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

The key messages the reader should note about this document are:

1. CPA and standard care plan are the frameworks for practice; assessment, care planning, implementation (coordination) and review.
2. Working collaboratively and sharing decision making with service users and carers to achieve wellbeing; recovery and physical and mental health.
3. Care coordination should be focused upon where the person is on their care pathway; roles should be shared with the named professional.
4. Reviews should be person centred; based upon a purpose and flexible.
5. Policy now includes guidance regarding discharge and transfer, including delayed transfer of care.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual, or local risk assessment.

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

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| --- | --- |
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| 0.1 | Documenting Carer involvement in PARIS | Request by Steve Taylor – Carers Leeds Service Delivery Manager |
| 0.1 | Amendment of timescale for follow-up arrangements from acute to community | Accuracy (internal change from 7 to 3 days) |
| 0.1 | Think Family, Work Family principles included in Safeguarding section | Request by Vanessa Colman – Safeguarding Lead |
| 0.1 | Inclusion of PREMs and amendment of CROMs and PROMs | Accuracy (internal change of outcome measures) |
| 0.2 | Inclusion of Triangle of Care approach and standards | Request by Dave Hamer – Clinical Team Manager |

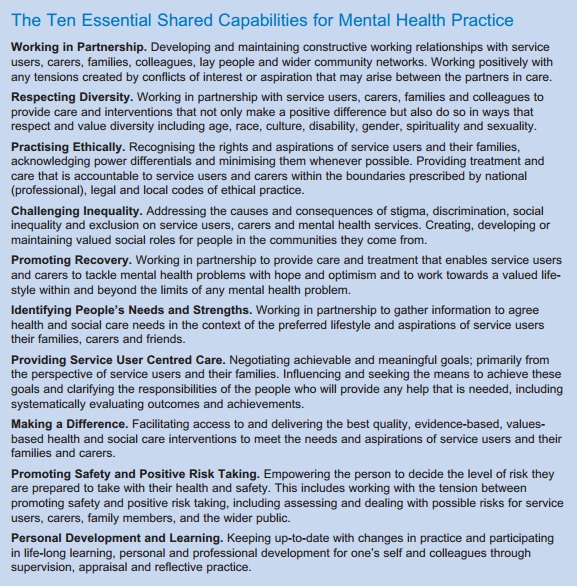
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**1.** **THE PROCEDURE**

**1.2 Description of Procedure/Process**

**.1 Values and Principles**

This policy is underpinned by the [Ten Essential Shared Capabilities](http://www.iapt.nhs.uk/silo/files/10-essential-shared-capabilities.pdf) (ESC). The ESC form part of the basic building blocks for all staff who work in mental health whether they are professionally qualified or not and whether they work in the NHS, the social care field or the private and voluntary sectors (DH 2004).



**.2 Principles of the Mental Capacity Act 2005**

The [5 principles of the act](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf) must be taken into account when incorporating this policy into practice:

1. 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
2. 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
3. That individuals 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.
4. Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
5. Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms

**.3 Overarching principles of the Mental Health Act 1983**

It is essential that all those undertaking functions under the Act understand the [five sets of overarching principles](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF) which should always be considered when making decisions in relation to care, support or treatment provided under the Act. These are:

1. Least restrictive option and maximising independence - where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient’s independence should be encouraged and supported with a focus on promoting recovery wherever possible.
2. Empowerment and involvement - patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
3. Respect and dignity - patients, their families and carers should be treated with respect and dignity and listened to by professionals.
4. Purpose and effectiveness - decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
5. Efficiency and equity - providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

**.4 Human Rights**

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. This means:

* putting human rights principles and standards into practice
* aiming to secure the full enjoyment of human rights for all, and
* ensuring rights are protected and secured

A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law.

**.5 Equality and Diversity**

The Equality Act was introduced in October 2010; 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, spiritual 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 should 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 should be recorded in the patient’s care plan.

Where necessary, every effort should 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. Wherever possible, people should be offered a choice as to preferred worker allocated – see Choice of Worker guidance in appendix A.

**.6 Confidentiality and Information Sharing**

Effective communication between all those involved in the delivery of care is a key element of the care coordination process; this includes the service user and carer (where agreed).

Service users should be informed of expectations regarding confidentiality and information sharing; this should invite a conversation with the service user allowing any questions/queries to be aired ahead of assessment or intervention. Written information should also be offered and made available to the individual. Consent to share information may be given orally or in writing and must be recorded in the persons electronic record including the date and any conditions that apply.

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

Information is confidential when it appears reasonable to assume that the provider of the information believed that this would be the case (based upon the information provided earlier). Where care is provided by health and social care professionals working in different agencies the sharing of information is essential to support the planning, coordination, delivery and review 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

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 or Child/adults safeguarding policy, as required.

Further detail can be found in [IG0001 Information Governance Policy](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Information%20Governance/IG-0001.docx) and [IG0003 Confidentiality Code of Conduct](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Information%20Governance/IG-0003.docx).

**.7 Communication**

All written communications with other health or social care professionals should be copied to the service user at the address of their choice, unless the service user declines this (NICE Guidance 136).

Service users should be informed about how to make a complaint and how to do this safely without fear of retribution.

Further guidance on Choice of Worker, including communication can be found in Appendix A.

**.8 Involving Carers**

The term carer is used to describe someone who informally cares for someone with a health and or social care need; the role is unpaid. A carer may be a family member, partner, spouse, friend or supporter. The carer may not describe them-self as a carer; it is important to understand and use the persons preferred term for their role.

The Triangle of Care is an approach which aims to provide better joined up working between the professional, the person receiving care, and their carer. It was initially developed by carers and staff seeking to improve carer engagement in mental health services. The approach was first rolled out to community services and is now being rolled out to other services across the Trust. Carers frequently report that their involvement in care is not adequately recognised and their expert knowledge of the ‘well person’ is not taken into account. A disconnected model of involvement like this can lead to carers being excluded at important points. This leads to gaps in practice which can result in the carer being left on the outside and in failures to share information that may be vital to risk assessment, care planning, and to acting in the best interests of both service user and carer.

There are six key standards for the Triangle of Care approach:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.

2) Staff are ‘carer aware’ and trained in carer engagement strategies.

3) Policy and practice protocols re: confidentiality and sharing information are in place.

4) Defined post(s) responsible for carers are in place.

5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.

6) A range of carer support services is available.

Carers often know a great deal about the service user’s life, interests and strengths as well as having personal experience of the service user’s illness. Some carers will have a significant responsibility to support, protect and keep in touch with someone who cannot manage alone because of their mental health and/or learning disability and /or complex needs. It is important to include carers in the care planning process whenever possible. If the decision not to include carers in the planning process this should be clearly documented with reasons why.

Carer details should be documented in the service user’s electronic patient referral system (PARIS). The name, relationship to the service user, and telephone number should be stored in the ‘Associated People / Next of Kin’ section and the ‘Carer’ box must be ticked.

Concern expressed from carers should be taken very seriously and should lead to the Care Coordinator / Lead Professional considering the need to take action, including initiating a review.

If a service user does not want their carer, who is aware of their contact with the Trust, to receive information, or to be involved in their care and treatment, staff must ensure that this is clearly and sensitively communicated to the carer and recorded in the service user’s electronic record. It is anticipated that such cases will be relatively few and the expectation is that the majority of carers will be involved.

