Kent and Medway NHS
NHS and Social Care Partnership Trust

Care Programme Approach (CPA) POLICY

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DOCUMENT TRACKING SHEET

CPA POLICY

Version	Status	Date	Issued to/approved by	Comments
4.1	Draft	June 2012	CPA Compliance & Development Manager	Review
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REFERENCES

Effective Care Co-ordination; Modernising the Care Programme Approach DOH 1999
Care and Support Statutory Guidance, DH 2014
Refocusing the Care Programme Approach, DH March 2008
Access to healthcare for people with a Learning Disability
Green Light Toolkit
Carers and their Rights- Clements 2011
No Health without Mental Health 2011
Live it Well Strategy
Making the CPA Work for you
Mental Health Act Code DH 2015
The Care Act DH 2015
The Care Standards Handbook CAA 2014

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Records (Clinical) Policy
DNA Policy
Section 117 of the Mental Health Act Operational Procedures
Admission and Discharge Policy for Older Peoples Services
Clinical Risk Assessment & Management Policy
Health of the Nation Outcome Scales (HoNOS) Including Payment by Result Cluster Tool Policy
Mental Capacity Act Policy and Guidelines
Transfer and Discharge of Care- Service users Policy
RiO Manual
Service line Standard Operating Procedures (SOPS)
Safeguarding & Protecting Children & Young People Policy
Safeguarding Vulnerable Adults Policy
Clinical Strategy
Protocol for Confidentiality and Information Sharing between Agencies

The Kent and Medway Multi Agency Policy
Cost Setting Guidance for Community Mental Health Teams- A Step by Step Guide
The Kent and Medway Multi- Agency Information Sharing Protocol
Taking steps towards living well- A Personal Guide
Assessment Policy- 2015- Care Act
KCC Eligibility Criteria Policy
KCC Direct Payments Policy and Guidance
KCC Care and Support Planning Policy
KCC Information and Advice Policy
KCC Promoting independence through review policy

Transitional Statements to support the Launch of the revised CPA Policy

- Reference throughout the Policy is to the supporting documentation. For explanation this refers to the existing forms used to support practice across all directorates.
- This document will be supported by Operational Guidance for each Service Line and Specialist service who are involved in the delivery of care planning under CPA arrangements.

CONTENTS

1 INTRODUCTION:

1.1 The term Care Programme Approach (CPA) has been used since 1990 to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. In 2008 the Department of Health issued national guidance in the form documentation entitled 'Refocusing the Care Programme Approach' with the aim of providing a wider focus for all service users which ensures consistency and ensuring that the focus is centred upon a good quality of care.

1.2 There are a number of care planning frameworks in operation within Kent & Medway NHS and Social Care Trust (KMPT) some of which are implemented in partnership with Kent County Council and other partners. This Policy provides the guiding principles for the delivery of care for all service users of KMPT where we are the lead agency and applies to all models of care delivery for example:

- 1.2.1 The Care Programme Approach (CPA),
- 1.2.2 The Common Assessment Framework (CAFA),
- 1.2.3 Person Centred Planning (PCP),
- 1.2.4 Care and Support Plan under the Care Act 2014
- 1.2.5 Personalisation
- 1.2.6 Care Management
- 1.2.7 National Drug Treatment Arrangements or
- 1.2.8 Any other service provided by the Trust.

2 PURPOSE:

2.1 This policy sets out the standards and principles that should be applied when care planning is provided to service users either under CPA or lead profession care (standard on RiO). The update of this policy also aims to incorporate current practice and developments related to the various elements of CPA which are occurring throughout the trust.

3 SCOPE:

3.1 This policy identifies duties, responsibilities, the mandatory training requirements of staff and the Service Line responsibilities in relation to its implementation and operation.

3.2 The recommended terminology used within current CPA guidance, differs from the previous policy and the electronic records system RiO, therefore the table below maps the differing terminology.

New Policy	Previous Policy	RiO
CPA	CPA	CPA
Other service users under lead professional care	Care Pathway	Standard
Services users not applicable to secondary care (will include those with social needs who are identified in Clusters 1,2, and 3) and under non KMPT mental health services.		Not Applicable

3.3 The CPA arrangements described in this policy apply to;

3.3.1 All service users who are receiving a service from the Trust and who meet the characteristics for CPA.

3.3.2 All service users where there is a formal or statutory requirement to provide care.

4 DUTIES AND RESPONSIBILITIES

4.1 The identified member of the Trust Board is the Director of Nursing and Governance who is responsible for the strategic leadership and implementation of CPA and other care planning frameworks. The key operating responsibilities of the CPA Policy are held by KMPT under the partnership agreement with KCC (Kent County Council).

