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Association of UK University Hospitals

Care Programme Approach Policy (Including Standard Care)

(Replaces Policy No. TPCL/006 V.6)

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EXECUTIVE SUMMARY:

Key Policy Issues

This policy details the approach to care planning being undertaken in the organisation, and emphasises the particular focus on person-centred care.

The CPA policy has been updated on a temporary basis, as new national guidance on the use of CPA has now been circulated as part of the new 'community mental health framework for adults and older adults'. We will be reviewing our policy in line with the new guidance over the next 6 months, in the interim please continue to use this policy.

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Team on: 0300 304 1195 or email: policies@sussexpartnership.nhs.uk

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1. INTRODUCTION

1.1 Purpose of the Policy

The Trust is required to provide mental health services using the Care Programme Approach (CPA). This approach requires trusts to provide an assurance that all people using services will have their mental health and social care needs assessed and will be involved in developing a resulting care plan that addresses their identified needs and any assessed risks associated with their situation. The NICE quality standard (2016) further emphasises that this should always be done in a way that is person centred, focused what on what the person sees as their own priorities, and involves the people that they would like involved.

People are also allocated a care coordinator (lead practitioner), and their care plan is then regularly reviewed at least annually, although they may well be reviewed considerably more often than this depending where a person is in their recovery journey. In 2008 the DH carried out a national review of CPA and introduced the notion that people can be provided with full CPA or a more concise version of care, which in Sussex Partnership Trust we call Standard Care.

This policy describes our person-centred approach to delivering care that builds on the CPA as the core process but seeks to strengthen the extent to which people who use our services and their families, friends and carers can be even more involved in determining their own support needs.

Sussex Partnership has co-produced this policy with people who work in our services, people who use our services and the families, friends and carers of people who use our services.

Whether subject to CPA or standard care, all people using the service will be allocated a named worker to be their main point of contact with the service and whose role is to oversee and coordinate their care. In this policy this staff member will be known as the 'Lead Practitioner'.

1.2 The Essential Elements of Care Planning

- A systematic **assessment** of health and social care needs,
- An agreed **plan** with actions identified for the person, their clinical team and their families, friends and carers (if involved)
- The appointment of a named **care co-ordinator** (lead practitioner).
- Regular **reviews** to reconsider need and/or safety and to adapt and change plans as necessary

Overall it is about communication, ensuring that everyone involved in an individual's care has a defined process for bringing all the elements of the support plan centrally, with the lead practitioner acting as a central point of contact for all parties including the service user and carer. An important additional element to consider is how the care plan and risk assessment link together to ensure that pertinent risks that have been identified on the risk assessment are being supported through the plan of care that is being delivered.

1.3 Definitions

- 1.3.1 *Standard Care* – For the service user who has been identified as having needs that can be met by a single mental health professional, and doesn't need the more formal full framework of CPA. Few if any other agencies involved.
- 1.3.2 *CPA* - Some service users have sufficiently complex needs to require being on CPA. They are individuals with complex characteristics whose needs are met from a number of services or who are most at risk and who need a higher level of engagement, co-ordination and support. (See 4.1)
- 1.3.3 *Family/friend/carer*- As defined by the Carers Trust (2018), a family, friend or is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

1.4 Scope of the Policy

- 1.4.1 The policy is designed specifically (but not exclusively), for use within adult mental health services that are provided across Sussex Partnership including secure settings, in-patient services, dementia services and for people who have a learning disability and who also have identified mental health needs. The policy will also be used in the care of young adults, particularly those who are preparing to move towards adult services from children and young people's services.
- 1.4.2 Where appropriate, adolescents who are receiving a service from Children and Young Persons Service (CHYPS/CAMHS) and are likely to transfer into Adult services, should be considered for inclusion on CPA prior to transfer, in order to provide a structured framework for a smooth transition between services. The CAMHS CPA Protocol contains detailed procedural guidance.
- 1.4.3 Those accepted into Trust Secure and Forensic services will receive care under CPA and the principles of this policy will apply. CPA will be informed by the regular interactions undertaken through the My Shared Pathway process. Detailed guidance on the aligned care delivery procedures can be found in the Secure and Forensic Services-MSP/CPA Procedure document.
- 1.4.4 Where the Trust and its local authority partners have agreed such flexibilities, health professionals in integrated teams who identify social care needs as part of a comprehensive assessment, must consider whether outlined in the Care Act 2014. Where they do, local authority resources may be used in order to meet them. These may include services such as professional social work support, residential care, respite care, home care, meals etc. The option of using the self-directed support (SDS) process to organise and pay for this should be offered and the application process supported where the service user is eligible.

Consideration of the persons needs against these criteria should be assessed separately from CPA eligibility. Where social care needs are not eligible for local authority support, advice and signposting to other sources of help should be offered. Where eligibility for care and support from the local authority is identified this does not automatically indicate eligibility for CPA.

1.5 Principles for Care Delivery

Sussex Partnership's Values underpin this policy:

People first

People are at the heart of everything we do.

Future focused

We are optimistic, we learn and we always try to improve.

Embracing change

We are bold, innovative and disciplined about making use of our resources to continuously improve.

Working together

We provide services in partnership with patients, families and others.

Everyone counts

We value, appreciate and respect each other.

This policy draws on emerging themes that stress the importance of providing care to people using a co-produced recovery approach. The policy reinforces the concept that a care plan document is, first and foremost, written by the person using our services, and is their document. It is not a document solely for staff, a handover document or a clinical record, but a tool to help people understand what to expect from their care and how to navigate their recovery.

Recovery focussed care planning shifts the relationship between professionals and people using services, to one with a greater emphasis on collaboration and partnership. It represents a transfer of the authority to define and recognise Recovery away from the professional to the individual.

To achieve this means changing the nature of day-to-day interactions and the quality of the experience in mental health services. Care planning is the daily work of mental health services and, within this context, care plans that enhance both the experience and the outcomes of a person's recovery are a key element for effective services.

(Miles Rinaldi and Flippa Watkeys THE JOURNAL OF MENTAL HEALTH TRAINING, EDUCATION AND PRACTICE VOL. 9 NO. 1 2014)

2.0 POLICY STATEMENT

All NHS mental health providers are required to have a CPA Policy. This policy has been developed to better accommodate the call from service users, carers and practitioners for a fresh approach to how we deliver CPA locally. This document clearly focuses on how care planning is more than a document but a process; care planning is about having high quality interactions between

people who use our services, their families, friends and carers and our staff to help people feel able to lead their own care and have choice around their care wherever possible.

3.0 DUTIES

3.1 Responsibilities of a Lead Practitioner

- 3.1.1 Participate in the assessment of the service user's needs and associated risks. In Adult services, this may be undertaken by the Triage Co-ordinator prior to a lead practitioner being allocated.
- 3.1.2 Maintain an up to date record of their care and treatment on Carenotes.
- 3.1.3 Work with the person to develop a personal support plan including numbers to call/points of contact to use if they need urgent/crisis help or support.
- 3.1.4 Monitor that the service user attended for their treatment and where they do not, take appropriate action.
- 3.1.5 Ensure that appropriate risk assessments, outcomes measures, and PBR cluster allocation are completed and reviewed as necessary.
- 3.1.6 Support the service user to access funding and other services if appropriate.
- 3.1.7 Act as the central point of contact for the service user, carer and other professionals involved in care, responding to concerns raised by in a timely and pro-active way.
- 3.1.8 Monitor the overall plan and call reviews as agreed or identified as necessary.
- 3.1.9 Manage any transfers of care.
- 3.1.10 Any carers must be made aware of their entitlement to a carer's assessment.

Additional for people on CPA

- 3.1.11 Work with the service user to formulate a comprehensive personal support plan, which includes safety and contingency plans and advance statements. Ensure copies are shared as appropriate.
- 3.1.12 Ensure that everyone involved in the personal support plan is clear about lines of communication and feels able to raise concerns or comments easily.

3.2 Responsibilities of Service Directors/General Managers

- 3.2.1 Responsible for ensuring implementation of this policy, high quality service provision, and ensuring learning is applied following adverse incidents.
- 3.2.2 Responsible for advocating a co-production approach.

3.3 Responsibilities of Clinical Supervisors/Line Managers

- 3.3.1 Responsible for ensuring all staff are aware of the principles and procedures detailed in this policy and monitor whether staff have received the appropriate training.
- 3.3.2 Responsibility for ensuring Team members are confident and competent in the trust expectations around care delivery, and address any developmental needs.
- 3.3.3 Responsible for monitoring use of the electronic clinical record system to ensure compliance to trust recordkeeping procedures.

4.0 PROCEDURE

4.1 THE CARE DELIVERY PROCESS

4.1.1 Assessment

Assessment is a staged process, which starts at the point of referral and will vary depending on the needs of the individual.

4.1.2 An initial assessment must take place within 28 days of a referral being received and will determine appropriateness in respect of the Trust's services. The assessment must consider and incorporate the following aspects, **where appropriate**:

- 1) Past life including any family history that might be useful
- 2) Current needs including employment and relationships physical health, spiritual and emotional needs
- 3) Who they are, including their age, disability, gender identity, pregnancy and maternity status, race, religion and belief, and sexual orientation.
- 4) An accurate diagnosis using ICD10 coding,
- 5) Allocation to a care cluster
- 6) An assessment of risks to safety of themselves or others
- 7) Their social circumstances, including accommodation, financial and social needs
- 8) Their current support networks, including family, friends and other professional carers, and how they would like these people to be involved (or not involved)
- 9) How they have been trying to cope including their use of alcohol or drugs prescribed or otherwise
- 10) What help they are seeking, what they want to achieve and how they might prefer that help or support to be offered
- 11) A formulation of the overall picture.

Assessment is an on-going process so not all information will be gained in the initial stages

After assessment a decision will be made as to which type of care – standard or CPA is most appropriate to meet the needs of the service user.

Where a higher level of need is identified a more comprehensive health and social care assessment will be undertaken, and these people will be considered for inclusion on CPA level of care.

4.1.3 Criteria for Standard Care

If someone can manage the basics of daily life, and has needs that don't require the more formal framework of the care programme approach (CPA), they will work with a single mental health professional (Lead Practitioner) to develop a plan of treatment.

Criteria may include;

- Relatively straightforward mental health problems – but still in need of support from secondary care services.
- Willing to attend appointments and engage in treatment
- Clear treatment pathway
- Supportive social networks/family/friends
- Engaged in meaningful occupations
- Only needs to be engaged with one worker/agency (or a limited number) to get support.
- Risk profile is low.