However this does not prevent staff from listening to that carer including in relation to issues of risk to themselves or the service user. Carers should be provided with information about access to support for carers, about their right to their own assessment and with generic information about mental health.

Where the service user has not given consent to share information with their carer who they live with and/or supports them and there are significant issues of risk there may be justification to share proportionate and necessary information about risk management without consent.

A lawful disclosure will be justified in circumstances where the appropriate healthcare professional/clinical team are satisfied that, the disclosure of confidential health information is necessary to prevent serious harm or abuse to the service user or another. In such circumstances the disclosure must be limited to that which is necessary and proportionate to the aim in mind. All disclosure considerations, decisions and subsequent actions must be clearly recorded in the service user’s electronic record. Each circumstance / situation is different and advice should be sought from the relevant person in the organisation e.g. Caldicott Guardian or Information Governance Lead.

To effectively involve carers, Care Coordinators and Lead Professionals should*:*

* Be aware of who the main carers are and their contact details.
* Ensure that the carer has the Care Coordinators/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 openly.
* Ascertain 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 [ML0005 Deprivation of Liberty Safeguards Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0019.docx)).
* Ensure that where safeguarding concerns regarding carers are identified, this is acted upon in line with the relevant Adult Safeguarding Policy and local procedures.

**.9 Carers Needs Assessments**

The Care Act 2014 gives local authorities a responsibility to assess a carers needs for support, where the carer appears to have such needs. This replaces the previous law, which said that the carer must be providing “a substantial amount of care on a regular basis” in order to qualify for an assessment.

This means that more carers are able to have an assessment, comparable to the right of the people they care for. The local authority will assess whether the carer has needs and what those needs may be. This assessment will consider the impact of caring on the carer. It will consider the things that a carer wants to achieve in their own day-to-day life, as well as other important issues, such as whether the carer is able or willing to carry on caring, whether they work or want to work, and whether they want to study or do more socially.

The assessment may be carried out by the local authority, Carers Leeds, the care coordinator or the lead professional.

If both the carer and the person they care for agree, a combined assessment of both their needs can be undertaken.

When the assessment is complete, the local authority must decide whether the carers needs are eligible for support from the local authority.

A carer can still be eligible for support, even if the ‘cared for’ person isn’t.

Leeds City Council is responsible for carers of people ordinarily residing in the Leeds, even if the carer lives somewhere else. Further guidance regarding carers assessment can be found in Appendix H.

**.10 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 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 identified  there is a 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 to consider referring to social care for early help support with consent 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.

**.11 Referral**

Leeds and York Partnerships NHS Foundation Trust 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 as such 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.

**.12 Assessment**

Everyone referred to LYPFT should have an assessment of their needs and wishes. This may comprise of an initial assessment such as screening or triage, which may or may not lead on to a full assessment.

Upon meeting, the service user should be greeted by staff in a warm, friendly, empathic, respectful and professional manner, anticipating possible distress. The person(s) undertaking the assessment should ensure that the service user understands:

* the process of assessment and how long it will likely last
* that the assessment will cover all aspects of their experiences and life
* confidentiality and data protection as this applies to them
* the approach of shared decision‑making
* that although they can be accompanied by a family member, carer or advocate for all or part of the time, it is preferable to see the person alone for some of the assessment
* that they can refuse permission for any other member of staff, such as a student, to be present (Nice Guidance 136)

When carrying out an assessment:

* ensure the assessment takes into account the name, DOB and school of any children in the family and record on central index
* ensure there is enough time for the service user to describe and discuss their problems/needs/wishes in the way that they want to
* summarise the conclusions of the assessment and provide opportunity for discussion
* Use plain English – explain any clinical terms used
* explain and give written material in an accessible format about any diagnosis given
* give information about different treatment options, including drug and psychological treatments, and their side effects, to promote discussion, shared understanding and informed decision making
* offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed (Nice Guidance 136).

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The assessment may be specific and led by the particular service area or more general; but should include consideration of the following:

* Continuing mental health needs
* Psychological needs
* Physical health
* Current treatment
* Daytime activities or vocation
* Accommodation
* Carers
* Risk and safety issues – including asking if the person has a history of or is experiencing violence and/or abuse
* Co-existing needs eg. Physical disability, learning disability,
* Substance use
* Parenting or caring needs
* Social, cultural or spiritual needs
* Managing finances
* Authorities and agencies involved - including out of area (MHA Code of Practice 2015)

To reduce duplication, services should aim to develop one assessment that will follow the person through a variety of care settings to enable the correct and necessary information going with them.

The assessment should be recorded on the electronic patient record; shared with the service user, referrer and others involved as agreed.

**.13 Children**

When assessing and providing services to an adult with mental health problems and/or a learning disability, professionals must be alert to the needs of children for whom the adult has parental or caring responsibilities, or with whom the adult has substantial contact to ensure that the children have adequate support and protection. A child is defined as someone under 18.

All assessments must inquire about the children in the adult’s family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact, even if there appears to be no immediate concern of significant harm.

Assessment must include the collection of all relevant information (the minimum being identified in relevant practice guidance / documentation) and areas of need perceived by the service user in relation to the child should also be identified and documented. Health and social care professionals must consider the needs of both the adult and the child, but the welfare of the child is always paramount.

Staff have a responsibility to contribute to the assessment of all children and families in need, not just those in need of protection and reference should always be made to the Trust’s Safeguarding Children Policy and procedures. Staff working with families where there are children should normally have undertaken children’s safeguarding training as required.

**.14 Safety/Risk Assessments and Management - principles**

* All individuals accepted into Leeds and York Partnerships NHS Foundation Trust should have their risk assessed 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.
* Safety/risk assessment and management should balance safety and effectiveness with the individuals rights to make choices and their right to take informed risks.
* The Safety/risk assessment and co-producing a safety plan should be a collaborative process involving face-to-face contact with the service user. Information and safety assessment should be clearly recorded on PARIS. The subsequent safety plan should be incorporated in the individuals Care Plan. This is essential to communication.
* Safety/risk assessment and safety plan should be reviewed in line with review of the Care Plan and as such, at least annually (see review section for further guidance). This should be facilitated by the named professional leading care within the particular pathway (this may be Inpatient, ICS, community or other). The Care Coordinator should be liaised with in these circumstances.
* 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 3 days after discharge from hospital for all individuals.
* For further guidance see [C0011 Clinical Risk Assessment and Management Procedure.](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0011.docx)

**.15 Safeguarding Concerns – Children and Adults**

**Safeguarding Children**

**Think Family, Work Family**

Working with the whole family requires a co-ordinated approach to assessment and intervention, thus protecting both children and adults at risk from harm.

Think Family, Work Family is particularly relevant when responding to the needs of families where substance misuse, learning disability or difficulty, domestic abuse or mental ill-health are evident in the parent’s life. Children are more susceptible to risk and harm where they are living with an adult(s) who has one or more of these vulnerability factors or needs.

Practitioners who are aware of a young carer, when either working directly with the child or young person or with the adult, must assess their needs and respond appropriately.