4.2 An identified CPA Lead has Trust wide responsibility for the CPA Policy, developments and implementation and for;

4.2.1 Ensuring the CPA policy is based upon current DH guidelines and standards.

4.2.2 Ensuring that regular audits to monitor compliance with this policy are completed.

4.2.3 Determining the levels of training required by staff to support compliance with this policy.

4.2.4 Providing reports to the Trust Board, Trust Wide Patient Experience Group, Trust Wide Clinical Effectiveness & Outcomes Group and other groups as required.

4.2.5 Trust Board, Patient Experience and other groups as required.

4.2.6 Ensure other key policies, including relevant partner organisational polices are consistent with and are reflected in the CPA policy.

4.3 Director of Operations will ensure that all staff are aware of the CPA policy and procedures to be followed.

4.4 Service Line Directors & Assistant Directors will be responsible for the performance of the care planning framework in their service line.

4.5 Team managers/ service managers are responsible for ensuring that compliance with CPA procedures and protocols is monitored through supervision.

4.6 CPA Care Coordinators/ Lead Professionals are responsible for;

4.6.1 Ensuring that care is planned and delivered according to Trust standards using a recovery approach.

4.6.2 Accessing regular supervision in accordance with the Trust's Supervision policy

4.6.3 Accessing agreed training as required.

4.6.4 Highlighting concerns impacting on the quality of service delivery of the care planning framework.

5 RECOVERY:

5.1 The Recovery Approach aims to put the service user at the centre of their care. It is a respectful approach with the aim of building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

5.2 Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness.

5.3 Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness…"Therefore, 'recovery' may have a unique meaning for each individual, a meaning defined by the individual. For example, for one person may mean discharge from mental health services, but for another individual may mean having a meaningful life with the support provided by mental health services.

5.4 Kent & Medway has made a commitment to providing a service that is recovery focused and as such our primary focus is to provide a service that facilitates recovery and social inclusion. At the heart of this is an aim to ensure that services are developed, provided and maintained to ensure that those who access our service receive support and assistance at the right time by staff committed to make recovery a reality for all.

5.5 Personalisation is at the heart of a recovery focused service. It means that service users with eligible social care needs have more choice and control over how their social care needs are met, through calculation of a personal budget and option of receiving a direct payment.

5.6 Recovery and Personalisation are key themes in the assessment and care planning process and should inform our approach to all interactions with the users of our services.

6 DEFINITIONS:

6.1 CPA will be used to describe the approach used by secondary (and tertiary services, where agreed) care mental health services to work in partnership with service users to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with KMPT who have complex presentations.

6.2 CPA should be recognised as a dynamic process, which reflects need and choice and is helpful to all parties, not simply a bureaucratic process.

6.3 Refocusing CPA guidance (DH 2008) restates CPA principles and practice and presents a new framework to replace 'Standard' and 'Enhanced' CPA.

6.4 The basic CPA Process involves Assessment, Care Planning, Risk Assessment, Review, Transitions (Transfer and Discharge) and Care Co-ordination.

7 WHO SHOULD BE ON CPA

7.1 CPA should be used if people have more complex needs, are at most risk or have mental health problems compounded by significant disadvantage. Decisions about whether a particular individual should be on CPA require clinical discretion, guided by indicators set out in the government guidance Refocusing CPA. Government guidance suggests CPA should be used if any of the indicators apply, unless there are clear reasons why Lead Professional Care or primary care is more appropriate.

7.2 Due to the overall complexity and risk factors associated with inpatients, all mental health inpatients will be placed under CPA on admission. However, in exceptional circumstances and after assessment and review by the Inpatient Consultant Psychiatrist (or their nominated deputy), the service user may be changed back to non CPA (standard) if their complexity and risks factors are assessed as being low or the service user only requires a short admission.

7.3 To provide clearer guidance to services so that they can better target engagement, co-ordination and risk management support to individuals that most need it, the current list of characteristics has been refined and a new list set out in the list below.

7.4 The list is not exhaustive and there is not a minimum or critical number of items on the list that should indicate the need for CPA. But there was clear consensus among those testing the list that it should provide the basis of a reliable and useful tool. However, it is also critical to stress that clinical and professional experience, training and judgement should be used in using this list to evaluate which service users will need the support of CPA.

