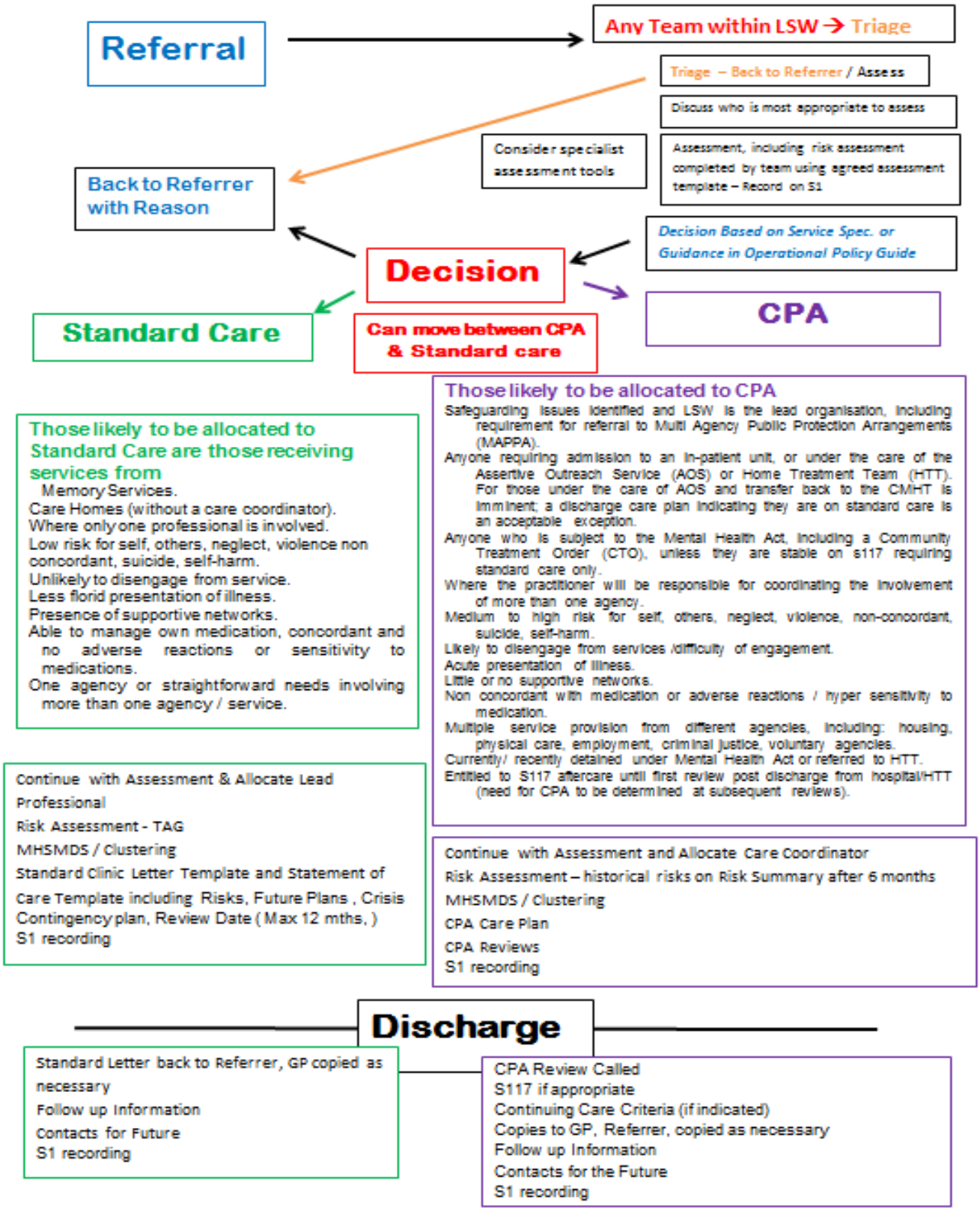
The patient **should only have a lead professional** if on standard care and **no** Care coordinator.

All patients being cared for within **community mental health services** with an **open referral** should have a team involved in their care and **should be on standard care or CPA.**

Memory service exception (ACI monitoring)- patients should have their referral kept open, allocation closed added to the waiting list (ACI Monitoring) lead professional/care coordinator role closed and CPA closed if they are not being seen by anyone else.

Children's services should work as above.

Appendix 2:


Referral
Any Team within LSW → Triage
Triage – Back to Referrer / Assess
Discuss who is most appropriate to assess
Consider specialist assessment tools
Assessment, including risk assessment completed by team using agreed assessment template – Record on S1
Back to Referrer with Reason
Decision Based on Service Spec. or Guidance in Operational Policy Guide
Decision
Standard Care
Can move between CPA & Standard care
CPA
Those likely to be allocated to Standard Care are those receiving services from
Memory Services.
Care Homes (without a care coordinator).
Where only one professional is involved.
Low risk for self, others, neglect, violence non concordant, suicide, self-harm.
Unlikely to disengage from service.
Less florid presentation of illness.
Presence of supportive networks.
Able to manage own medication, concordant and no adverse reactions or sensitivity to medications.
One agency or straightforward needs involving more than one agency / service.
Those likely to be allocated to CPA
Safeguarding issues identified and LSW is the lead organisation, including requirement for referral to Multi Agency Public Protection Arrangements (MAPPA).
Anyone requiring admission to an in-patient unit, or under the care of the Assertive Outreach Service (AOS) or Home Treatment Team (HTT). For those under the care of AOS and transfer back to the CMHT is imminent; a discharge care plan indicating they are on standard care is an acceptable exception.
Anyone who is subject to the Mental Health Act, including a Community Treatment Order (CTO), unless they are stable on s117 requiring standard care only.
Where the practitioner will be responsible for coordinating the involvement of more than one agency.
Medium to high risk for self, others, neglect, violence, non-concordant, suicide, self-harm.
Likely to disengage from services /difficulty of engagement.
Acute presentation of illness.
Little or no supportive networks.
Non concordant with medication or adverse reactions / hyper sensitivity to medication.
Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
Currently/ recently detained under Mental Health Act or referred to HTT.
Entitled to S117 aftercare until first review post discharge from hospital/HTT (need for CPA to be determined at subsequent reviews).
Continue with Assessment & Allocate Lead Professional
Risk Assessment - TAG
MHSMDS / Clustering
Standard Clinic Letter Template and Statement of Care Template including Risks, Future Plans , Crisis Contingency plan, Review Date (Max 12 mths,)
S1 recording
Continue with Assessment and Allocate Care Coordinator
Risk Assessment – historical risks on Risk Summary after 6 months
MHSMDS / Clustering
CPA Care Plan
CPA Reviews
S1 recording
Discharge
Standard Letter back to Referrer, GP copied as necessary
Follow up Information
Contacts for Future
S1 recording
CPA Review Called
S117 if appropriate
Continuing Care Criteria (if indicated)
Copies to GP, Referrer, copied as necessary
Follow up Information
Contacts for the Future
S1 recording