**Think Family Work Family simply means:**

* **Think Family –** people rarely live in isolation so you need to think about the needs of the whole family, regardless of whether it is an adult or child that you are working with.
* **Work Family** – you need to communicate with others working with different family members and co-ordinate your efforts for the best outcomes for the whole family.
* **Think Family Work Family** is an approach whereby in their day to day roles, all practitioners across Adult and Children’s services are identifying, considering and appropriately responding to the safeguarding needs of all family members.
* **Think Family Work Family** places a responsibility on all practitioners to respond to identified issues, from signposting and referral, through to providing services.

Consideration of immediate risk should be prioritised as follows:

* The welfare and safety of the child, including assessment and ensuring their views are sought (Paramount in law - Children Act 1989).
* The welfare and safety of adults at risk who may be at risk from violence or abuse and who may or may not have capacity to make informed decisions. (HM Govt 2000; Mental Capacity Act, 2005).

**If a child is at risk of significant harm you should contact Children’s Services Duty** **and Advice (guide), tel: 0113 3760336 (out of hours 0113 240 9536). Or for York tel: 01904 551900.**

[**childrensfrontdoor@york.gov.uk**](mailto:childrensfrontdoor@york.gov.uk)

**Following discussions with line managers and safeguarding leads, concerns regarding the identified needs of an adult can be discussed with the Safeguarding Adults Partnership Advice Line: 0113 224 3511. If an adult is at risk of abuse you should contact Leeds Adult Social Care, tel: 0113 2224401 (out of hours 0113 240 9536). Or for York Safeguarding adults tel: 01904 555111 – York out of hours tel: 01904 534527.**

The safeguarding section on PARIS for services which use this form of recording should be used to record a chronology of significant safeguarding events.

It is the responsibility of all staff (employed, contracted or volunteers) to take appropriate action when they know or suspect a child has been subject to abuse or is at risk of abuse or where they become aware that an adult represents a risk to children - [SG0001 Safeguarding Children’s Policy and Procedures](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0056.docx) should be referenced and enacted appropriately.

The CPA Care Plan or Standard Care Plan should include the agreed interventions and approaches that safeguard children and promote the welfare of the child and family.

**Safeguarding Adults**

Safeguarding within The Care Act 2014, replaces the No Secrets guidance 2000. Safeguarding duties apply to an adult who:

1. Has care and support needs
2. Is experiencing, or at risk of, abuse or neglect; and
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Vulnerability may be a permanent state e.g. disability or temporary or when a person lacks capacity either permanently or temporary. As such staff should have regard to and knowledge of the Mental Capacity Act, Deprivation of Liberty Safeguards and its code of practice in relation to decision making to safeguard adult at risk.

The majority of domestic abuse is committed by men towards women, however it can also involve men being abused by their female partners, abuse in same sex relationships, and by young people towards other family members, as well as the abuse of older people in families. Domestic abuse occurs irrespective of social class, racial, ethnic, cultural, religious or sexual relationships or identity. As such involvement in multi-agency domestic violence processes plays a key part in safeguarding activity.

[SG 0001 Safeguarding Adults Policy](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0001.docx) and [SG0003 Domestic Violence Procedure](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0054.docx) should be referenced and enacted appropriately.

The CPA Care Plan or Standard Care Plan should include the agreed interventions and approaches that serve to safeguard the person(s); this should dovetail with any other plans in place.

**.16 People with Learning Disability and Mental Health Problems**

People who have both Mental Health problems and Learning Disabilities can experience difficulty in accessing one or the other service; sometimes both services will be required. It is the role of the Care Co-ordinator/Lead Professional to support individuals to receive the best quality care.

Procedure to support Care coordinators/Lead Professionals is available on Staffnet: [C0027 Procedure for the planning of care for adults with both mental health needs and learning disability or autism](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0027.docx)

For reference, the associated standards are:

1. Individuals who require support from both mental health and learning disability services have this need identified and addressed within their care plan (CPA)
2. Individuals who require support from both mental health and learning disability services have a named care coordinator or lead professional (CPA)
3. Individuals who have a learning disability are identified and pathways of care are reasonably adjusted to meet the heath needs of these patients (Monitor RAF).

**.17 Clinician Rated and Patient Reported Outcomes, and Patient Reported Experience Measures**

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 agreed with the individual and carer(s) at the beginning of the care process so that the plan is personalised to the service user.

All service users should have a Clinician Rated Outcome Measure (CROM) and a Patient Reported Outcome Measure (PROM) completed at assessment and at key review points; amounting to at least once a year. Service user should also be offered the opportunity to complete a Patient Reported Experience Measure (PREM) during their period of care with each team/service.

CROMs - The use of the Clinical Global Impression Scale (CGI) is used in LYPFT adult and older people services and the Health of the Nation Outcome Score (HoNOS) is used in some specialist services.

PROMs – Recovering Quality of Life 10 (ReQoL-10) and Clinical Outcomes in Routine Evaluation 34 and 10 items (CORE-34 and CORE-10) are currently agreed for use within working age adult Leeds Care Group services; the Quality of Life in Alzheimers Disease (QoL AD) is to be used in dementia services and more options for older people with mental health problems will be explored over time.

PREMs – The Trust is working towards developing co-produced PREMs in all services. Some Specialist services have already achieved this and they are embedded into routine clinical practice. Older people’s services will use the Patient Experience Questionnaire (NCHC).

**.18 Unmet Needs**

Assessment should focus on the person’s needs, rather than the services available. Any needs identified within the assessment that cannot be met through health and/ or social care personalisation should be discussed with the individual and recorded on the care plan. This should also be explored in clinical or management supervision.

**.19 Care Programme Approach and Standard Care Plan**

The term Care Programme Approach (CPA) describes the approach used in secondary mental health care to assess; plan; review and co-ordinate the range of treatment, care and support needs for people who have particular characteristics or are within particular groups. The term approach is used as it is as much about how this is achieved, as it is about what is done. CPA is about supporting individuals who need further support with engagement, co-ordination and safety.

Standard Care Plan is applied for individualswho do not have the characteristics defined under CPA, are those who are assessed as having a need within secondary mental health services, and:

* have straightforward needs
* likely one person involved, delivering a time limited intervention
* have no problems with access to other agencies/support
* do not need extra support with keeping safe

It is acknowledged that some service users who receive services from LYPFT do not have an identified mental health need e.g. people with learning disability who are referred for physical health problems however the principles of best practice in care planning should still apply.

Guidance in understanding who needs CPA and Standard Care Plan, including the characteristics, can be found in Appendix B - Guidance for staff when deciding if a person needs CPA or Standard Care Plan.

**Care Planning**

**.20 Promoting choice, involvement and shared decision making**

In working with people 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, accessible information to enable them, wherever possible, to make an informed choice, sharing the decision making.
* Are offered information about what CPA and Standard Care Plan is and what they can expect.
* Are signposted to reliable sources of information, for example, [NHS Choices](http://www.nhs.uk/pages/home.aspx) and [Choice and Medication](http://www.choiceandmedication.org/leedsandyorkpft/)
* Are encouraged to explore their options and to access universal services to support their wellbeing and recovery; focusing on balancing self-management and support.
* 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.

See Appendix C for the Service User Network ‘Key Messages’.

**.21 Care Planning**

All people accessing mental health services within LYPFT should have a care plan. If the person is on CPA, then this will be the CPA Care Plan (the name for this may be different e.g. ‘My Wellbeing and Recovery Plan’). Where the person is on Standard Care Plan, then the persons care plan should be captured on the Standard Care plan. Care Plans must be recorded on the electronic patient record as soon as is practicable. If this is not imminent within the usual timescales for a particular team, then the care plan should be initiated and reflect this, indicate when the care plan should be expected and the plan in the interim with a review date eg. Extended assessment due to service user not being available; will review in 4 weeks.