7.5 Indicators suggesting people are likely to need CPA are:

7.5.1 Severe mental disorder (including personality disorder) with a high degree of clinical complexity

7.5.2 Current or potential risk(s), including:

7.5.3 Suicide, self harm, harm to others (including history of offending)

7.5.4 Relapse history requiring urgent response

7.5.5 Self neglect/non concordance with treatment plan

7.5.6 Vulnerable adult, adult/child protection issues

7.5.7 Exploitation, for instance financial/sexual

7.5.8 Financial difficulties related to mental illness

7.5.9 Disinhibition

7.5.10 Physical/emotional abuse

7.5.11 Cognitive impairment

7.5.12 Child protection issues

7.5.13 Current or significant history of severe distress/instability or disengagement

7.5.14 Presence of non-physical co-morbidity including substance/alcohol/ prescription drugs misuse, learning disability

7.5.15 Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.

7.5.16 An inpatient.

7.5.17 Currently/recently detained under Mental Health Act, on Supervised Community Treatment or Guardianship, and most people subject to S.117 MHA or referred to crisis/home treatment teams

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

7.5.19 Experiencing disadvantage or difficulty as a result of:

a) Parenting or other caring responsibilities

b) Physical health problems/disability

c) Unsettled accommodation/housing issues

d) Employment issues when mentally ill

e) Significant impairment of functioning due to mental illness

f) Ethnicity (such as immigration/asylum seeking status; race/cultural issues; language difficulties; spiritual or religious practices);

g) Sexuality or gender issues

8 OTHER SERVICE USERS UNDER A LEAD PROFESSIONAL (NON CPA)

8.1 Other mental health service users will be seen by some services within KMPT who do not meet the current requirements of CPA.

8.2 The rights of the service user (and their carer) to have an assessment of their health and social care needs needs, the development of a care plan and a review will continue.

8.3 A Lead Professional will be allocated rather than a care coordinator

8.4 Ongoing clinical notes including an assessment, care plan, risk assessment and HoNos should also be maintained and annual reviews undertaken, unless a change in circumstance dictates the need for an earlier review.

8.5 It should be the aim of interventions to, wherever possible, gradually move service users from CPA to non CPA (standard on RiO), and then discharge back into primary care.

8.6 Service users who are not under CPA and who remain under a Lead Professional (Standard on RiO) are likely to follow the following characteristics;:

8.6.1 Their needs are described as being more straightforward and less complex.

8.6.2 Be seen by one mental health professional

8.6.3 Present with low risks

8.6.4 Be in the process of recovery, close to discharged or being transferred to shared care.

8.6.5 Do not need active engagement

8.6.6 Will have self directed support

Figure 1- Characteristics to consider when deciding if the service user is on CPA

Need/Support	New CPA (CPA on RiO)	Other Service Users under Lead Professional Care (Standard on RiO)
Professional Support	Support from Care Co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload). Service user self-directed care, with support.	Support from Lead Professional as part of clinical/practitioner role. Service user self-directed care, with support.
Assessment	A comprehensive multi-disciplinary, multi-agency and self directed assessment covering the full range of needs and risks. Assessment includes the assessment of strengths goals and aspirations.	A full assessment of need for clinical care and treatment, including supported self directed assessment is complimented by assessments by other agencies where appropriate. Assessment includes the assessment of strengths goals and aspirations
Assessment of Social Care Needs (Care Act 2014)	An assessment of social care needs against eligibility criteria. Please see KCC Policy Eligibility Criteria 2015.	An assessment of social care needs against eligibility criteria. Please see KCC Policy Eligibility Criteria 2015.
Written Care Plan	Comprehensive formal written care plan: including diversity, risk and safety/contingency/crisis plan which must be explained and given to the service user. This should include reference to NICE and best practice recommendations where appropriate.	Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter) which must be developed in collaboration with the service user, explained and given to the service user. This should include reference to NICE and best practice recommendations where appropriate.
Review of Needs	On-going review, formal multi-disciplinary, multi-agency review at least 6 monthly but likely to be needed more regularly. Will include review of status under Mental Health Act (e.g. Section 7 and 117) and Mental Capacity Act (DOLS) where relevant.	On-going review as required at least every 12 months
Review of Need for CPA	At review, consideration of continuing need for CPA support	Continuing consideration of need for move to CPA if risk or circumstances change
Support & Assistance	Increased need for advocacy support, interpreter/ signer support etc	Self-directed care, with some support if necessary
Carers Involvement and Support	Carers identified and informed of rights to own assessment. Agreed arrangements for carer involvement.	Carers identified and informed of rights to own assessment. Agreed arrangements for carer involvement.