4.1.4 Criteria for CPA

If someone has mental health problems with other inter-related issues which impact significantly on daily life and needs intensive support, usually from several services/agencies, then they may need support under CPA.

The same applies if the person using our services is unable to manage their own care and treatment plan without the ongoing support of Lead Practitioner

Criteria may include;

- **Severe mental health problems** (including Personality Disorder) with a high degree of clinical complexity
- **Current or potential risk(s)**, could include -
Suicide, self-harm (especially in later life), harm to others (including history of offending)
Relapse history requiring urgent response
Self-neglect/non-concordance with treatment plan
Vulnerable adult: adult/child protection, Physical/emotional abuse, financial/sexual exploitation
Cognitive impairment
Experiencing significant or multiple loss
- **Current or significant history** of severe distress/instability/disengagement or social isolation
- **Presence of non-physical co-morbidity** e.g:
substance/alcohol/prescription drugs misuse, learning disability
- **Multiple service provision from different agencies**, including: housing, physical care, employment, criminal justice, voluntary agencies
- **Currently/recently detained under Mental Health Act**, on CTO or referred to Crisis/Home Treatment team for intensive support
- **Significant reliance on carer(s)** or has **own significant caring responsibilities**
- **Significant impairment of function** due to mental illness
- **Social Factors including** lack of meaningful daily activities and occupation, Unsettled accommodation/housing issues.
- **Physical Health concerns**

This list is not exhaustive, and there is no minimum or critical number of items to include, clinical and professional judgement needs to be used in evaluating the needs of the person – consider do they need multi agency support, active engagement, intensive intervention, support with dual diagnosis and are they at high risk? If yes they probably need to be on CPA level of care.

- 4.1.4 Assessment is an on-going process which will continue through the episode of care, however it is important to get a clear understanding of the person's needs, risks and strengths at an early stage, so that a complete and fully rounded support plan can be determined as soon as possible. This should include consideration of capacity.
- 4.1.5 The assessment must be undertaken collaboratively with the person, and the carer (where appropriate) as partners. Advocates and interpreters should be involved as necessary, to facilitate this. Reference must be made to any other existing or previous assessments, to avoid duplication of information gathering, ensure all the relevant information is considered and that appropriate people are included as part of the care team.
- 4.1.6 The assessment and support planning process must focus on the needs, hopes aspirations and choices of the person, not just what the service can provide. Processes must be transparent, consistent and flexible enough to meet expectations of service users and carers.
- 4.1.7 In addition to the comprehensive assessment, other assessments may need to be carried out, dependant on the individual circumstances of the person. These may include more detailed specialist professional assessments and including issues related to the safeguarding of children and vulnerable adults.
- 4.1.8 Standard Care/Outpatient Psychiatry is possible for high risk individuals who require multiagency support when the risk to others is being managed by the referring agency (e.g. NPS, LD Services) and where assessment indicates lone practitioner intervention meets the presenting need.

4.2 Carers' Assessments

- 4.2.1 Carers (including young carers) must be identified during the assessment process. A carer is someone who helps another person, usually a relative or friend, in their day to day life. This is not the same as someone who provides care professionally, or through a voluntary organisation. The Care Act 2014 gives local authorities a responsibility to assess a carer's needs for support, where the carer appears to have such needs. If someone is providing care they must be told of their right to an assessment of their care and support needs. This assessment will consider the impact of caring on the carer. It will also consider the things the carer wants to achieve in their own day to day life. It must consider 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. Following assessment, carers must be offered their own written support plan that must be discussed and implemented in discussion with them. The carers tab should also be updated on our electronic system.
- 4.2.2 If the Lead Practitioner is not undertaking the carer's assessment, they must advise the carer as to how this will be carried out. The Lead Practitioner retains responsibility for the quality and appropriateness of the

carer's assessment and any resulting support plan, which must then be shared with the care team. (In East Sussex this is the responsibility of Adult Social Care)

4.2.3 Where a carer declines the opportunity for their own assessment, every effort should be made to gain agreement for them to be provided with details of the service user's crisis and contingency plan. As a minimum, details of who they can contact in a crisis should always be provided.

4.2.4 The clinical record should clearly indicate that carers assessment has been offered and the outcome of this.

4.3 Assessment of Risk

4.3.1 The assessment of risk, and its management through the care plan, is a key requirement of effective care planning, not just at discharge but also throughout the life of the plan. Risk assessment must take into account all the available information from a variety of relevant sources and must be regularly undertaken when necessary i.e. when any significant circumstances change, on admission/discharge from inpatient services, etc. and at least six monthly if not triggered by specific events. Risk assessments and corresponding updates to the care plan must also be done with the person at any point of transition or significant change in their care.

4.3.2 Risk processes within the Trust must meet the minimum standards as detailed in the Trust's current Clinical Assessment and Management of Risk policy.

Trust Standards for Assessment

- The first assessment appointment must be within 4 weeks of a referral being received
- During the assessment process consideration must be given all aspects of the person's life and must include any diversity, housing, employment, physical health and parenting needs, as well as the person's strengths.
- During the assessment process, an exploration of the person's experience of violence and abuse must be discussed.
- Once a clear understanding of the person's needs and strengths has been explored, the way forward will be discussed and clearly documented to them, and to the referrer.
- Once a good understanding of the person's needs has been determined, a decision will be made as to the level of care which best meets the person's needs (standard or CPA)
- Details of the assessment (including risk assessment) will be entered onto the electronic care record system within 2 days of the meeting.
- If accepted into service, the person will receive details of what will happen next, together with who they are likely to see and when this might be. This will form the basis of the first personal support plan and should contain details of who they can contact in a crisis.
- This next meeting must take place within 18 weeks of receipt of the referral.

4.4 Mental Capacity Act

The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people who are unable to make all, or some, decisions for themselves. The MCA explains who can take decisions, in which situations, and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity.

The Mental Capacity Act is based on a presumption of capacity - every adult has the right to make their own decisions and must be assumed to have capacity to do so unless proved otherwise. However, if there is a question about whether or not someone has the capacity to make a particular decision then it is important that a thorough mental capacity assessment is undertaken in line with our MCA policy.

This will be particularly important in situations where there are concerns about self-neglect or about unwise decisions, and in situations where capacity is fluctuating.

4.5 Allocation of a Lead Practitioner

4.5.1 The lead practitioner role is twofold, primarily they are the main point of contact for the person with the services they are receiving and they are also the staff member that helps that person to navigate the range of services that may be available to them either within the Trust's services or beyond. If receiving standard care the person in need may only see one worker, if the person is on CPA they may see a number of practitioners one of whom will be assigned to become the main contact who knows what is happening for them and who works with them to develop and review their support and safety needs.

A named lead practitioner must be identified as soon as possible after agreeing what level of care is needed.

4.5.2 A lead practitioner can be any suitably trained practitioner working for Sussex Partnership whether professionally qualified or not. They are responsible for ensuring that the person's health, social care needs and safety needs are met either by themselves or with the help of others, they will also be responsible for developing a support plan with the person and reviewing this at regular intervals according to the changing nature of their needs.

4.5.3 Decisions about who should be a lead practitioner should take account of;

- The service user's needs and choice in respect of gender, culture, language and religion.
- The priority area the person has identified, which they want support with.
- The training, experience and current workload of proposed lead practitioner.

- 4.5.4 The person's views should be sought and considered when allocating to the role of lead practitioner in order to maximise the potential therapeutic benefit of the relationship. Where preference is expressed, consideration must always be given to ensure that this preference has a positive therapeutic benefit and does not reinforce any discriminatory bias. This should also be the case where someone requests a change to their Lead Practitioner
- 4.5.5 The person assigned the role of lead practitioner must either be present or have given prior consent to accepting the role. Any change of lead practitioner must be handled sensitively; with the person and carer informed throughout (see 4.3 Transfers of Care for more detail).
- 4.5.6 Where two people in a relationship are both users of the mental health service, they should not have the same lead practitioner. This will ensure a proper focus for each individual's needs. However liaison between the lead practitioners and care teams is likely to be of benefit to all involved, and permission to share information in this respect must be sought in line with existing confidentiality procedures.
- 4.5.7 The DH guidance states that psychiatrists should not usually be lead practitioner for those on CPA,. (see 4.1)
- 4.5.8 In the case of Psychiatrists working as Lead Practitioner in out-patient settings a contemporaneous entry in Carenotes on the day of review must be made. A care plan should be opened in carenotes and in first field an entry made directing to the appropriate GP letter which should be uploaded and clearly labelled in correspondence section.'
The standard GP letter should include a risk assessment and management plan as part of the personal support plan and be completed and sent out within two weeks of the out-patient appointment with a copy sent to the service user/significant other by agreement with the service user. The letter can be found on carenotes
In the Correspondence Tab, under 'Letters and Printable Forms', select 'Letters General' and the template is headed 'Psychiatrist GP Letter V2'.

Trust Standards for Care Co-ordination

- A named lead practitioner must be identified as soon as possible after agreeing what level of care is needed.
- The lead practitioner must ensure that any informal carers are identified and offered the opportunity to undergo a carer's assessment.
- The lead practitioner must maintain regular contact with the service user, carer and other members of the care team to ensure relevance of the personal support plan to current situation.
- The lead practitioner must ensure that the service user and carer are given the opportunity to be actively involved in all decision making processes and that choices, where expressed, are respected wherever possible.

- Where the service user's situation requires admission to residential/acute care settings, the lead practitioner will liaise with the receiving care team and support the person at the point of transition, throughout the stay.
- This may involve working closely with any Crisis Resolution Home Treatment services who are involved.
- The lead practitioner will be actively involved in the acute care discharge process and will ensure that contact is made within 3 days of discharge.
- The lead practitioner must ensure that the personal support plan review takes place, as appropriate, and that the process is fully documented and shared with relevant parties.
- Where a transfer of care is necessary, the lead practitioner will facilitate the process to ensure a smooth and effective transition.

4.6 Developing Care Plans

4.6.1 Developing the care plan will start at the outset of the assessment stage. The person's own views of what will best support their recovery must be sought and considered, as should the views of any family members, friends or carers that the person would like involved.. This is a collaborative process and it may take time for a clear view to emerge. .