The care plan should be developed in collaboration with the service user and their carer (with agreement) and based upon their assessment and formulation. The Care Coordinator or lead professional should offer choice and provide sufficient information upon which shared decisions can be made as to which interventions are agreed; based upon a shared understanding of strengths and need. Care planning should be a side by side activity rather than an office based activity wherever possible.

Care planning is the role of the care coordinator or lead professional; this may be delegated where the service user is another part of the care pathway – for example, if the service user is accessing acute services, then the care planning role is best undertaken by the named primary mental health worker identified within that setting and will constitute that particular care settings care plan eg. in-patient treatment plan.

Care planning is an integral part of care; care plans are a road map, identifying where someone is going (journey) and outlining the supporters and enablers along the way, friends, family, groups as well as more formal support. Central and key to this is the role that the service users takes. The care plan should not be a list of needs and service provision; it should draw upon and utilize the strengths that the person has. The actions that the person has agreed to take themselves should be included within the care plan. The care plan should consider the person in their usual residence and aim to draw upon universal services and wider community provision to support the person’s wellbeing and recovery.

The care plan should be written using clear, unambiguous language, reflecting the persons own way of describing their health and social needs where possible. Acronyms should be avoided. Writing in the first person may be considered. The care plan should recognise the diverse needs of the person, reflecting cultural and ethnic background, as well as gender, sexuality and any disability. The way that the care plan is written reflects the extent that the person was involved in developing and agreeing the care plan.

Should the person prefer to write their own care plan then this should be welcomed and facilitated.

The care plan should outline 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 should be involved in care planning.

Where the person is on CPA, the care plan should include:

* an overarching plan that considers the persons needs, including:
* mental health and/or learning disability including psychological needs
* physical health
* medication
* social/occupational
* finances
* housing
* carers
* supporting parents and children
* discharge/transfer planning
* consideration of section 117 (see Section 117 Aftercare Guidelines appendix D)
* individualised goals and/or expected outcomes
* self-directed support where social care needs are identified and eligible
* time frames and/or frequency of interventions
* opportunities for self-management
* contingency and crisis plan, including contact names and details
* name and telephone details of the Care Coordinator and others involved
* reference to any known advance statement or advanced decision

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.

The contingency and crisis plan are integral to the Care Plan and should be reviewed and shared accordingly.

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.

The care plan should be recorded on the approved CPA documentation on the electronic patient record. Where the individual is on Standard Care Plan, the approved Standard Care Plan should be completed in full or, where the care plan is recorded elsewhere eg. a clinic letter or team/profession specific care plan, then this should be indicated (name and date of document) on the Standard Care Plan.

Guidance on how to use the CPA Care Plan ‘My Wellbeing and Recovery Plan can be found here; a template for the care plan can be found [here.](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/My%20Wellbeing%20and%20Recovery%20Plan%202015/My%20Wellbeing%20and%20Recovery%20Plan%20-%20guidance.docx)

Guidance on how to use the Standard Care Plan can be found here; a template for the standard care plan can be found [here](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/Standard%20Care%20Plan%202015/Standard%20Care%20Plan%20-%20guidance.docx).

**.22 Mental Capacity Act and Care Planning**

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.

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.

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.

When a person lacks capacity to accept, understand or participate in decision making regarding their care plan, the clinician delivering the care plan needs to act in the person’s best interests and records must 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.

For further guidance see [ML0010 Mental Capacity Act 2005 Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0061.docx) or The Mental Capacity Act 2005, Code of Practice (DoH 2007).

**.23 Advance Decisions and Advance Statements**

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 sections 24-26 of the Mental Capacity Act.

An advance decision to refuse treatment enables a person aged 18 or over, whilst still capable, to refuse specific medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment. If the advance decision to refuse treatment is deemed valid and applicable, it is legally binding.

An advance statement, although not legally binding, is a statement identifying preferences about care and treatment. There is a statutory duty under the Mental Capacity Act 2005 to consider previously expressed wishes, such as advance statements, when making a best interest decision.

Advance decisions and advance statements are seen as an important part of care planning, that encourages a dialogue between the person, their carer and those involved in their mental health and social care. Any advanced decision should be documented within the Care Plan.

Other advance plans such as ‘Relapse Plans’, and ‘Wellness Recovery Action

Plans’ (WRAP) can be created by service users alone or in collaboration with health staff to support recovery, maintain well-being and prevent recurrence of mental health problems by setting out a contingency plan in case of early signs of relapse.

* Further guidance can be found in [ML0008 Procedure for Advance Decisions and Advance Statements](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0037.docx)

**.24 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 (for infection control guidance following death please refer to [IC0014 Last Offices - Procedure For Management Of The Cadaver In Healthcare Premises](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Infection%20Control/IC%20-%200014.docx)).
* 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.

[Further guidance can be found from NICE](https://www.nice.org.uk/guidance/ng31) (pending LYPFT guidance).

**.25 Care Coordination**

The term Care Coordinator refers to the CPA Care Coordinator***,*** supporting and working with those individuals on CPA. The term Lead Professional describes the role within Standard Care Plan.

**CPA Care Coordinator**

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 carer’s and other professionals/agencies involved.

The Care Coordinator is a community based role. Where the service user is in another part of the care pathway, for example, in hospital or with Intensive Community Services (ICS) then the coordinator role can reasonably be delegated to the named professional leading the individuals care, for example, to the primary nurse. This should be done in a collaborative and consensual manner. It is expected that the care coordinator remain involved in the individuals care; actively participating in discharge planning. The expectation of the primary nurse is that the assessment is completed, that the care plan reflects actions being taken to address immediate needs and anticipated needs going forwards, and that planning for discharge commences from the point of admission.

**Care Co-ordinator - Principles of Practice**

Care co-ordination is predicated on the principle that people, wherever they are in their journey, should share in decision-making; that they are knowledgeable about themselves and the effect their conditions have on their lives; and that they should be empowered and enabled to inform their own wellbeing and 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 persons 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 to the care plan (as apposed to service targets).
* encourages the prevention and early detection of ill health, wherever there are factors that present a risk to their health and welfare, such as taking part in vaccination and screening programmes as part of the wider Public Health and ‘parity’ agenda.
* supports the person to make healthy living choices concerning exercise, diet and lifestyle.

**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:

1. Comprehensive needs assessment
2. Risk assessment and management
3. Crisis planning and management
4. Assessing and responding to carers’ needs
5. Care planning and review
6. Transfer of care or discharge

**CPA Care Coordinator competencies**

The member of staff identified to co-ordinate an individual’s care must be competent, suitably skilled in delivering mental health care to fulfil the role identified within their job description. Therefore the CPA Care Coordinator 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.

In most instances individuals subject to Community Treatment Orders will have their care coordinated by a Trust based care coordinator because of the legislative responsibilities associated with the application of the CTO to the individual.

It is critical that the CPA Care Coordinator has the authority to ensure the delivery of the care plan.