9 CPA AND HONOS (PBR)

9.1 The HoNOS Payment by Results Scales (PbR) and the Mental Health Cluster Tool (MHCT) are a means of allocating clients to care clusters which in turn supports care planning and enables mental health payment by results.

9.2 The CPA Process has strong links with HoNOS and PbR which are part of the assessment process within CPA.

9.3 HoNOS scoring can help assess service users' level of functioning in a range of areas and can be a central part of measuring recovery. A series of scores can help service users and carers review development over a period and help people identify more clearly their strengths and areas they may need more support. At team, service and Trust levels they can be a valuable

way of assessing the effectiveness of interventions and types of service which can influence commissioning decisions.

9.3.1 Managers should ensure that all staff completing scales are appropriately trained. HoNOS scores should be completed:

a) At Initial Assessment

b) On admission to hospital - within a week of admission, at 4 weekly intervals and at discharge

c) At CPA review for people on CPA

d) At least annually for people on Lead Professional Care

e) At discharge from service

f) At transfer of care

g) If there is a significant change in circumstances, including working with the crisis team/home treatment team

9.4 All service users must have the HoNOS and PbR completed and recorded on RiO.

10 CPA ROLES AND RESPONSIBILITIES

10.1 CPA Care Coordinator

10.1.1 Ensure a comprehensive, multi disciplinary and multi-agency assessment of a service user's health and social care needs is carried out in partnership with the service user.

10.1.2 Co-ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them.

10.1.3 Arrange for someone to deputise if absent and pass on the care coordinator role if no longer able to fulfil it.

10.1.4 Ensure crisis and contingency plans are formulated, updated and circulated.

10.1.5 Ensure that the service user is at the centre of their care, has choice and is supported to identify their goals. This can involve the use of peer support.

10.1.6 Ensure that carers and other agencies are involved and consulted where appropriate.

10.1.7 To be identified and told by the Care Co-ordinator that they have the right to have their health and social care needs assessed

10.1.8 Ensure that the service user understands the role of the care coordinator, how to contact them and who to contact if the care coordinator is not available.

10.1.9 Ensure that the service user is assisted with the process of registering with a GP and that the GP is informed or involved as necessary.

10.1.10 To maintain regular contact with the service users GP on at least a six monthly basis (more frequent if circumstances require this).

10.1.11 Maintain regular contact with the service user (and where appropriate their carer) and monitor his/her progress, whether at home or in hospital, including prison regardless of progress.

10.1.12 Organise and ensure that reviews of care take place, and that all those involved are invited, consulted and informed of any outcomes.

10.1.13 Explain to the service user, their relatives and informal carers the CPA process and make them aware of their rights and roles.

10.1.14 For carers to be identified and told by the Care Co-ordinator that they have a legal right to have their health and social care needs assessed

10.1.15 Consider the need for advocacy for the service user, or carers if appropriate, and make them aware of how they can access these services.

10.1.16 Encourage service users to access peer support, including third sector support.

10.1.17 Identify any unmet needs and communicate any unresolved issues to the appropriate managers, through the appropriate systems.

10.1.18 Ensure that service users with eligible social care needs are offered a personal budget and if they choose to receive Direct Payments as per Cost Setting Guidance using the Cost Setting Guidance Tool to cost the service, please see Personal Budgets Policy KCC.

10.1.19 Take responsibility for ensuring continuity of care, using home visits or visits to where the service user is located if in out of area placement, including hospital or prison.

10.1.20 Have face-to face contact with service users within 7 days of discharge from inpatient care (incorporating early discharge facilitated via CRHT).

10.1.21 The complexity of the Care coordinator's role in any service user's case will reflect in the complexity of the presenting needs and risks. The role is essentially one of coordination and communication.

10.1.22 To ensure all safeguarding concerns are considered and raised if appropriate following the Joint Agency Safeguarding Protocol.

10.1.23 To ensure the coordination of a review of the service user's legal status where appropriate, considering Mental Health Act and Mental Capacity Act.

10.1.24 Due to the complexity of a care coordinators role and the emphasis of community care at no times would inpatient staff be required to take on the role of a care coordinator.

10.1.25 All care coordinators must abide to the 10 Essential Shared Capabilities Framework (ESC) 2004.

10.2 **Lead Professional**

10.2.1 In many cases the lead professionals roles and responsibilities will be very similar to a Care Coordinators with the major differences being:

10.2.2 Ensuring a comprehensive assessment of a service user's health and social care needs is carried out rather than a multi disciplinary and multi-agency assessment.