4.6.2 The care plan document forms the basis of this approach. This plan must provide a record of the person's support needs and the jointly agreed ways in which those support needs will be met. The support plan is developed by the person with their lead practitioner and is shared with all the people involved in the person's care, including staff within the Trust and any other agencies involved in the person's care as well as others that the person wishes to share the support plan with, such as a partner, family member or supportive friend. There is now one universal template on our Carenotes system that should be used for all people, whether they are receiving standard or enhanced CPA. This should be used for all people at all points in their care. This document is a live document that should be updated by all people involved in the person's care and treatment and should be a true reflection of them, what is important to them and where they are at in relation to their life and their recovery journey.

4.6.3 Although co-developed with the person, the support plan will also need to articulate clear information to people who may need to become involved in that person's care if problems arise or circumstances change. Safety plans may also be included in the relevant section on the template to help people manage their safety and the safety of those around them in crisis situations. A section on the universal care plan template also includes a dedicated section to be used when planning a transition period in the person's care.

4.6.4 The care plan must contain:

- A focus on the person's needs and choices not just what the professional or service can offer. Specific actions in relation to the persons mental health issues.
- Plans for action in relation to other aspects of the person's life that need support as identified during the assessment process and may include

accommodation, occupation, social inclusion, benefit entitlement, etc. As well as any issues relating to their physical health

- It should reference risk management strategies identified during the risk assessment process.
- Agreed goals of all interventions
- Estimated time scale for achievement or review of each goal
- Contributions of all agencies involved and who is responsible for each action
- Name and contact details of Lead Practitioner
- Date of next planned review
- Details of any outcome measurement scale
- Relapse prevention strategies and who to contact in a crisis.

Additionally for those with more complex needs:

- Detailed crisis and contingency plans including Advance Decisions to Refuse Treatment (ADRTs), advance statements or Lasting Powers of Attorney (LPAs) where available, which address coping skills and relapse prevention, in addition to contact details 24 hours a day/ 7 days a week. (See the Trust's ADRT and Advance Statements policy and Mental Capacity Act 2005 policy for further information).

- 4.6.5 Support plans must be made available in accessible formats where necessary e.g. in larger font versions, 'easy read' versions and/or in other languages to aid understanding. The Trust Equality and Diversity Team advise on this.
- 4.6.6 Where specialist plans have been developed within interventions, these should be reflected in the overall support plan, so that all treatment activity is reflected in one place.
- 4.6.7 Plans must show a clear relationship to assessed needs, be developed collaboratively with service users and carers, focus on strengths and promote recovery. They should reflect the diverse needs of the individual, taking into account their protected characteristics,
- 4.6.8 Where appropriate, support should be given to the service user developing their own self-management plan. The lead practitioner should support the person to identify existing resources eg Wellness Recovery Action Plan (WRAP), Taking Back Control etc and incorporate elements of this into the Personal Support plan, subject to the person's agreement.
- 4.6.9 Consideration should be made to establishing a clear relationship with any other agencies or services actively involved in the persons care or treatment including substance misuse services, so their input is recognised on the personal support plan.

- The personal support plan must be in a format accessible to the person, using the universal care plan template.
- Efforts must be made to fully engage the person in developing and agreeing the plan. The care plan must be led by the person wherever possible.
- Care plans should clearly demonstrate how families, friends and carers have been involved (if the person wishes for this) and record who was involved in the development of the care plan.
- All care plans should be written using first person terminology and the person's own words. (the only exception to this may be in cases of learning disability or advance dementia, where 3rd person may be appropriate if the care plan is developed with the involvement of carers and the person is not able to participate themselves)
- The care plan details must be recorded in the electronic care record system within 7 days of the Assessment/Review meeting and the person should have a copy (which is a true reflection of the interaction that they have had when developing the care plan)
- For those on CPA the plan must also include detailed crisis and contingency plans
- The care plan must clearly reflect how any key risks identified in the risk assessment are being supported.
- As a minimum, any carers must be given information on who to contact in a crisis regardless of information sharing permissions.
- The care plan should demonstrate use of trauma-informed thinking and language.
- Care plans should always be framed in a way that uses positive language that is non-labelling and non-judgemental. Language should ordinarily avoid jargon (unless this is what the person uses) and be in the person's own words.
- Care plans should always demonstrate an ethos of hope and recovery.
- Easy read and dementia friendly care plans must be used as available. There may also be situations where arrangements need to be made to translate a care plan in to the person's own language.
- Care plans should feel manageable and achievable for the person and be reflective of the person's current place on their recovery journey.
- Care plans should clearly include what is important to the person, their values and their belief systems.
- All care plans should be developed/updated following a quality therapeutic discussions with the person who uses our services (and any other person they choose to have involved in that discussion).

4.7 Reviewing the Care Plan

4.7.1 The review of the care plan must consider:

- All the person's health and social care needs including risks,
- Whether those needs and risks have changed,
- Whether the input provided has helped the person's recovery, in relation to
 - rebuilding hope for a better future

- restoring the person's life roles and functioning
 - maintaining/enhancing self esteem
 - Any changes that may be needed to the plan in order to sustain this.
 - The need to remain on or transfer to a different level of support.
- 4.7.2 The lead practitioner will ensure that there is a comprehensive review of the support plan in line with the cluster review period. Reviews may be held as frequently as circumstances warrant above this minimum, including at the request of service users, carers, or any member of the care team. Care plans should also be reviewed as needed as points of change and/or transition in their care and after any learning from incidents.
- 4.7.3 Ideally all parties involved in the care process including service user and families, friends and carers (if appropriate) should be given the opportunity to attend the review meeting, however where this is not possible or is not the desired format of the service user, written reports may be submitted to the Lead Practitioner to be included in the meeting.
- 4.7.4 To enable active participation the service user should be adequately prepared for the review meeting. Use of the Review checklist (see Appendix) can be helpful. Roles like peer support workers can be very beneficial in helping a person feel confident and prepared for their care plan review.
- 4.7.5 A decision to move service users on CPA to standard care should be made after careful consideration at a CPA review meeting, or other appropriate time, and the reasons why recorded in the revised personal support plan. The additional support of CPA should not be withdrawn without:
- an appropriate review and handover (e.g. to the GP);
 - exchange of appropriate information with all concerned, including with carers;
 - plans for review, support and follow-up, as appropriate;
 - a clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that person's mental well-being.

For service users on standard care a decision to move on to CPA should be made by the MDT after discussion with the service user, any carer and the lead practitioner who had been involved in the treatment of the serviced user.

Trust Standards for Care Plan Reviews

- Reviews must take place in line with specific care pathway requirements/maximum 12 months

- Prior to the review, the service user should be invited to attend the review, reminded of the content of the current plan and be given the opportunity to discuss the review process to maximise the beneficial effects.
- During the review process needs identified during the original assessment must be considered alongside the current situation
- The service user's preferences for format, location and attendees in respect of the review should be discussed and where possible accommodated. Where this is not possible, a clear explanation must be given.
- The service user and carer must be put at the centre of the review process, with active involvement in discussions and their views sought on all aspects of the support plan.
- Any disagreements, differences of opinion or differences of belief must be acknowledged and recorded within the support plan.
- At each review the need to remain on the current level and the potential to change the level of support must be considered, alongside the appropriateness of discharge back to primary care.
- In addition to the planned interventions, crisis and contingency plans, risk assessments and outcome measurements must be also be reviewed in line with trust requirements.
- Following the review meeting, the lead practitioner will ensure that the revised support plan is recorded in the electronic care record within 2 working days
- A copy of the revised plan must be offered to the service user, carer (if appropriate) and other members of the care team within 5 working days of completion.

4.8 PERSONAL SUPPORT PLANS AND INPATIENT CARE

Admission to mental health inpatient services will usually lead to CPA level of support being indicated, if this was not the case before, given that admission usually indicates a high level of complexity and risk. Where the admission does not lead to an increase in the support level in the community post discharge, the circumstances under which this decision was made should be clearly recorded in the clinical notes.

Inpatient Care Plan – Acute and Dementia Care

- On admission the identified nurse will complete a care plan if one is not already in place, or will update the existing care plan if one is already available.
- For the dementia wards, a consideration of capacity is also included in the care plan.
- The care plan universal tool has a menu of categories that may be included in care plans. For inpatient care, some particular areas that should be considered may be:
 - Supporting my risks
 - Supporting my mental health needs
 - Supporting my physical health care needs
 - Supporting my social, practical and communication needs
 - My Medication
 - Working towards my discharge from hospital/ My transition plan

- The care plan must be reviewed on a regular basis, wherever possible this should be weekly and must include the patient. The care plan should also be reviewed and updated following an incident.
- It is important that the care plan is dated.
- It is important that the patient is offered a copy of the care plan and if this is not possible then the reasons why is recorded.
- If the patient agrees a copy can also be given to family members, friends and carers in line with the person's wishes.
- Other professionals can add to the relevant section of the care plan.

4.8.1 Inpatient admissions from outside trust area

When a service user supported by the CPA of another trust is admitted to Sussex Partnership NHS Foundation Trust inpatient services, the responsibility for maintaining care co-ordination, reviewing the care plan and leading on discharge arrangements will rest with the home trust, although we will still ensure that the person has an appropriate and up to date care plan that is regularly reviewed and updated for as long as we provide care to them. Our key focus should always be on the person (and their family and friends), and making sure that they have a meaningful and positive experience with us, as well as doing whatever we can to help get them back closer to their home. The existing Care Co-ordinator/Lead Clinician should be identified and contacted at the earliest opportunity as a copy of any existing care plan and risk assessment will be required on admission or as soon as practicable thereafter. Planning for discharge should be considered from admission onwards, even when the planned discharge date is remote. The home trust and their local authority partner are strongly encouraged and facilitated in maintaining links.

4.8.2 Where a patient not supported by any existing care arrangements is admitted, efforts will be made to identify which trust and local authority may be liable to provide aftercare, following normal residency rules, as soon as practicable following admission to hospital.

4.9 Three Day Follow-Up

4.9.1 During an acute inpatient admission patients will usually be included on CPA, regardless of previous status. Multi-disciplinary discharge planning will consider whether this status will be appropriate on leaving inpatient care. Where this is determined not to be necessary, the circumstances must be clearly recorded in the clinical notes/care record.

4.9.2 Those discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care under CPA, arrangements must be made to follow up within three days of discharge. This is a maximum contact period and contact should be considered appropriate to the person's needs within this timeframe. This will also apply to those who self-discharge against medical advice. Guidance on the process and responsibilities around 3 day discharge can be available.

4.9.3 Details of who is to undertake this contact must be clearly recorded and

advised to the patient. The contact will usually be face-to-face and only in exceptional circumstances be undertaken by phone. Where face to face contact does not occur, details of why this course of action has been taken must be clearly recorded.