The CPA Care Coordinator:

* 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 to meet the individual’s needs and to oversee care planning and resource allocation for an individual requiring CPA in the community.
* Will work closely with the persons ‘named professional’ (eg primary nurse) when the individual is accessing other parts of the care pathway eg acutre services or specialist services.
* 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
* may also be responsible for coordinating 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, including review and documented.
* willensure that detailed integrated professional records are maintained to document the assessment, care planning and review processes within the CPA policy framework
* 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 Coordinator discussion needs to take place with the person, care Coordinator 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 - guidance is in Appendix A Choice of Worker.

**.26 Lead Professional**

The member of staff identified to co-ordinate an individual’s care must be competent, suitably 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. Often only one professional is involved in the persons 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 Standard 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 the electronic patient record. A copy of the Standard Care Plan should be given to the person and communicated to any other person involved.
* review the Standard Care Plan as the need arises but at least annually. Consideration of the need to transfer care to CPA should be made at any point. The person should receive a copy of the review (as the Care Plan) as soon as possible following 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 persons care.  
  .
* arrange cover for planned absence if required and ensuring that contingencies are in place for the care team to cover any unplanned absences.

**Review**

A review is a continuous and dynamic process that involves working in partnership with the service user, carer, the multidisciplinary team involved and any partner agencies to evaluate progress and agree a future care plan.

A review is an opportunity:-

* + - * To have a shared understanding of the person and their carers’ views of the current care plan and support/interventions provided.
      * To have a shared understanding of the views of the multidisciplinary team and others involved.
      * To evaluate the progress towards identified goals.
      * To review the plan in place taking into account any changes – circumstance and presentation.
      * To renegotiate the goals and care plan.
      * To communicate with all involved including other agencies.

The review should be tailored to the wishes and preference of the individual. When deciding upon how the format of the review, staff should consider factors such as safety, the engagement of the person and the complexity of the care plan, as well as being clear upon the purpose of the review. The decision should be reached based upon clinical judgement and in discussion with the service user and carer. Examples of where a full multidisciplinary review is likely include (but are not limited to):

* Where there are safeguarding issues – child or adult
* Where there is potential for misinterpretation of information
* Where there is disagreement in best interst
* Where there is complexity and/or significant safety issues

The purpose of the review should be determined based upon the desired outcomes, for example, a discharge plan, a plan to manage changes in safety.

The following review formats should be considered:

1 A meeting between the person, their carer and Care Coordinator (and named professional if in another part of the care pathway) 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 Coordinator ( care coordinator role may be being fulfilled by the named professional within the care pathway eg primary nurse), with others involved contributing separately eg. 1:1 meetings, post, phone or other communication media.

In both instances above; the review may take place over a short 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, care coordinator and other agencies involved in care, treatment and support.

There will be occasions where a professionals meeting is the best way forward. Further guidance on good practice in professionals meetings can be found in Appendix E.

**Frequency of review**

* A review should occur in line with the interventions outlined in the care plan; this should be negotiated with the service user and carer and be congruent with the care plan. The national minimum requirement is a twelve monthly review.
* Specific care areas may have agreed standards for frequency of review.
* If there are unanticipated changes to the person’s needs or safety that are not outlined in the care plan already, then a review should be convened by the Care Coordinator/Lead Professional. Care, support and treatment should not be delayed awaiting this.
  + Anyone involved in the care of the person, including the person them self, can request a review of the care plan. If the care team and the individual decide that it is not necessary or appropriate to hold a review, then the reasons for the decision must be communicated to those involved and recorded.

**Planning a multi-disciplinary 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, facilitator 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, ahead of the review.

The Care Coordinator (or named professional ) should discuss with the person regarding an attendance list of those involved in the persons care that are to be invited to participate in the review. This should include the carer and advocate, where involved.

Ensure the purpose of the review is clear to everyone involved, agreed in advance and appropriate. Where other elements of the persons care, support and treatment also require formal review, then these should be included within the CPA review wherever possible, for example, safeguarding; this reduces duplication.

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 should be given the opportunity to contribute by other means.

**During a multi-disciplinary 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 in the community setting. Alternatively, the facilitation should be undertaken by the named professional within the care pathway, for example, the primary nurse may be well placed to facilitate a review when the person is in hospital.

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 incorporated in the care plan.

The need for continued support of CPA should be considered.

The holistic assessment should be updated as informed by the review.

The results of outcome measures should be taken into account

A review of any ongoing section 117 entitlement (see guidelines in appendix D) 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 [ML002 Supervised Community Treatment Order Protocol).](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0002.docx)

Eligibility for NHS funded Continuing Care should 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 eligible and that the service provider is delivering the personalised services as planned. Review of social care provision should take place at the CPA review; this includes personalisation/self directed support.

The next review dateshouldbe agreed.

**Following a multi-disciplinary review**

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

Where the individual is moving to the community from acute services, the Care Co-ordinator is responsible for ensuring that the outcomes of the review are recorded on the CPA care plan. This should be circulated to the individual, carer, relevant individuals and professionals as soon as possible, ideally immediately but 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.

**Best Practice in review (for all formats)**

The person and carer should be involved throughout; the persons experience is paramount. Shared decision making should be sought wherever possible; this should be reflected through acknowledging wishes and preferences. Documentation should reflect this, with the persons own words/phrases used where appropriate.

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 – see professionals meetings guidance in appendix E.

Where the individual is admitted to the acute pathway, then a CPA review should be arranged promptly to ensure that discharge plans are put in place at an early stage; the format for the review should be informed by the desired outcome, for example discharge plan. This ensures the admission is not prolonged unnecessarily and engages the person.

**.28 Progress Notes and Records of Intervention**

A record of contact with the individual must be kept. This is supported through the electronic patient record, 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 safety 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 safety issues.

The guidance above also applies to Care Plan.

**.29 Transitions of Care**

Transfers of care should 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 should be clearly documented on the electronic record.

**Transition 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 changes to levels of care relating to Standard Care Plan and CPA, and record on the electronic record.

**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 the electronic record through completion of the Standard Care Plan and allocation of the lead professional.

**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 the electronic record.
* 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, a review should be convened and held in a timely way – see review section for flexible ways of achieving this.

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

**.30 Transfer of Care (community)**

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 Coordinator or Lead Professional

This may involve transfers within or between care groups.

* 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 Coordinator 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 agreementbetween 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, including risk, and care plans will have been amended to incorporate the transfer plans. These 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.

**.31 Transfer of Care to services outside the Trust (community)**

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

Prior to an out of area transfer of care, the Care Coordinator 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 Coordinator 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 D).
* 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.

**.32 Discharge (community)**

Discharge from CPA or Standard Care Plan should 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 secondary or specialist mental health or learning disability services as assessed by the Care Coordinator or Lead Professional and agreed by the individual.

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

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

* Summary of services received and progress
* 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.

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 the electronic record.

**.33 Section 117 After-Care Provision**

Guidance for section 117 after-care is located in Appendix D.

An individuals section 117 after-care entitlement should be recorded on the electronic patient record (within the CPA Review Information section).

**.34 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 (if applicable and the person meets the service criteria).

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 persons electronic record with clear specific action plans.

Further guidance can be found in the [SG008 Guidance for Staff Working with Service Users where poor Engagement of Disengagement is a factor (DNA) Procedure](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0045.doc)

**.35 Admissions to Acute Services**

Acute services include in-patient services and services that are identified as an alternative to hospital admission, for example CRISS (Crisis Resolution Intensive Support Service). All individuals admitted to acute inpatient services will be on CPA, however not all service users who are receiving support from ICS (Intensive Community Service) will be on CPA.