10.2.3 Formulate and update the care plan, ensuring that this details how care and treatment will be carried out and to whom. This may be in the form of a GP letter depending upon the service line.

10.2.4 Ensure ongoing reviews occur instead of CPA Reviews.

10.2.5 Less need of coordinated support.

11 FIRST POINT OF CONTACT

11.1 Prior to screening all referrals must be logged on to the RiO system and where applicable SWIFT (e.g. safeguarding).

11.2 At the first point of contact, the clinician will follow the good practice guidelines:

11.2.1 Gather historical information from EPEX/ RiO/ SWIFT.

11.2.2 Completion of RiO Screening Form whilst considering FACS eligibility.

11.2.3 Consideration of safeguarding throughout screening and completion of SG1 (Safe Guarding Alert) / recording on SWIFT if appropriate.

11.2.4 Contact the service user if necessary for further information if required and record any contact in RiO.

11.2.5 Make a clear decision if the referral requires routine, urgent or emergency response time or needs to be screened out.

11.2.6 If the service user is ineligible for services, outline the reasons why they are ineligible for the service in a letter to the GP/ referring clinician within 3 days.

11.2.7 If the service user is accepted for services, the clinicians RiO diary should be accessed offering the service user a suitable appointment, considering the service users needs and the clinician's availability their expertise/ clinical skills. A letter must be sent to the GP within 5 days of the assessment

11.2.8 Administrative staff should be completing administrative functions only. Anything deemed as a clinical task or contact must be completed by a clinician.

12 PRINCIPLES OF ASSESSMENT

12.1 Assessment: We have a statutory requirement (under S.9 of the Care Act, 2014) to provide an appropriate assessment of health and social care needs for all service users (and where appropriate their carers) who are referred to our service.

12.2 The purpose of assessment is to:

a) Identify the health and social needs of service users in order that eligible needs are addressed in the care planning process.

b) Evaluate the individuals strengths

c) Identify the service users goals, aspirations and choices

d) Assess the level of risk

e) Identify the need for specialist assessment

f) Determine whether intervention from services is appropriate

g) Identify the persons need for CPA

h) Establish an information base

12.2.2 The needs assessment be holistic, in partnership with the service user with the aim of promoting recovery and self-ownership.

12.2.3 All service users must have the assessment recorded within the core assessment section on RIO.

12.2.4 The assessment forms completed on RiO can slightly differ within the individual service lines depending upon their needs, so therefore the clinician must refer to their Service Line RiO Standard Operating Procedures.

12.3 The assessment will also address any risks including any Safeguarding (Adults or Children) issues and any concerns must be recorded on SG1 for Adults (as per Multi-agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway, 2015) and Children's Social Services Child in Need and Child Protection Form for Children (as per Safeguarding & Protecting Children & Young People Policy).

12.4 After the initial assessment the clinician must write to the GP/ referring clinician within 5 days outlining the assessment, any treatment plan and risk factors.

12.5 **Assessment under the Care Act:**
Under the According to The Care Act, 2014 (Section 9) a needs assessment is both a statutory duty and a critical intervention. It should not just be seen as a gateway to care and

support, but should be a critical intervention in its own right. The golden thread running through the assessment process is the concept of wellbeing and focusing on outcomes that matter most to people.

12.6 Assessment as a critical intervention:
A needs assessment can help people to:

a) understand their situation and the needs they have
b) reduce or delay the onset of greater needs
c) access support when they require it
d) understand their strengths and capabilities
e) understand the support available to them in the community and through other networks and services.

12.7 Decisions about whether an adult or carer has eligible needs should be made after the assessment.

12.8 Assessments should focus on what the individual can or cannot do without the carer. During the assessment must consider all of the adult's care and support needs, regardless of any support being provided by a carer. Where the adult has a carer, any care that they are providing must not be considered until after it has been determined that the adult has eligible needs, during the care and support planning stage. The role of the carer only comes in during care and support planning when it is being decided which of the eligible needs KCC has to meet. (Please see KCC Assessment Policy and Guidance, 2015).

12.9 After the assessment

12.9.1 Part 1, section 12, sub-section 3 of the Care Act 2014 tells us that we must give a written record of a needs assessment to:

a) the adult who has been assessed
b) any carer that the individual has, if the individual has requested this
c) any other person named by the assessed individual.

12.9.2 Where an independent advocate is involved in supporting the individual, the assessor should keep the advocate informed so that they can support the person to understand the outcome of the assessment and its implications.

12.9.3 The practitioner can now make a decision about whether the adult is entitled to care and support arranged by the local authority by applying the national eligibility criteria.