4.9.4 Where someone is discharged to prison, contact should be made via the

prison in-reach team and agreement reached as to level of on-going contact appropriate to the person's needs.

4.9.5 Where a carer has been identified, their views and concerns must be

sought during this period and consideration given to any issues that may arise. Clear reasons for any actions taken where the carer is not in agreement must always be given.

4.9.6 As with all care plan reviews, the service user and carer (if appropriate)

should be actively involved in the Acute Care discharge planning meeting and offered a copy of the completed Discharge Review Summary and Care Plan, which should also be made available on the electronic care record, if not electronically completed.

4.9.7 Each CDS follows a standard procedure to manage the 72 hour follow up requirement. Local procedures are in place for what will happen when a person is discharged immediately prior to a weekend or bank holiday and other specific circumstances when the usual clinical team/lead practitioner may not be available to provide the follow up. The standard procedure is included in the appendices below. Locally agreed procedures can be obtained in each CDS. The key difference to note is that in Brighton and Hove, The Haven service are responsible for managing this process and typically provide a follow up phone call which is documented on to the Carenotes system (so that if there was to be a concern about the person then they may be invited to attend The Haven rather than A&E .

Trust Standards for 3 Day Follow-up

- Prior to discharge from inpatient services, a discharge review meeting must identify who is responsible for making contact with the service user in the 72 hours following discharge.
- A copy of the discharge care plan including who will undertake follow-up must be offered to the service user and any carers.
- The clinical/electronic care record must clearly indicate the name of practitioner responsible for 3 day follow-up
- Following discharge, if not already agreed, contact must be made by the nominated practitioner to arrange a follow up visit.

- If the follow-up is not to be undertaken by the lead practitioner, the visiting practitioner must liaise with the lead practitioner to ensure they are fully aware of current situation and to plan a formal handover of care.

4.10 TRANSFERS OF CARE

4.10.1 Transfers of care may happen between areas, services or settings either within the trust area or outside of it. This a vulnerable time for care delivery and it is essential that any transfer of care is managed in a structured, organised way to minimise the chances of communication or continuity of care breakdown, and using the agreed transition care plan.

4.10.2 Fully completed CPA documentation comprising of assessment, risk assessment, support plan and review summary documentation must be sent to the receiving team within 5 working days of the review meeting at which the decision to transfer was agreed.

4.10.3 If a service users care is being transferred to another area, and during this process the person risks increase, the original team is contacted and assesses if the service user needs urgent follow up, they must either:

1. Telephone the receiving team and verbally share risk information, agree an urgent follow up plan and update the risk assessment.
2. If the receiving team cannot be contacted immediately, take responsibility for offering urgent support, update the receiving team as soon as possible and update the risk assessment.

4.10.4 In all transfer situations, the service user and carer (if appropriate) must be offered a copy of the Review Summary and Support Plan.

Trust Standards for Transfers of Care

- Any decision to transfer care must be preceded by a review meeting within which the reason for the transfer, the timescale and the person responsible for undertaking the transfer is clearly indicated.
- The service user and any carers must be invited to be involved in the transfer process by way of attending meetings and being actively involved in decision making.
- Copies of the latest documentation (assessment, risk assessment, personal support plan) must be forwarded to the receiving team to facilitate identification of a suitable replacement lead practitioner.
- Once the receiving team has identified who is taking over from the existing care co-ordinator, a joint meeting should be arranged so that the service user and carer have an opportunity to meet them.
- Where the transfer is planned and the person's needs are complex, it may be appropriate to undertake a period of joint working to ensure a smooth transition.

INFORMATION SHARING

- Personal support plans must be proactively **developed with** the service user unless not clinically appropriate. They should also be shared with other people and agencies involved, this should include the person's general practitioner, and any carers/supporters agreed with the person.
- Consideration should be given to ensuring the person has given consent in line with the Information Governance Policy, and exceptions to the need to have consent. Information can be shared without the consent of the service user if it is to prevent harm to other people.

5.0 DEVELOPMENT, CONSULTATION AND RATIFICATION

This policy has been developed using multiple sources of information. These include previous trust CPA policies; positive practice examples provided by the Department of Health within the Refocusing the CPA Review 2008 guidance, and previous government guidance documents. In addition, directives issued by bodies such as the National Patient Safety Agency, Care Quality Commission and Monitor have been taken into account in this version. Initial drafts were reviewed by members of the Trustwide CPA Development Group for comment.

Wider consultation was subsequently undertaken through dissemination to staff, service user groups and carers forums across the trust. Feedback received has been considered and utilised as appropriate within this policy.

Ratification is through the Professional Practice Forum.

6.0 EQUALITY IMPACT ASSESSMENT

The guidance produced by the Department of Health, 'Refocusing the Care Programme Approach 2008' upon which this policy is based underwent an Equality Impact Analysis to ensure that it takes account of the diverse individual needs of the service user, paying proper account of issues of age, disability, gender, gender identity, sexual orientation, race, religious beliefs and ethnicity.

The trust has also carried out its own Equality Impact Assessment Analysis and made subsequent revisions to the policy accordingly in this version.

7.0 MONITORING COMPLIANCE

Quality Assurance for Care Delivery

The trust with its local authority partners will seek continuously to improve consistency and quality in its implementation of Care Planning.

The views of service users and carers on the effectiveness of care delivery in providing the support they need, in ways they prefer, will be central to this. This will be achieved, using the outcomes from the National Patient Survey, the Friends and Family Test and local questionnaires to ensure compliance to trust standards and identify areas of concern.

The trust will meet the requirement to conduct an annual audit of care records to ensure that those who need the more structured framework of care around them are receiving this. This audit will be a standing item on the trust's annual audit plan and will be conducted by the Audit and Effectiveness Team.

8.0 DISSEMINATION AND IMPLEMENTATION OF POLICY

Copies of the ratified policy and its associated procedure document will be disseminated to all service directors and managers for cascading to teams. In addition details will be publicised using trustwide communication systems such as the Partnership Bulletin. An electronic version will be made available on the trust website.

The requirement for staff and bank workers (where appropriate) to undertake training in CPA will be published in the Trust's Training Needs Analysis for Essential Training. This is included in the Trust's Essential Training Policy.

9.0 DOCUMENT CONTROL INCLUDING ARCHIVE ARRANGEMENTS

Following ratification, logging, availability and archiving of the document will be dealt with in accordance with the trust's Procedural Documents Policy V5 2012

Review of the policy will be the responsibility of the Trustwide Personal Support Planning Development Group in line with documented timescales.

10.0 BIBLIOGRAPHY

11.0 GLOSSARY

Advance Decision to refuse treatment Advance decisions to refuse treatment (ADRTs) are legally binding instruments under the Mental Capacity Act 2005 (MCA), by which a mentally competent adult can refuse a specific treatment intervention if that person loses capacity in the future. Prior to the introduction of the MCA in 2007, ADRTs used to be referred to as advance directives or living wills, but these terms are no longer in use.

Advance statements (sometimes referred to as Advance Care Plans), although not legally binding, record the patient's wishes and encourage patient participation. They enable Trust staff to make informed decisions about a patients care and treatment.

Care Co-ordinator The practitioner responsible for co-ordinating care for an individual. Their responsibilities include co-ordinating care, keeping in touch with the service user, ensuring the care plan is delivered and ensuring that the reviews take place as required.

Carer An individual who provides or intends to provide practical or emotional support to someone with a mental health problem. They may or may not live with the person cared for. They may be a relative, partner, friend or neighbour. They may be a young person who finds themselves in the position of needing to support an unwell person. A person may have more than one carer.

Common Assessment Framework (CAF) The term Common Assessment Framework (CAF) is used to describe assessment systems in adult health and social care and in children's services. It is the overarching assessment framework to which specialist assessment processes such as CPA, SAP and HAP belong. The adult CAF is currently in development.

Dual Diagnosis Within this document the term dual diagnosis refers to co-existing mental health and substance (alcohol and/or drug) misuse problems unless otherwise specified.

Homeless or Unsettled Accommodation The reference to homeless people refers to people not in settled accommodation, this includes: rough sleepers; people living in insecure accommodation e.g. hostels, night shelters, squats, living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the homelessness duty..

Recovery At the heart of recovery is a set of values, which place as central a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms.

Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life" (Shepherd et al, 2008).

The principles of recovery are central to current government policy on mental health services (*No Health without Mental Health*, 2011)

Self Management involves skills learnt to help control the symptoms of psychiatric or physical illness by setting and achieving goals. It involves planning and problem solving techniques to overcome the issues faced. Through these techniques, people should understand more about how to manage their symptoms and improve their quality of life. Further details on recovery-focussed working and building self-management skills can be found in the recovery pages of the trust intranet and in the Recovery and Wellbeing Toolkit.

Social Inclusion This can be defined as all individuals having the same opportunities to participate in, and contribute to, society and community as the rest of the population regardless of disability. It involves increasing options and empowering to have the confidence in their own abilities and aspirations. Key areas are education, employment, housing, family and relationships, financial security, leisure, arts, cultural and religious opportunities and participation in civic life.

12.0 CROSS REFERENCE

Sussex Partnership NHS Foundation Trust

Policies

Active Engagement Incorporating Did Not Attend (DNA) Management Policy & Procedure
Clinical Audit Policy
Clinical Risk Assessment and Management Policy and Procedure
Data Protection, Security and Confidentiality policy
Data Quality Policy
Dual Diagnosis – Mental Health & Learning Disability Policy
Dual Diagnosis – Mental Health & Substance Misuse Policy
Essential Training Policy
Health Records Policy
Safeguarding Adults At Risk Policy
Safeguarding & Child Protection Policy
Supervised Community Treatment Policy (S17 A-G MHA 1983-Community Treatment Orders)
Advance Decision to Refuse Treatment (ADRT) and Advance Statement Policy
Mental Capacity Act 2005 Policy

Procedures and Guidance

CAMHS Transition Protocol (CAMHS to Adult MH or LD Service)
Carers Assessment Practice: Adult Mental Health Standards and Guidance
Carers & Confidentiality Guidance for staff
Information Sharing Protocol
CAMHS CPA Protocol
Recovery and Wellbeing Toolkit
S117 Practice Guidance

Relevant Local Authority Policies (Appropriate policy will be dependant on locality)

Fair Access to Care Services (FACS)
Carers and Carers Assessment

13.0 APPENDICES

APPENDIX 1

Preparing to Discuss My Care Plan

From time to time it is important that you have an opportunity to get together with your care team to discuss how you feel are getting on and to review what care and treatment might best suit you.