An identified individual within acute services will undertake the CPA coordination role alongside the CPA Coordinator; this will involve undertaking delegated responsibilities.

Where a CPA CareCoordinator is known, it is expected that the purpose of admission and expected outcome be agreed with the admitting nurse ahead of admission. Where admission occurs out of hours, it is the responsibility of the admitting nurse/ward to have this conversation and agreement with the care coordinator as soon as is practicable.

People will be allocated a CPA Care Coordinator within two working days of their admissions (if not already known). It is the responsibility of the named /primary nurse to refer to the locality team for allocation within 3 days of admission.

The allocated Care Coordinator should make contact with the service user within three working days of allocation; this can be negotiated with the named/primary nurse. The purpose of this contact is to start to build a working relationship, to explain the role of the locality team and to start to gain a shared understanding of strengths, needs and possibilities for support following discharge.

The named/primary nurse should liaise with the CPA Care Co-coordinator and the service user and carer to agree the most appropriate method of review ahead of discharge or transfer – see review section for guidance. It is expected that collaborative work between acute services and the care coordinator is undertaken with clear communication and documentation of roles. This enhances the persons experience through reduced duplication and reduction of delays in the acute journey. The review should include:

* Formulation of needs and risk/safety
* Identification of outcomes required to facilitate discharge
* Care planning to support timely discharge – who is doing what, by when etc.
* Agreement of goals ahead of discharge, including detailed arrangements for follow-up within 3 days of discharge
* Identification of likely discharge routes
* Identification of likely discharge date

This will be communicated to all involved agencies.

Any discharge planning must take into consideration the requirements of the safeguarding and welfare of children.

**Key Principles of Discharge/Transfer**

There are key principles which underpin effective discharge and transfer of care which apply regardless of time of day/day of week:

* The purpose of admission and expected outcome, including timescale are known to the service user and MDT; effective discharge is anticipated and planned.
* The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge
* The process of discharge planning should involve the care manager, care co-ordinator or named designate who has responsibility for co-ordinating all stages of the ‘patient journey’. This involves liaison with the pre-admission care manager/care co-ordinator (if appropriate) in the community ahead of admission where possible and the transfer of those responsibilities on discharge.
* Effective use is made of transitional and intermediate care services so that existing acute hospital capacity is used appropriately and individuals achieve their optimal outcome; this should be anticipated and planned.
* The assessment for health and social care provision following discharge/transfer is done in partnership with the service user and those already involved in the persons care and support. Accessible information should be provided and shared to enable them to make informed decisions about their future care.
* It is recognised that discharge or transfer taking place outside of normal working hours (ie. Monday to Friday 9.00am-5.00pm) requires careful planning with all relevant team members. In the event that an informal service user chooses to discharge themselves out of hours, then appropriate team members (ie. duty doctor) should always be informed to review safety issues collaboratively.
* The process for transfer into and out from private care should follow the same principles of discharge and transfer as outlined within this policy.

**The Discharge Process**

* The discharge process starts at the point of admission to hospital and should involve the CPA Care Co-ordinator.
* Plans for care, support and treatment following transfer or discharge should be in place ahead of discharge, including 3 day follow-up arrangements. This should be agreed with the service user at a CPA Review and recorded on the care plan. There is a range of ways that this can be undertaken – see review section for further guidance.
* There should be at least 48 hours’ notice provided of intended discharge; the 48 hour checklist should be completed at this time.
* It should be noted that patients detained under section 3, 37, 45A, 47, 48, conditional discharge and patients subject to Community Treatment Orders under the Mental Health Act have a legal right to after-care services and it is important that any after-care arrangements for these patients are jointly agreed with the local authority (see the section 117 guidance, Appendix D).
* In circumstances where inpatient care has identified delusional beliefs or suicidal ideas involving children, then staff in mental health services must always consider the child’s needs, if the patient is a parent, and where an inpatient has expressed delusional beliefs involving specific children or there is a risk that the service user might harm a child as part of a suicide plan, the multi-disciplinary team must all be involved in the decision regarding agreeing the leave or transfer or discharge from hospital, and where appropriate a referral will be made to Children’s Social Care.
* It is important to list clearly the medication that a patient is taking at the point of discharge and to indicate that dosage and duration of prescription issued. This should be clearly communicated to the GP, and the patient at discharge.

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.

**.68 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.

**.37 Delayed Transfers of Care (DTOC)**

Delayed transfers of care are a significant concern to frontline staff. Once a patient is well enough to leave hospital, staff wants to treat other people with greater needs. There are also potential effects on the patient. Longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation, which can affect a patient’s health after they’ve been discharged and increase their odds of re-admission. There are also financial consequences. There is a wasted investment in unnecessary care for every day that a patient is kept in hospital longer than necessary (kings Fund 2015).

More specifically in mental health, delayed transfers of care are resulting in people being treated away from their local area. The impact being upon their wellbeing and recovery when faced with time away from their family, friends and usual support. Access to resources and delays in decision making are also delaying discharges (NHS Providers 2015).

The first step to making a difference to people whose discharge is delayed, is accurately understanding who this applies to. This then enables energy to be focused upon addressing the specific issues/blockages, enabling the person to be discharged.

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from that care and is still occupying a bed. A patient is ready for transfer when:

1. A clinical decision has been made that patient is ready for transfer **AND**
2. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
3. The patient is safe to discharge/transfer.

Guidance on identifying where a delayed transfer of care is occurring and what actions to take is provided in Appendix F; process for adding a delay can be found [here](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Adding%20a%20delay.docx).

**.38 Mental Health Act and Mental Capacity Act**

* In the case of detained patients who have appealed against their detention the discharge process should be taken into account prior to a hearing because of the possibility that the patient might be discharged from their detention by either the Tribunal or the Mental Health Act Managers. It may be necessary to discuss with the patient the possibility of them remaining as a voluntary patient until after-care arrangements have been finalised for them or ensuring that after-care arrangements are ready to commence if the patient decides to leave hospital.
* Special provisions apply to patients being considered for discharge to another hospital or care home, who lack capacity and have no-one who is willing or able to be consulted or the decision maker feels it is not practical or appropriate to consult with friends or family.

In these cases if the move to another hospital is for longer than 28 days or for longer than eight weeks in residential accommodation then an Independent Mental Capacity Advocate must be instructed before the patient is discharged.

* If a patient lacks capacity to agree to a move to another hospital or a care home then a decision to transfer them must be made in their best interests under the provisions of the MCA. A standard authorisation under Deprivation of Liberty Safeguards may need to be considered (refer to the [ML005 Deprivation of Liberty Safeguards Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0019.docx)).
* In the case of a patient, who lacks capacity and is already deprived of their liberty under the Mental Capacity Act Deprivation of Liberty Safeguards, a new standard authorisation should be requested by the receiving hospital or care home from the supervisory authority before the patient moves.

If the move has to take place before the standard authorisation is in place at the new hospital or care home they will need to consider the use of an urgent authorisation.

If a relative, friend or carer is objecting to the discharge to another hospital or care home then advice should be sought from the Mental Health Legislation Department on how best to proceed with the discharge plan.