12.9.4 The assessor must provide a written record of their eligibility decision and the reasons for coming to their decision. (For more details please read the Eligibility Criteria Policy) Regardless of whether or not the person meets the eligibility criteria, the practitioner must provide information and advice in an accessible format about what can be done to prevent, delay or reduce development of the person's needs.

12.9.5 Where the assessor has determined that a person has any eligible needs, KCC or Medway Council must meet the unmet eligible needs subject to:

a) Meeting the financial criteria
b) Ordinary residence requirement
c) The person agreeing to the authority meeting their needs.

12.10 For teams who are not within the Partnership agreement (Older Adults and Medway), based upon the assessed need, a referral will be made to the local authority following current protocols and agreements.

13 ELIGIBILITY CRITERIA AND PERSONAL BUDGETS

13.1 The Care and Support (Eligibility Criteria) Regulations 2014 set out the single eligibility threshold for adults with care and support needs and carers. This means there is a minimum threshold which establishes what level of needs must be met by the local authority if these needs are not already being met.

13.2 For teams who are not within the Partnership agreement (Older Adults and Medway), a referral will be made to either Medway Council or KCC following current protocols and agreements.

13.3 Eligibility is determined following a needs assessment under section 9 of the Care Act 2014 (please see KCC Eligibility Criteria Policy and Practice Guidance , 2015)

13.4 Key messages of the Eligibility Criteria Policy and Practice Guidance (2015)

13.4.1 The national eligibility criteria is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

13.4.2 There is no hierarchy of needs so needs to develop relationships is as important as the need to manage toileting needs.

13.4.3 We must consider an individual's needs over an appropriate period of time to ensure that all of their needs have been accounted for when the eligibility is being determined.

13.5 An adult's needs are only eligible where they meet all three of the following conditions

13.5.1 The adult's needs arise from or are due to a physical or mental impairment or illness. This includes conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

13.5.2 The effect of the adult's needs is that the adult is unable to achieve 2 or more of the specified outcomes (stated below).

13.5.3 As a consequence of the person being unable to achieve 2 or more of the outcomes, there is, or is likely to be, a significant impact on the adult's well-being

13.6 Specified Outcomes Eligibility is related to whether, as a consequence of the person being unable to achieve 2 or more outcomes, their wellbeing is significantly affected.

13.7 The specified Outcomes are:

13.7.1 Managing and maintaining nutrition

13.7.2 Maintaining personal hygiene

13.7.3 Managing toilet needs

13.7.4 Being appropriately clothed

13.7.5 Being able to make use of the adult's home safely

13.7.6 Maintaining a habitable home environment

13.7.7 Developing and maintaining family or other personal relationships

13.7.8 Accessing and engaging in work, training, education or volunteering

13.7.9 Making use of necessary facilities or services in the local community including public transport and recreational facilities or services

13.7.10 Carrying out any caring responsibilities the adult has for a child.

13.8 The adult is regarded as being unable to achieve an outcome if the adult:

13.8.1 is unable to achieve it without assistance

13.8.2 is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety

13.8.3 Is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health and safety of the adult or others

13.8.4 Is able to achieve the outcome without assistance but takes significantly longer than would normally be expected.

13.9 Focusing on condition 3: unpacking the concept of significant impact on "well-being"

13.9.1 The Care Act 2014 (Part 1: Care and Support, section 1, point 2) defines "wellbeing" as a broad concept and describes it as relating to the flowing areas in particular:

a) Personal dignity

b) Physical and mental health and emotional wellbeing

c) Protection from abuse and neglect

d) Control by the individual over day-to-day life (including over care and support provided and the way it is provided)

e) Participation in work, education, training or recreation

f) Social and economic wellbeing.

g) Domestic, family and personal relationships

h) Suitability of living accommodation

i) The individual's contribution to society

These should be considered of equal importance with no hierarchy.

13.10 To assess "significant impact", practitioners should consider how the adult's needs impact on the areas of wellbeing set out above.Practitioners should determine whether:

13.10.1 The adult's needs impact on an area of wellbeing in a significant way; or

13.10.2 The cumulative effect of the impact on a number of the areas of wellbeing mean that they have a significant impact on the adult's overall wellbeing.

13.10.3 In making this judgement, assessors should seek to understand the adult's needs in the context of what is important to him or her. The impact of a given need will be different for different individuals, because what is important for the individual's wellbeing may be different. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another.

13.10.4 Practitioners will need to consider the difference between a person's needs having an impact on their wellbeing and a significant impact on their wellbeing.