You may want to consider the following questions when you are discussing your Personal Support Plan.

Does the plan reflect your key concerns? Are there any new priorities?
Are you happy with the treatment you are receiving at the moment; is there anything else you would like to consider?

Do you have any concerns about any medication you are taking for your mental health problems, (for example any side effects) Would you like any more information about it?
Are you happy with your crisis and contingency plan, and are you clear about the options you have if you become unwell or need extra support?
How is your physical health? – Are any physical health concerns (including pain) you have, identified as part of your personal support plan?
If you are being referred to another service, is the process clear, with information on who to contact for more information?
Are there identified carers/supporters you would like to be involved in process of agreeing your personal support plan?
Do you and your carers need a review of the overall support being offered to you?
Are you seeing other services or agencies for support that you would like us to know about?
Is the personal information held about you up to date; - including the following areas?

<ul style="list-style-type: none">The basic information held about you including contact details, next of kin, who to contact in an emergency, who information about your care can be shared with.
<ul style="list-style-type: none">Accommodation status – what type of housing you have and if that has changed since the last review meeting.
<ul style="list-style-type: none">Employment status – if you are working or not, and whether this has changed recently
<ul style="list-style-type: none">Information about you as a person (religion or belief, ethnicity, sexual orientation, age etc) which may affect how you want to be treated.
<ul style="list-style-type: none">Any other issues you want to discuss?
Name and Date

APPENDIX 2

Our Ref:

Date:

CONFIDENTIAL

Dear

We met with [NAME] & (CARERS) at (location) on the [DATE] for an initial assessment.

Re:	
------------	--

NHS No:	
Clinical Impression/formulation:	<i>Overall picture of the person, their strengths and issues, consider using the 5 p's – presenting, predisposing, precipitating, perpetuating, protective factors.</i>
Risk Statement: (Suicide/Self Harm, Neglect & Violence)	
Outcome of assessment/recommendations	<i>Level of Care – standard or CPA (if accepted into mental health services) Agreed actions and who is responsible</i>
Lead Practitioner (if accepted into mental health services)	

Reason For Referral, Presenting Problem, Service User View

Family & Personal History, Past Mental Health & Substance Use/Misuse

Current Physical State, Mental State (including capacity assessment),

Past treatments and what has or hasn't worked (Include therapies).

Yours sincerely

**Assessment & Treatment Service
Specialist Mental Health Team**

Cc Service User, or statement re why not

APPENDIX 3

Confidential



Name
Address 1
Address 2
Address 3

19 March 2020

Dear XXXXXXXX

Following your appointment on xx/xx/xx, I am writing to confirm the details discussed.

Summary of assessment/progress since last review

Personal Support Plan	
This outlines the Care we have agreed the service will provide.	
Lead Practitioner	Name Tel. No. [Insert No]
Plan of Care/Treatment Including medication.	
What strategies we have agreed you will use to manage your mental health stay well and prevent a relapse.	
How to access services in a crisis	<p>1. In the event of a crisis between 8:30am and 5pm on week days please contact [Insert Team Name] on [insert telephone no.] and ask to speak to your lead practitioner. If they are not available at this time leave a message and it will be answered within the working day by your lead practitioner or, if they are not available, another member of the team.</p> <p>2. Outside of the above hours, please contact the Mental Healthline on 0300 5000 101</p>
Review date/Next Appointment	

If your circumstances change and you need professional assistance, please either contact me on the above number or contact your GP, who will be able to help and if necessary arrange an earlier appointment or a home visit.

A copy of this letter has been sent to your GP so that he/she is aware of your care plan.

Yours Sincerely

[Name]
Lead Practitioner

You are welcome to bring another person to any appointments for support or for any other reason that you would find helpful.

APPENDIX 4- UNIVERSAL CARE PLAN TEMPLATE FROM CARENOTES

APPENDIX 5



[DATE OF CLINIC]

GP Name and Address

Contact details of Assessment
Treatment service

Dear Dr [LAST NAME]

Re Patient's name, DOB

Name		Date of birth	
NHS No		Hospital No	
Home address			

New ICD10 Diagnosis:	
Confirmed historical ICD10 Diagnosis:	
Comorbid Physical Health Problems	

Care Co-ordinator or Lead Professional (including name, contact no and email) :

.....

Medications:

Medication	GP to continue [yes/no]	Other instructions e.g. started to today, increased today, given 14 day FP10, please monitor FBC

- Medications recently stopped include: [\[Add detail\]](#)

Recovery Plan

Including specific goals / any support from Third Sector etc as well as social and psychological support and interventions

Follow-up arrangements including next planned contact:

If discharging to the GP, provide a timescale for a medication review for GP to undertake

Physical Health Care Plan

Including date of last annual review

Brief History and summary of Mental State Examination:

Clinical Narrative and formulation

Safety/ Crisis Plan including Risk Statement:

In Brighton this would be standard MHRRS paragraph in most cases – but also highlight any exceptional factors – eg no lone workers

I hope this information is useful to you. Please contact me or my colleagues with any queries.

Yours sincerely

Doctor's Name and Title

—

APPENDIX 6
**Forensic Healthcare Care Delivery Service (v4, September 2017)
 Inpatient Procedure for CPA and My Shared Pathway**

Notes:

My Shared Pathway is a recovery-focussed framework for patients within secure care. The forensic healthcare CDS uses My Shared Pathway within the CPA process. To support the procedures outlined below, a “SAFS CPA suite” has been created on the shared drive. This folder contains all standardised procedures, information, documents and templates required to deliver the CPA framework within Forensic Healthcare inpatient services. If any My Shared Pathway’ documents have already been completed in previous services, review these documents for relevance (in collaboration with the patient) rather than beginning a new document.

Timeline	Procedure	By whom	Evidence / format
Pre admission	<ul style="list-style-type: none"> CPA assessment completed within access assessment. – access assessment formulation to inform provisional care plans/management plans When admitting ward is decided upon, identify staff member who will be acting as inpatient care co-ordinator (usually primary nurse). Identify potential service user “buddy” on ward. (organise telephone contact if possible) Primary nurse to identify and contact existing care coordinator to inform them of admission plans. When appropriate / possible, organise a handover CPA meeting between services (ideally hosted by referring service) Remind the referring organisation to include existing care planning records in handover bundle. primary nurse to begin formulation of core care plan(s). 	<ul style="list-style-type: none"> Assessors allocated by Referrals meeting Ward manager Primary nurse Primary nurse / Ward manager Referrals co-ordinator Primary nurse / MDT 	<ul style="list-style-type: none"> Access assessment Initial Care plans Ward procedures MDT notes Referrals meeting mins / MDT notes Documentation MDT file – initial

	<ul style="list-style-type: none"> Begin “MSP - A Shared Understanding” document: “A shared understanding” can be partially completed during access / transfer assessment 	<ul style="list-style-type: none"> Assessors / Patient 	<p>care plans present</p> <p>“ASU” doc in assessment pack</p>
On admission	<ul style="list-style-type: none"> Preliminary “Core” Care plans to be written (in collaboration with service user if possible). - may have been completed pre admission. Primary nurse or care team representative and Buddy meet on first day. During introduction to ward structures and meetings, hand over Welcome pack, & Patient Portfolio with generic information - available on the ward. 	<ul style="list-style-type: none"> Primary Nurse and patient Buddy, Primary Nurse, Patient 	<p>ECPA or Paper Care Plans in MDT file</p> <p>MDT notes</p>
By first ward review (admission - 14 days)	<ul style="list-style-type: none"> Decision made about capacity to start populating portfolio with personal information –i.e. patient’s ability to safely store personal information is assessed. “Care plan meeting” with patient to introduce / explain CPA process and trust CPA principles. If not already done so, Provide leaflets (CPA standards and My shared pathway) with explanation if required. Plan with resident how to move forward in coming weeks with care plans and ‘a shared understanding’ documents. Book in first CPA meeting (approximately 3 months from admission). Consult with patient about invites / best time / day for meeting Begin recording care pathway and routinely involving patient in care delivery and planning using recovery review documentation at each review. 	<ul style="list-style-type: none"> Responsible Clinician, MDT Primary Nurse, Patient, MDT Primary Nurse Primary Nurse, MDT. 	<p>Recovery review</p> <p>MDT notes</p> <p>Recovery Review / MDT notes</p> <p>Recovery Review</p>
14 days – 3 months	<ul style="list-style-type: none"> “A shared understanding” to be focus of My Shared Pathway for first three months of admission, but if possible start completing the MOPP document in whatever depth is appropriate to patient. Both documents can be use to help complete care plans. For patients unwilling to participate – have discussion about benefits of participating (e.g. tribunal) and downsides of opting out. Record in recovery review and in notes if patient does not wish to participate. 	<ul style="list-style-type: none"> MDT and Patient, co-ordinated by Primary Nurse Primary Nurse 	<p>ASU and MOPP documents</p> <p>MDT notes</p>

	<ul style="list-style-type: none"> • Primary nurse and MDT to work with patient to further develop collaborative care plans. Emphasis should be on developing the 3 “core” care plans in first three months, but other care plan templates can also be developed if patient / staff consider them relevant (e.g. joining substance misuse programme triggers use of “my recovery from drug and alcohol problems”) • MSP champion or peer support worker to be available to support process. • 6 weeks before CPA meeting – Primary Nurse to complete CPA meeting checklist and use as a CPA meeting ‘agreement’ on which CPA standards will apply at the forthcoming CPA meeting. • Primary nurse and patient to inform invitees of CPA meeting arrangements and preferences in good time for the meeting, e.g. CPA meeting checklist (or summary) sent to all invitees 4 weeks before – primary nurse responsible for co-ordinating Invites (prepared with service user if requested) sent at least 4 weeks before. • 2 weeks prior to CPA review: reminder to all involved staff (both invited and not) (from admin) – The My CPA document is on the ward shared drive and all involved staff should contribute. Detailing what professional contributions have been against active care plans. ready in 1 week. • Week before – My CPA pack compiled including service user views, all entries must have been shared with the service user and submitted to meeting administrator at least one week before meeting. My CPA pack held as ‘draft’ document on shared drive. • Consider inviting community care co-ordinator or inviting one to first CPA meeting – to help with recovery planning 	<ul style="list-style-type: none"> • Primary Nurse, MDT, Patient • Ward MSP champion • Primary Nurse / patient • Primary Nurse / ward Admin. • Ward Admin • Team Administrator • Team administrator 	<p>Care plans in MDT file or on ECPA</p> <p>MDT notes</p> <p>CPA meeting checklist</p> <p>Copies of letters in file. Emails. MDT notes</p> <p>Email</p> <p>Presence of e-documents on shared drive</p> <p>Invite</p>
<p>1st CPA meeting</p>	<ul style="list-style-type: none"> • Use CPA meeting checklist / agreement to organise meeting in keeping with patient preferences / 20 CPA standards. • Patient reminded of option to use “a shared understanding” document to 	<ul style="list-style-type: none"> • Meeting Chair • Primary Nurse or member 	<p>CPA meeting checklist. CPA meeting audit</p> <p>-</p>