For further guidance refer to the Mental Capacity Act Code of Practice chapter 10 and the Deprivation of Liberty Safeguards Code of Practice.

* It is important to ensure that the patient has access to the appropriate entitlement to welfare benefits and also that there is a plan to secure adequate housing. Liaison with partner agencies involved with the individual (e.g. housing provider, CAB, job centre plus etc. will improve smooth transfer/discharge). It is also important to identify a plan to secure suitable employment or other identified occupational activity.

**The risk assessment and management**

The risk assessment should be updated prior to discharge/transfer in order to reflect current risk at point of discharge.

The care plan must include safety management interventions as well as the arrangements for follow-up within 3 days (see Appendix G for 3 day follow-up guidance)

The care plan on discharge will allow for more intensive provision of care in the first three months after discharge, particularly where significant risk of harm was present ahead of/during admission and will identify how community living is supported.

See [C0011 Clinical Risk Assessment and Management Procedure](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0011.docx) for guidance.

**Action Check List 48 hours prior to Discharge**

Prior to discharge it is important to establish the whereabouts of keys, access to heating and access to food and drink. If the patient has access to children then any child protection issues should be addressed to ensure the safeguarding of children. If they have pets then their safety and wellbeing need to be considered.

The check list of actions requiring completion 48 hours prior to discharge/transfer will form a key part of the process; this can be found on the electronic record.

**Transfer**

* External Transfer - in the event that patients are transferred from one of the Leeds and York Partnership NHS Foundation Trust care groups, or between wards, services or teams, then information about that patient should be made available to the receiving hospital/ward/service, at or before the time of transfer. This should include the most current plan of care, the risk assessment and care co-ordination care plan plus any appropriate medical information and notes. The inter-healthcare infection control transfer form should also be completed and included as part of any discharge/transfer procedure.
* In addition to the above requirements in the case of detained patients granted leave of absence to other hospitals and transferred for medical treatment for physical conditions it is important to ensure that the hospital receiving the patient is notified that the patient is subject to section 17 of the Mental Health Act and given a copy of the leave of absence form. It is also important to explain the provisions of section 17 leave to the nurse in charge of the receiving ward/unit and to ensure that any conditions of section 17 leave are clearly stated on the section 17 form.. They must be made aware that the patient remains liable to be detained by Leeds and York Partnership NHS Foundation Trust for his/her mental disorder. The duty to provide after-care under Section 117 of the Act also applies to patients whilst they are on leave of absence. The Mental Health Legislation Department must be advised of the transfer as soon as possible.
* Before transferring a detained patient for medical treatment to Leeds Teaching Hospitals NHS Trust consideration should be given to the use of section 17 leave. If this is not appropriate an agreement must be obtained from the Leeds and York Partnership NHS Foundation Trust employed Approved Clinician (Liaison Psychiatry). The Approved Clinician must be in agreement to act as the patients Responsible Clinician. In the absence of this agreement or pending this agreement then section 17 leave must be used in order to facilitate a transfer to receive medical treatment. In the event of a physical health emergency, verbal authorisation from the RC or Duty Consultant should be sought where possible, though this should not delay emergency treatment (refer to [ML0004 Patients Leave of Absence Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0018.docx))
* For patients transferred to other services under section 19 of the Mental Health Act, contact should be made with the receiving hospital to check whether the original detention documents are required or if copies are acceptable. If original documents are required, contact should be made with the Crisis Team at the Becklin Centre who can access documents for Leeds patients. Part 1 of form H4 needs to be completed on behalf of the hospital managers of the transferring hospital and part 2 of the form is completed by the receiving hospital. A copy of the completed form should be returned to Mental Health Legislation at LYPFT.
* Where a patient under a Community Treatment Order is moving to a new area and responsibility for that patient is transferring to a different Trust the Mental Health Legislation department should be contacted. A form CTO10 will need to be completed to formally transfer responsibility. Agreement needs to have been sought from the receiving Trust prior to transfer and a Responsible Clinician identified.
* Patients detained under section 5(2) cannot be transferred to another hospital. If urgent medical treatment is required, the section 5(2) lapses when the patient moves from the hospital named on the form H1. Therefore consent needs to be obtained from the patient before they are transferred. If they do not have the capacity to consent then a best interest decision should be made in line with the Mental Capacity Act.
* Under the Mental Capacity Act an Independent Mental Capacity Advocate (IMCA) *must* be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever it is proposed to arrange accommodation in another hospital or care home and the person will stay in hospital for longer than 28 days or in the care home for longer than eight weeks. Further responsibilities are explained in the Mental Capacity Act Code of Practice in Chapter 10.
* Internal Transfer (within Trust) - if any patient is identified as in need of other services within the Trust, they should be subject to a care planning meeting at the earliest opportunity. A member of staff from the area that the patient is to be transferred to should be invited to this meeting, so that a process of initial assessment should begin as soon as possible. The care planning process associated with the transfer should attempt to provide a realistic timetable for the transfer of the patient between teams, once a decision has been made that the patient is appropriate for transfer. The inter-healthcare infection control transfer form should also be completed and included as part of any discharge/transfer procedure.
* Legislative Requirements

Where a patient is being transferred to another hospital within the Trust, a local transfer form must be completed and returned to the Mental Health Legislation department. A form H4 is not required.

If a patient is subject to a DOLS authorisation and is being transferred to another ward or hospital (internal or external), the DOLS authorisation does not transfer with the patient. The receiving ward or hospital should consider putting in place a new authorisation if the patient continues to be deprived of their liberty.

* Care Planning when a child or young carer is involved

If a person to be transferred/discharged is 16 years of age, or under 19 years old, and is in statutory education, then it is appropriate for the local child and adolescent mental health service (CAMHS) to be involved. The care co-ordination process, however, will remain the same.

In a situation where a patient has a dependant child, the welfare of this child will be an important part of the ongoing care plan discussions. The impact of any leave, discharge, or transfer plan on the child should be particularly considered. If the child is a young carer, provision should be made as to the best way to include them in the care planning process. Their rights to a carer’s assessment and care plan should be respected. Child visiting arrangements should be arranged according to the child visiting guidelines.

**2 Appendices**

(or the link to the relevant document(s) on staffnet)

|  |  |  |
| --- | --- | --- |
| **Appendices** | **Title** | **Location** |
| A | [Choice of Worker](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Choice%20of%20Worker%20Guidance%20-%20Final.docx) | Intranet |
| B | [Guidance for staff when deciding if a person needs CPA or Standard Care Plan](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/CPA%20Guidance.docx) | Intranet |
| C | [Service User Network Key Messages](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/SUN%20Key%20messages%20Nov%202015%20V2.pptx) | Intranet |
| D | [Section 117 Aftercare Guidelines](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Sec%20117%20guidance.docx) | Intranet |
| E | [Professionals meetings good practice guidance](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Professionals%20Meeting%20Good%20Practice%20Guidance%20Version%205%20Updated%20May%202015.docx) | Intranet |
| F | [Delayed Transfer of Care (DTOC) process](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Process%20for%20the%20identification%20of%20Delayed%20Transfers%20of%20Care(1).docx) | Intranet |
| G | [3 day follow up](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/7DFU%20guidance%20Final.docx) | Intranet |
| H | [Carers – Assessments and the Care Act](http://staffnet/Topics/Corporate%20Functions/CPA/Documents/CPA%20Policy%20and%20Appendix%20docs/Factsheet_E1029__Assessments_and_the_Care_Act_updated_27_March_2015.pdf) | Intranet |

If you do not have access to the Intranet, please contact [sara.sewell@nhs.net](mailto:sara.sewell@nhs.net) for a copy of the guidance required.