13.11 Fluctuating needs: Where a person has fluctuating needs, assessors must look at the adult's needs over a sufficient period of time to get a complete picture of those needs. Individuals with fluctuating needs may have needs which are not apparent at the time of the assessment, but may have arisen in the past and are likely to arise again in the future. Therefore, assessors must consider an individual's need over an appropriate period of time to ensure that all of their needs have been accounted for and taken into account when eligibility is being determined.

13.11.1 Where fluctuating needs are apparent, this should also be factored into the care planning process that details the steps we will take to meet circumstances where needs fluctuate.

13.11.2 Needs currently met by carers: The eligibility determination must be made without consideration of whether the adult has a carer, or what needs may be being met by a carer at that time.

13.11.3 The eligibility determination must be made based solely on the adult's needs, regardless of whether these needs are being met by a carer.

13.11.4 If an adult does have a carer, the care they are providing will be taken into account when considering whether the needs must be met (i.e. during the care and support planning process).

13.11.5 We are not required to meet any eligible needs which are being met by a carer, but those needs should be recognised and recorded as eligible during the assessment process. This is to ensure that should there be a breakdown in the caring relationship, the needs are already identified as eligible, and therefore the local authority must take steps to meet them without a further assessment.

13.12 Practitioners must provide a written record of their decision about a person's eligibility and their reasons for coming to their decision. This will provide transparency on how and why decisions were made.
This means providing a written record when either:

a) The person does not meet the eligibility criteria, or

b) The person meets the eligibility criteria

13.13 Where the individual does not have eligible needs, the assessor must also provide:

13.13.1 Information and advice on what can be done to meet or reduce the needs (for example: what support might be available in the community).

13.13.2 Information about what preventative measures might be taken to prevent or delay the development of needs in the future.

13.13.3 When evidencing your professional judgement, it is expected that the assessor will write their decision in a person centred way and focus the specific impact for the person they have assessed as opposed to writing in a generic way.

13.14 If the adult has some eligible needs, the assessor must:

13.14.1 Agree with the adult which of their needs they would like KCC to meet

13.14.2 Consider how KCC may meet those needs (this does not replace the care and support planning process but is an early consideration of the potential support options)

13.14.3 Establish whether the person meets the ordinary residence requirement, i.e are they ordinarily resident in Kent?

14 PERSONAL BUDGETS AND CARE AND SUPPORT PLANNING

14.1 The estimated Personal Budget is calculated following assessment using the Cost Setting Guidance; it is based only on the eligible needs of the individual.

14.2 Where non - eligible needs have been identified, the practitioner will provide information, advice and guidance as appropriate.

14.3 The care and support plan is then developed in line with the Care and Support Planning Policy. The actual Personal Budget is confirmed following support planning and applies only to eligible needs.

14.4 For teams who are not within the Partnership agreement (Older Adults and Medway), based upon the assessed need, a referral will be made to the local authority following current protocols and agreements.

15 ALLOCATION OF CARE COORDINATOR

15.1 Who can be a care coordinator?

15.1.1 Any suitably trained professional can take on the role of the Care Coordinator or Lead Professional as long as they are;

15.1.2 Competent to do so

15.1.3 Have received training in the areas of assessment and formulation.

15.1.4 Are in a position of authority

15.2 A care coordinator should be allocated according to a variety of factors including the service user's current needs, the care coordinators skills and the size of the care coordinators caseload.

15.3 When all staff members are allocated a new service user, they must be clearly informed by the person allocating them.

16 PRINCIPLES OF PERSON CENTRED CARE PLANNING

16.1 All staff should work towards the following principles of person-centred care planning:

16.1.1 Care Plans should be a continuous process not a product;

16.1.2 It is a dynamic process of discussion, negotiation, collaboration, decision making and review that takes place between the individual and the professional – who have an equal partnership;

16.1.3 The care plan should be based upon their needs, strengths, goals, aspirations and lifestyle wishes.

16.1.4 The person should be encouraged to have an active role in their care, be offered options to allow informed choices, and empowered to make their own decisions with adequate information or signposting – all within a framework of managed risk.

16.1.5 Carers will be involved in care planning and if appropriate, offered carers assessment.

16.1.6 As good practice, care plans should wherever possible be formulated by the multi professional team in partnership with the service user adopting the differing professions expertise and philosophies.

16.1.7 The care plan must address all social care needs, that KCC is going to meet and how it intends to do so. Please refer to KCC Support Planning Policy for Guidance on Care Planning Social Care Needs 2015.