	<p>structure their feedback to first CPA meeting, or “<u>My Outcomes Plans and Progress document</u>” in subsequent CPA meetings. – patients also welcome to use the My CPA format to give feedback</p> <ul style="list-style-type: none"> • <u>My CPA pack</u> to be available to all at the meeting. • Standard agenda to be followed (may be altered according to patient preferences) • <u>CPA meeting audit questionnaire</u> and Trust <u>CPA evaluation postcard</u> to be handed to patient (and carer) for completion after the meeting. 	<p>of MDT</p> <ul style="list-style-type: none"> • Admin • Meeting Chair • Meeting Chair 	<p>CPA meeting audit</p> <p>CPA meeting audit</p> <p>Recorded in My CPA doc.</p>
Within 1 week of CPA meetings	<ul style="list-style-type: none"> • <u>My CPA</u> pack finalised and checked by patient. Comments of patient recorded on meeting minutes. • Minutes of meeting shared with attendee’s (Including patient). Finalised My CPA pack uploaded to Ecpa and placed in file • Patient and carer have completed and returned <u>CPA meeting audit questionnaire</u> (copies to be held in MDT file alongside CPA meeting checklist so can be audited) 	<ul style="list-style-type: none"> • Admin and Primary Nurse • Admin and Primary Nurse • Patient and carer 	<p>Meeting minutes</p> <p>ECPA</p> <p>CPA meeting audit</p>
CPA meetings (at least every 6 months)	<ul style="list-style-type: none"> • Complete <u>CPA meeting checklist</u> 6 weeks before each CPA meeting. Identified person responsible for implementing checklist requests for each CPA meeting. • Continue to develop <u>MOPP</u>, with scores, tracking progress that hopefully results from care planning and interventions • All CPA meetings organised with fidelity to 20 user defined standards. • <u>My CPA</u> document used to co-ordinate CPA pack / paperwork 	<ul style="list-style-type: none"> • Primary Nurse and patient • MDT team and patient • MDT team • Admin 	<p>CPA meeting checklist</p> <p>MSP and care plan docs</p> <p>CPA meeting audit</p> <p>My CPA document</p>
Discharge planning CPA	<ul style="list-style-type: none"> • <u>My CPA</u> final page format to be use at meeting. • Include <u>section 117</u> meeting (aftercare planning) in CPA framework if applicable – with aftercare plans. These can make use of Care Plan templates if applicable 	<ul style="list-style-type: none"> • Admin • Responsible Clinician 	<p>My Discharge CPA document used</p> <p>117 references in CPA paperwork</p>

Care Programme Approach Policy

	<ul style="list-style-type: none">• If applicable, / timings allow, Include receiving service / community service in list of invites, in consultation with patient.	<ul style="list-style-type: none">• Admin	Letters copied in MDT file
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MSP = My Shared Pathway

MOPP = My Outcomes, Plans and Progress

ASU = A Shared Understanding

CPA = Care Programme approach

APPENDIX 7

CHYPS Care Plan Approach (CPA) Protocol

Protocol Authors: Sue Kelly, Juliet Lowther, Naomi May and David Malone

Date: 20th November 2015

Reviewed September 2017

The following protocol incorporates Children and Young people's service (ChYPS) specific amendments to enable CPA and the Trust CPA Policy to be used within ChYPS as required and to help inform the rationale in deciding which children / young people and their parents / carers should have a formal CPA applied to their situation and which of those should follow the CPA guidance without the more formal aspects of the approach.

The four essential elements described within the Trust CPA policy are applicable to ChYPS services and are outlined as follows:

The Essential Elements of CPA

The CPA is a delivery system for mental health care with four essential elements:

- A systematic **assessment** of both mental and physical health together with social care needs
- An agreed **care plan**
- The appointment of a named **Lead Practitioner** for all young people referred to ChYPS whose role is to ensure that the CPA is implemented where appropriate or that the care of the young person is appropriately managed where full CPA is not appropriate
- A regular **review** to reconsider need and / or risk and to adapt and change care plans as necessary

A comprehensive assessment of the mental health and social needs of a child or young person will invariably include parents, guardians or carers except in circumstances when the young person is 16 or over and requests confidentiality.

The initial assessment for all young people will be documented on the Choice and Partnership Approach (CAPA) Assessment and Initial Care Plan documentation in Carenotes. On completion of the assessment it will be determined whether CPA will apply using the criteria set out in Appendix 1 of this document. With regard to good practice ChYPS CPA formatted forms will appear in Carenotes so that the use of documentation is consistent across the care delivery service. These forms may be

completed over a number of appointments or days. Additional assessments that are condition specific can also be uploaded into Carenotes to inform the assessment and decision about the appropriateness of CPA.

The assessment, review and other meetings should be young-person friendly. Careful consideration should be given to the language used, timing of meetings and location of venue and who is invited to the meetings. Information leaflets and paperwork that is engaging and age-appropriate should be used where possible. All meetings should be managed in such a way as to ensure that young people's views are heard and taken into account.

The assessment may also involve the process of gathering information via psychological / medical testing, review of case records and contact with colleagues from partner agencies in addition to personal interviews.

Young people should be supported in this process, using an advocate if necessary and assisted in developing skills to voice their views. The views of their parents and carers should also be incorporated, and where appropriate, distinguished from those of the young person.

Care Plan

A care plan is a record of needs, actions and responsibilities written in a way that is accessible to all parties. It exists for the benefit of the child / young person and their family / carers and should be based on their needs not the ability of the service to provide. It should detail interventions, actions required to achieve agreed goals, who is responsible, timescales, any disagreements, date of the next planned review and crisis and contingency plans. If the service cannot meet the identified need and the need cannot be met in other local services, then the Team Leader / Service Manager should be informed.

The care plan for the young person should consider all aspects of the young person's life including:

- Family
- Relationships
- Housing
- Employment
- Education
- Leisure
- Spirituality

Crisis / Coping & Resilience Plan

This forms part of the care plan and should set out the action to be taken in a crisis. It should detail who the child / young person is most responsive to, how they can contact that person, any previous strategies that have been successful and any early warning and relapse indicators.

Contingency Plans

Contingency planning prevents crises developing by detailing the actions to be taken or arrangements to be used where at short notice, either the care co-ordinator is not available, or part of the care plan cannot be provided.

All these plans should be written in language accessible to young people and their parents / carers.

The involvement of parents and carers

On completion of the assessment, a parent's/carer's care plan should be drawn up and recorded to meet any need identified and parents/carers should also receive information on support available to them and the care and services being provided for the person for whom they are caring. Consent must be sought from the service user before providing confidential information to the carer except in cases where it is appropriate to share confidential information, for example, when it is considered that the young person or someone else may be at risk of harm and that the parents can provide safety.

Parents/carers should be kept up-to-date and involved in the care plan and wherever possible, carers should be included in reviews. Parents/carers can expect their views to be kept confidential if they so wish.

An assessment of the needs of the parents/carers as part of the main assessment could lead to a referral to the local authority family support or child protection team as social care for children and young people is the responsibility of the appropriate local authority.

Service user participation

The young person is the prime focus and should be a central participant throughout the CPA process. Children / young people should be provided with information on all aspects of the CPA process, using interpreters and an advocate to facilitate this when appropriate. The process should be transparent, consistent and flexible, and the young person needs to be involved fully from the start.

The young person should be asked if they would like to make an advance directive and trust staff should assist them in this process where appropriate. The advance directive might include treatment preferences and/or treatments that the young person would prefer not to have. Advance directives made at the time by people under the age of 18 have no legal standing but as a matter of good practice, regard should always be given to them when planning and giving treatment.

When a young person's needs are met and managed predominantly in primary and social care and they have a mental health need which is not complex or with significant risk that care maybe managed through Children's Assessment Framework (CAF) or area related process such as the Education Health Care plans (EHCP) in Hampshire.

Where the care is shared across agencies it must be clear who takes the lead in which part of the care plan. This is especially important for those children / young people who may have a Lead Professional appointed across different agencies as part of the CAF or equivalent process. Mental health assessments, care plans and reviews will be communicated to the Lead Professional via the Care Co-ordinator for secondary mental health services.

Risk Assessment / Management

As a Care Delivery Service (CDS) ChYPS recognises 3 levels of Risk Assessment and Risk Management which are as follows:

Screening

This must be completed as part of the initial CPA Assessment on Carenotes and it should be comprehensive enough to inform any Care Plan and resilience / coping plan. This screening may be enough as a stand-alone assessment of risk regardless of whether the service user is required to be placed on formal CPA or not.

Level 1 – Risk Assessment

This should be used when the child / young person's risks warrant further formal multi disciplinary input within the wider Tier involvement such as Tier 4 acute services. This assessment maybe used to help advice and support the Care Co-ordinator or Lead ChYPS Professional in making judgement around Risk Assessment and Risk Management.

Level 2 – Risk Assessment

This should be used where there is a requirement for wider multi agency involvement in supporting and managing the child / young person's risk. There is also an assumption that the level 2 Risk Assessment maybe more complex. It might also be appropriate for both levels 1 and 2 to be active on a service user care plan at any one time.

Out of Hours – Risk

All risk and crisis plans need to be recorded on Carenotes. These can then be accessed out of hours.

General Risk Management

Describes the development of flexible strategies aimed at preventing any negative event occurring or if this is not possible minimising the harm caused. The management plan should be built on recognition of the young person's strengths and those of the family and should emphasise recovery and promote resilience. It should be developed in collaboration with the child/young person, parent/s and carer/s (where appropriate). Any risks identified can be highlighted on the young person's electronic file with the aid of a risk alert available on Carenotes

Consent

It is recognised that clinicians are required to regularly make judgement calls around the sharing of information and capacity issues for young people. To help inform such judgements The Every Child Matters HM Government Guidance provide various how to guides for professionals in relation to good practice and the HM Government guidelines regarding the sharing of information (see appendix) should also be referred to.