**PART B** (This will not be uploaded onto staffnet, it will be kept on a separate area for reference only)

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Care Group Governance Groups | Consultation - collaborative across: Leeds Mental Health Care Group & Specialist and Learning Disability Care Group |
| Members of the Care And Safety Planning And Recovery Group | Responsible for overseeing development and progression; members responsible for sharing with their care group and teams, including service user and carers groups. |
| Care And Safety Planning And Recovery (CASPAR) Group | Approval |
| Policy and Procedures Group | Approval & Ratification |

**4 REFERENCES, EVIDENCE BASE**

Care Quality Commission <http://www.cqc.org.uk/>

Department of Health (2004) [**Ten Essential Shared Capabilities – A framework for the whole of the Mental Health Workforce**](http://www.mhhe.heacademy.ac.uk/silo/files/tenescpdf.pdf), HMSO, London

Department of Health (2006) **Reviewing the Care Programme Approach**, COI, London

Department of Health (2007) **Mental Capacity Act 2005 Code of Practice**, TSO, London

Department of Health (2008) [**Refocusing the Care Programme Approach, policy and positive practice guidance**](http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf), COI, London

Department of Health (2015) **Code of Practice, Mental Health Act 1983**, TSO, London

Department of Health (2014) **Care Act 2014**, DH, London

Kings Fund (2015) **Delayed transfers of care: a quick guide** <http://www.kingsfund.org.uk/topics/measurement-and-performance/delayed-transfers-care-quick-guide>

[Accessed 27/4/16]

Leeds and York Partnerships NHS Foundation Trust (2013) **Improving Health, Improving Lives, our strategy for 2013 to 2018**

Monitor (2015) [**Risk Assessment Framework**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455893/RAF_revised_25_August.pdf)**,** Monitor, London

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

NHS Providers (2015) **Right Place, Right Time Better Transfers Of Care: A Call To Action,** London

**5 ASSOCIATED DOCUMENTATION (if relevant)**

[SG 0001 Safeguarding Adults Policy](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0001.docx)

[ML 0002 Supervised Community Treatment Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0002.docx)

C0011 Clinical Risk Assessment and Management Procedure

[ML 0004 Leave of Absence Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0018.docx)

[ML0005 Deprivation of Liberty Safeguards Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0019.docx)

[C0027 Procedure for the planning of care for adults with both mental health needs and learning disability or autism](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0027.docx)

[ML0008 Procedure for Advance Decisions and Advance Statements](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0037.docx)

[SG0008 Guidance for Staff Working with Service Users where poor](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0045.doc)

[Engagement of Disengagement is a factor (DNA) Procedure](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0045.doc)

[SG0003 Domestic Violence](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0054.docx)

[SG0005 Safeguarding Children’s Policy and Procedures](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0056.docx)

[ML0010 Mental Capacity Act 2005 Protocol](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Clinical%20and%20Medical/CM-0061.docx)

[IG0001 Information Governance Policy](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Information%20Governance/IG-0001.docx)

[IG0003 Confidentiality Code of Conduct](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Information%20Governance/IG-0003.docx)

[IC0014 Last Offices - Procedure For Management Of The Cadaver In Healthcare Premises](http://staffnet/Topics/Policies%20and%20Procedures/Document%20Library/Infection%20Control/IC%20-%200014.docx)

**6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)**

|  |  |
| --- | --- |
| **#** | **Standard** |
|  | **Care Coordination:** |
| **1** | All people who have an ongoing need for services will be allocated a Care Co-ordinator or Lead Professional and as such will receive care via CPA or Standard Care Plan.  All service users have a named professional, responsible for coordinating their care, support and treatment. |
| **2** | All service users have the name & contact details of their named professional recorded on their care plan |
|  | **Assessment:** |
| **3** | All service users receive an holistic assessment of their health and social care needs and strengths |
| **4** | Carers are identified |
| **5** | Carers are offered an assessment |
| **6** | It is known if the service user is a parent or has access to children |
| **7** | Best interest decisions are recorded |
|  | **Care planning:** |
| **8** | All service users have a written care plan that is developed with the individual (and carer where appropriate) |
| **9** | All service users are given a copy of their care plan |
| **10** | Where the individual is subject to a Community Treatment Order, then a summary of the conditions and the name of the Responsible Clinician are recorded on the care plan |
| **11** | * All care plans consider and address at least the following (as appropriate):  |  | | --- | | * Mental health | | * Finances | | * Discharging planning including 3 day follow up | | * Accommodation | | * Occupation/education/training | | * Physical health – Health check to be completed for people on CPA for over 12 months | | * Medication | | * Family support/safeguarding * Safety plan | |
| **12** | All care plans contain a personalised contingency and crisis plan |
|  | **Review:** |
| **13** | All service users have a review at least annually; and at each transition point of care |
| **14** | All service users are involved in their review |
| **15** | All service users are encouraged to involve carer and/or advocate in their review |
| **16** | All service users should have a Clinician Rated Outcome Measure (CROM), a Patient Reported Outcome Measure (PROM) and a Patient Reported Experience Measure (PREM) completed at assessment and at key review points; amounting to at least once a year. |
|  | **Transitions** |
| **17** | All transitions involve the service user and carer and are planned |
|  | **Discharge/transfer** |
| **18** | All discharge/transfers involve the service user and are planned |
| **19** | Delayed transfer of care is known and actively managed. |

**7. EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure  might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified  any potential negative impacts for any of the nine protected groups.

Signed:

Print name: Caroline Bamford and Sara Sewell

Job title: Head of Diverstiy and Inclusion / CPA Development Manager

Date: ……..

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

**CHECKLIST**

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This is a checklist and is part of the working papers. It does not form part of the final version of the procedural document to be uploaded to staffnet.

|  | **Title of document being newly created / reviewed:** | **Yes / No/** |
| --- | --- | --- |
| **1.** | **Title** |  |
|  | Is the title clear and unambiguous? | *Y* |
|  | Is the procedural document in the correct format and style? | *Y* |
| **2.** | **Development Process** |  |
|  | Is there evidence of reasonable attempts to ensure relevant expertise has been used? | *Y* |
| **3.** | **Content** |  |
|  | Is the Purpose of the document clear? | *Y* |
| **5.** | **Approval** |  |
|  | Does the document identify which committee/group will approve it? | *Y* |
| **6.** | **Equality Impact Assessment** |  |
|  | Has the declaration been completed? | *Y* |
| **7.** | **Review Date** |  |
|  | Is the review date identified? | *Y* |
|  | Is the frequency of review identified and acceptable? | *Y* |
| **8.** | **Overall Responsibility for the Document** |  |
|  | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | *Y* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed by the Chair of the Committee / Group approving** | | | |
| If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified. | | | |
| Name | Care And Safety Planning And Recovery (CASPAR) Group | Date | *7th January 2019* |
| **Signed by the chair of the Group/Committee ratifying** | | | |
| If you are assured that the group or committee approving this procedural document have fulfilled its obligation please sign and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet. | | | |
| Name | *Cath Hill* | Date | *27 February 2019* |