Guidance is currently being developed in line with the IAPT process in terms of how to record consent issues, in the meantime, any decision regarding consent to share information should where possible be discussed with the young person and their family and the discussion and outcome should always be recorded in Carenotes. It

should however be noted that with regard to the immediate safety of a child, appropriate information may be shared without consent.

Review

A planned review of the care plan should be held at a time and place accessible to all parties including the child / young person, parents and carers. It should consider all health and social care perspectives and revisit the care plan and the risk management plan to ensure things are progressing as originally anticipated and that the aims and objectives are still appropriate. **If risk factors appear to have remained significant or have increased then consideration must be given to increasing the risk status i.e. the pursuit of level 1 risk assessment or level 2 where there is a requirement for wider multidisciplinary or other agency involvement.** The next planned review date must be determined at the preceding review however reviews can be called at any time by any member of the care team (including child / young person, parent(s) and carer(s) should the need arise.

Care Co-ordination

Whether or not the young person requires the full CPA process, they will be allocated a Lead Practitioner. The Lead Practitioner has responsibility for co-ordinating care, keeping in touch with the child / young person, parent/s and carer/s, ensuring that the care plan is delivered and ensuring that the plan is reviewed when required.

The role of Lead Practitioner is designed to ensure that:

- Effective communication takes place across all involved within the care planning and delivery of services to ensure a continuities process
- The strengths of the young person and their family are identified and employed of to enhance the recovery process
- They will be proactive where necessary in facilitating appropriate transition processes
- All parts of the assessment are completed, involving co-workers and other professionals as needed
- The individuals safety profile is kept up to date and includes appropriate completed ChYPS risk assessments which are updated when a new incident occurs
- A co-worker may take responsibility for other work with the young person

APPENDIX 8

Guidance for completing the Inpatient Care Plan – Dementia Care Wards

This aims to provide you with the guidance to complete the new care plan template on care notes.

It has been developed following feedback from both the acute and dementia care inpatient staff and aims to enable you as a clinical to develop a collaborative care plan with the patient and wherever possible the carer.

On care notes – go to the Care Plan section and choose **Inpatient Care plan**.

- A number of the fields will automatically be populated, such as patients name, MHA status, CIS number and NHS number etc.
- On admission, you will need to complete the inpatient care plan.
- **Within this first section, you will see a button asking you to select ‘Dementia’.**
- Click yes as this will give you 3 additional specific care areas for the dementia wards, namely.
 - Consideration of capacity.
 - Daily living needs
 - Wellbeing
- The care plan will predominately be completed by the registered nurse - usually the Primary Nurse but it has the function for other professional, such as the OT to add to the care plan.
- The first section is for you to refer to the outcome of the capacity assessment either completed on admission or as part of the on-going MDT care, such as the FACE assessment.
- The second section of the care plan is designed to enable you and the patient/carer to talk about triggers, strengths and helpful strategies when feeling distressed or agitated.
- The third section will guide you and the patient/carer to describe the types of care required while they are in hospital.
- When developing a collaborative care plan, it is OK to have different perspectives on the issues/problem areas – the important thing is to discuss these differences.
- It is important that you sign and date the care plan and offer the patient the opportunity to do so as well.
- The Care notes team are asking us at the moment not to upload a signed copy by the patient of the care plan – instead indicate the date the care plan was signed. This function has been built into the care plan.
- It is important that, wherever possible, the patient is given a copy of their care plan.
- Once you have completed the care plan, make sure you confirm it. It is really important that you do this as it is like signing and dating paper records. You will be able to come back to the care plan to edit and add to it.
- The care plan has a ‘re-plan’ function, which means that you can review, edit and amend as required.
- When another professional other than a registered nurse contributes to the care plan, it will give you the function to add to the care plan and sign and confirm. Your name will then be listed as a contributor to the care plan.

Patient's name:	Date of Admission:	Ward:
Mental Health Act Status:	Primary Nurse:	
Other people involved in my care: - list professionals as well as support staff (MIND groups etc..) and family/carers/ friends		
What is the outcome of the assessment of my capacity to be involved in making decisions about my care (please refer to capacity assessment)	Person has capacity – care plan completed and agreed with the person	Drop down menu - Complete the relevant box
	Person does not have capacity – care plan completed in best interests in collaboration with family	
	Person does not have capacity – care plan completed in best interest using staff knowledge only. Why?	

Really important that you use the patient's words and write in the first person

Triggers to my difficulties: - will help you and the understand things that increase symptoms, such as content of voices, overwhelming anxious thoughts, alcohol/drug use etc..	Things that help me when I am feeling distressed or agitated: - such as 1:1 time, time in the sports hall/ sports/ therapeutic group/ time alone/communal area of the ward etc..
My strengths and interests: - helps to focus on interests outside of hospital and positive aspects of a person's life.	My Therapeutic day while I am in hospital: - helps to start to think about structuring the day while in hospital.
What I feel needs to change so I can be discharged from hospital: - helps start to understand the barriers to discharge but also some of the anxieties in relation to discharge.	

Area of care (Supporting my)	Summary of current needs from my perspective	Summary of current needs from my staff member's perspective	Our Goals	Interventions – what will help me achieve this?	Monitoring my progress
Safety and risks	Write in the first person 'I think..' If the person is reluctant to be involved, then try to explore why - try to avoid saying 'patient reluctant to be involved in their care plan' instead say why in the first person. Also	Your views may differ from the patients – record the risks you are concerned about (refer to the R/A completed on admission)	What are you hoping to achieve/ aiming for. You can record different goals – ie Patient and Nurse	List the interventions – again ensure they are individual and person centred. Try to avoid general statements like 'offer 1:1 time' instead describe what the 1:1 time is to be use for ..	Reviewing the progress to date and discussing what had gone well and what has not worked so well. This should be completed on a regular basis.
Mental health		Again, your		List the	

Area of care (Supporting my)	Summary of current needs from my perspective	Summary of current needs from my staff member's perspective	Our Goals	Interventions – what will help me achieve this?	Monitoring my progress
difficulties	consider the person's capacity to be involved.	views may differ from the patients – record the mental health difficulties you are concerned about	As before	interventions – again ensure they are individual and person centred.	
Physical health	As before Also consider the person's capacity to be involved.	Physical health issues and physical health monitoring – falls, nutrition, pressure area care, continence etc..	As before	List the interventions – again ensure they are individual and person centred.	
Social, practical, sensory and communication needs	From the patients /carers perspective, understand the issues that may be preventing the person from being discharged. Also consider the person's capacity to be involved.	Understanding the social issues will assist in understanding barriers to discharge but also life events frequently occur prior to a person's mental health deteriorating	As before	List the interventions – again ensure they are individual and person centred.	
Activities of daily living	From the patients/carers perspective, the type and level of care they feel they Also consider the person's capacity to be involved. need.	Describe the needs of the care you feel the person needs.			
Wellbeing	Things the person/carer feels will	Needs from you perspective that need to be			

Area of care (Supporting my)	Summary of current needs from my perspective	Summary of current needs from my staff member's perspective	Our Goals	Interventions – what will help me achieve this?	Monitoring my progress
	support the person's well-being.	considered in regards to maintaining a person's well being			
My medication	From the patient's perspective, help understand the persons' understanding and attitude towards their medication. Also consider the person's capacity to be involved.	It is not expected that you list all of the medication here but to help understand any difficulties with the medication + physical checks needed – ie ECG,	As before	List the interventions – again ensure they are individual and person centred.	
Working towards my discharge from hospital	Steps the patient feels need to occur to enable discharge. Also consider the person's capacity to be involved.	May feel similar to the section above but this is designed to plan for discharge	As before	List the interventions – again ensure they are individual and person centred.	

My views of my care plan: - again written in the first person –

Patient's Signature - at the moment it is not possible for patient's to sign but you can say when the patient signed or if the person refused. Date write
date given to the patient Copy given to patient YES – if NO say why

Name and role of staff members contributing to my care plan:

Name XXX
 Role Primary Nurse

Signature
 Date - add

Name XXXX
 Role OT

Signature
 Date - Add

Name xxxx
 Role Psychologist

Signature
 Date - add

Permission given to share the care plan with carer – Yes No – if yes state name of carer the patient agrees the care plan to be shared with.		
If No – reason why		
Care plan shared with carer	Yes	If Yes – state date
No		

APPENDIX 9

MARKERS OF A GOOD QUALITY PERSONAL SUPPORT/CARE PLAN

Factor	Descriptor	What to look for/audit against
Personalised to the individual	<p>Taking into account each person's individual identity, their values – what matters to them</p> <p>Capturing the person's skills, talents, attributes, including personal strengths</p>	<p>Plan is informed by what the person wants as well as what the service can offer.</p> <p>Plan is written in accessible language (plain English)</p> <p>Actions identified encourage independence and self determination to help people maintain control over their own support and care</p>
Clear goals of treatment	Are there clear goals which can be monitored	There are clear action owners, timescales and milestones.
Treatment offered	Treatment/intervention should be evidence based, in line with NICE guidance and best practice.	Clear description with clinical rationale, of treatment offered by staff, In care plan.
Safety Planning	Good quality risk assessment should lead to the development of a safety plan which is linked to the overall plan of care agreed with the person and their carers if appropriate.	Completed crisis /contingency plan in the appropriate section of the personal support plan (standard care and CPA)
Including carers	<p>Involving carers and supporters in developing and delivering the overall personal support plan to the individual</p> <p>As well as ensuring the carer has their own assessment of needs</p>	<p>If appropriate:</p> <p>The carer has been given a copy of the plan</p> <p>Actions on the plan for the carer to be involved with</p> <p>Carer assessment has been offered and completed</p>
The plan should be confirmed in Carenotes	<p>Plans on carenotes should be confirmed as soon as possible</p> <p>And shared with the service user (and others as appropriate) within 5 working days of completion.</p>	<p>Development of plan commenced within 7 days of the assessment/review meeting.</p> <p>Evidence in Carenotes that plan is confirmed and has been shared</p>
Review	The plan should be reviewed in line with the persons cluster review period	Plan reviewed in line with cluster review period - minimum of annually (community)
Where is the plan stored	The plan should be in the approved format for the CDS/type of care the person is receiving.	Completed plan in an approved format in the care planning tab on Carenotes.

APPENDIX 10

Brief Guidance on the Lead Practitioner Role

Everyone will have a **Lead Practitioner** to be their main contact with the services, they will work together to agree a **Care Plan/ Personal Support Plan**.

Responsibilities of a Lead Practitioner

- Participate in the on-going assessment of the service user's needs and any associated risks.
- Maintain an up to date record of their care and treatment on Carenotes.
- Work with the person to develop a collaborative personal support plan including numbers to call/points of contact to use if they need urgent/crisis help or support.
- Monitor that the service user attends for their treatment and where they do not, take appropriate action.
- Act as a point of contact for the service user.
- Ensure that appropriate risk assessments, outcomes measures, and cluster allocation are completed and reviewed as necessary.
- Support the service user to access other services if appropriate.
- Monitor the overall plan and arrange reviews as agreed or identified as necessary.
- Manage any transfers of care.
- Ensure any carers are made aware of their entitlement to a carer's assessment.

Additional for people on the Care Programme Approach

- Work with the service user to formulate a comprehensive personal support plan, which includes safety and contingency plans and advanced statements.
- Ensure copies are shared as appropriate with other people involved in the support plan.
- Ensure that everyone involved in the personal support plan is clear about lines of communication and feels able to raise concerns or comments easily.
- Act as the central point of contact for the service user, carer and other professionals involved in care, responding to concerns raised by in a timely and pro-active way.

Key Quality Indicators for the Lead Practitioner Role

Work in a Collaborative Way

Personal support plans are developed in partnership, including the person's support network if appropriate

The language of the person is incorporated – so there is a shared understanding of the goals and outcomes.

Responsibility for recovery is with the individual – they define what is important to them, and what a good outcome looks like.

It requires a relationship between worker and person using the services, based on trust, hope, reciprocity and respect.

Be Aware of Core Values

Value 1 – the primary goal of mental health services is to support personal recovery	Providing treatment is a means towards achieving this goal not an end in itself
Value 2 – Actions by mental health professional will primarily focus on identifying, elaborating and supporting work towards the person's goals	Avoiding imposing clinical meanings and assumption about what matters. Offering support in line with the person's values
Value 3 – Mental Health Services work as if people are, or (when in crisis) will be, responsible for their own lives	Staff should be "on-tap" not "on-top". Role is to support people to develop and use self-management skills. Work in partnership and collaboration

REF: Refocus Manual 2nd Edition

Communicate Clearly and in a Timely Way

With the person using the service

With any carers or supporters they have identified

With any other staff or agencies involved in the overall personal support plan

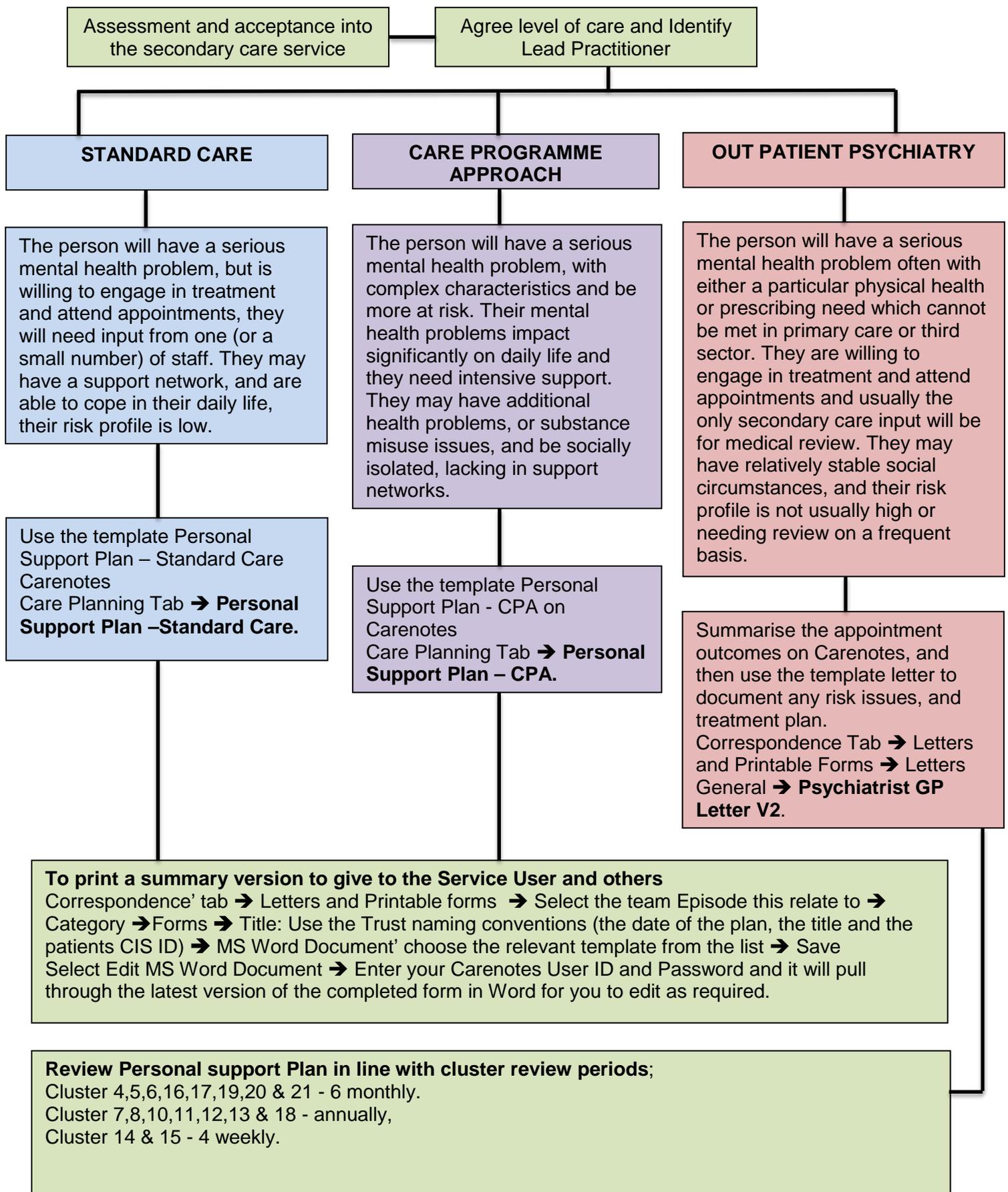
Managing Crises

Make sure the person and any carers know what to do if they are struggling to cope.

Encourage the identification of signs of relapse, so the person can better manage their mental health, using

coping techniques and seek support

Flowchart – Personal Support Planning Adult Services (Community)



72-HOUR FOLLOW-UP GUIDANCE (September 2019)

Discharge must not take place unless a clinician has been identified to undertake 72-hour follow-up

- **All** service users discharged from our inpatient units, including ECR beds where the person is not transferred to a Trust inpatient ward, must be followed up, in person (face to face or by telephone), within the first 72-hours of discharge.
- *NB – the day of discharge is Day 0 and any contact on this day is not used for the outcome measure. The follow-up contact must be between 00:01 hours on Day 1 and 23:59 on Day 3. There are no allowances for weekends and/or Public Holidays.*
- For service users that cannot be contacted within the first 72 hours following discharge, follow-up must be completed within 7 calendar days.

72-hour Follow-up Responsibility

Position at Discharge	Follow-up Responsibility
Discharge from ECR bed to place of residence	Haven or responsible community team BH ATS or CRHT Coastal / East / NWS
No ATS or CRHT involvement on discharge eg discharged abroad or out of area	Discharging ward
Discharge over a weekend/public holiday	Responsible community team if feasible. If not then the Haven. It is the community team/LPs responsibility to liaise with the Haven to request they carry out a telephone follow up. BH CRHT – Coastal/East/NWS
Self-discharge (unplanned)	Discharging ward or responsible community team if under their care.
Discharge to general hospital ward	Mental Health Liaison Team
Discharge from Dementia Ward over a Bank Holiday Weekend	Discharging ward

Planning Discharge/Follow-up Contact

Step 1 – Discharge Planning Meeting	<ul style="list-style-type: none"> • The person responsible for the follow-up contact will be identified. • As part of this planning, consideration to face-to-face or telephone contact will be agreed by the MDT. If face-to-face is required, this will be forwarded to either CRHT or ATS. • The member of staff identified to do the follow-up must be informed verbally (directly or via shift coordinator/duty). • Above to be documented as a casenote in Carenotes (summary heading – “72 hour follow up arrangements”) to
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	avoid confusion and for clarity.
Step 2 - Contact	<ul style="list-style-type: none"> • Actual Contact – complete and outcome a diary appointment form in the usual way using 04 7-Day/72 hour Follow-up as an event (activity tab in Carenotes) • Attempted Contact(s) – complete CPA7 record form (activity tab in Carenotes) • Evidence of a full handover of care to the local community team must be recorded in Carenotes for service users discharged out of area, within the UK.
Step 3 – Escalation	<ul style="list-style-type: none"> • If within 36 hours of discharge, contact has not been made with the service user, the identified clinician must escalate to their Team Leader or Service Manager.

Exception Description	Reporting Process and evidence required
Service users with an advanced stage dementia diagnosis who are discharged from a dementia ward to a Care Home – a proxy contact is valid	<p>The appointment should be pre-planned by the Trust in agreement with the Care Home.</p> <p>Evidence of the follow up by the Trust clinician, with either the patient, or the Care Home staff should be recorded as a 04-CPA7 follow up diary appointment on Carenotes by the Trust clinician.</p>
Patient discharged to another NHS Psychiatric Inpatient Facility or private PICU or Private Mental Health Acute Ward	Record of transfer (including full name and address of ward or unit) to be recorded clearly in Carenotes.
Deceased	Carenotes process for recording notification of death to be followed.
Where legal precedence has forced the removal of the patient from the country	Clear clinical notes relating to the circumstances of this removal to be added to Carenotes.
Discharge from SPFT Ward directly to Prison	Clear clinical note relating to the arrangements for discharge to prison.

Exceptions – these are accepted by NHSi

Working Principles

In the event that the planned follow up appointment does not take place, all reasonable efforts must be made to contact the patient. Reasonable efforts must include ALL of the following as a minimum and be evidenced in the patients' record using the CPA7 Record Form (activity tab in Carenotes):-

1. Documented telephone call.
2. Letter encouraging the patient to contact an identified ward / team / person to be sent/delivered.
3. Where the patient's home address is known, 2 visits to their residence.
4. Where the patient has a known carer, an attempt to contact the carer by phone.

September 2019