16.1.8 Where social services needs have been assessed as not meeting the eligibility criteria, to provide individualised information and advice (which has legal status under Care Act 2014) and how to delay/ or prevent those needs that are not eligible for support.

16.1.9 All contacts should be recorded in a formulated way following the corresponding care plan.

16.1.10 All service users must receive a full explanation of the care they are receiving and have their care plan or plan of care must be printed off RiO and given to them.

16.1.11 The service user will be encouraged to sign their care plan/ plan of care to state they agree to it. The giving of the care plan will then be recorded on RiO under Care Plan Distribution. If they do not agree with the care plan/ or part of the care plan, the reasons why will be recorded on RiO under Care Plan Distribution.

16.1.12 If the care plan incorporates the Recovery Star, this will need to be uploaded onto RiO.

16.1.13 As part of clinical effectiveness all clinicians have a responsibility to ensure that they are adhering to best practice and specifically NICE guidance where applicable when formulating person centred care plans and as a result their care plans will be audited on a regular basis as per service line and professional audit tools/ protocols.

16.1.14 Care plans will address physical health needs as well as psychological and social needs.

16.2 Within KMPT, there are several ways a care plan may be recorded depending upon the CPA level.

16.2.1 For service users under CPA, there must be a full RiO Care Plan.

16.2.2 For service users under non CPA (standard), the care plan may be within a GP letter or be within a memory clinic care planning template (OPMHS). For the exact way of recording Care Plans within your service line, please refer to your service users Standard Operating Procedure.

16.3 CPA Audit standards, the trust has a robust care plan audit process in place within all service lines, the results of these audits are reported to commissioners. Regardless if the care plan is on the Care Planning Section on RiO or within a GP letter, all care plans must follow the audit standards below. The audit standards vary slightly between each service line but the general standards are:

16.3.1 Does the care plan clearly identify the service user's problems, needs & challenges?

16.3.2 Does each problem have clearly identified goals and activities including frequency?

16.3.3 Does each problem have clearly identified client's views?

16.3.4 Is there evidence of service user involvement throughout all aspects of the care plan?

16.3.5 Does each problem have clear start dates and end dates (review dates)?

16.3.6 Has the service user had opportunities to sign the care plan to indicate they have agreed to their plan of care?

16.3.7 Is there evidence that the service user has been offered a copy of the care plans?

16.3.8 Are all clinical risks, risk management, and crisis relapse & contingency plans clearly identified and completed?

16.3.9 Is the care plan explicit in relation to MHA, capacity and Rights?

16.3.10 Are all aspects of the care plan up to date and an accurate reflection on the patient's current wellbeing?

16.3.11 Is the care plan simple and straight forward, avoiding any unnecessary and lengthy explanations or narrative?

16.3.12 Is the extent of carers' involvement explicit in the care plan?

16.4 Behavioural Support Planning

16.4.1 The new Mental Health Code of Practice (DH 2015) stipulates that all service users who are liable to present with behavioural disturbances need a care plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. This care plan is commonly known as a behavioural support plan.

16.4.2 Therefore all service users within the trust who are liable to present with behavioural disturbances need a RiO care plan which covers-

16.4.3 Primary Preventative strategies aim to enhance the service users quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances. These will draw information from the assessment as to what may exacerbate behaviours of concern and tailor strategies around these factors.

16.4.4 Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm (de-escalation, distraction, diversion)

16.4.5 Tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area.

16.5 Advanced Statements/ Advance Care Planning

16.5.1 An advanced statement or advanced care plan is a written set of decisions that the service user has made about what they would like to happen to them in the event they have to go back into hospital at some point in the future.

16.5.2 Service users who benefit from an advanced statement are those who have previously been in hospital and can now decide what their advance care plan will look like. The types of things that could be included in an advanced care plan is down to the service user as it is about their personal choice, however examples could be:.

a) the client smokes they should decide what type of nicotine replacement they want as they will not be able to smoke in hospital in 2015.

b) If they have family members they could decide how information and communication is provide to them when they become unwell or go into hospital.

c) If they have pets and property they can decide what they want to be done to ensure they are safe.

d) If they have a particular choice about treatment or medication they can decide how they want to be treated.

16.6 **Crisis and Contingency Plan**- A crisis plan is an agreed plan of action which is implemented in a crisis, ensuring that the service user, their carers and professionals know who to contact when they are in crisis.

16.6.1 A contingency plan details the information and arrangements needed to prevent any unforeseen circumstances turning into a crisis, e.g. the care coordinator or carer going on leave. It should contain the information necessary for the continuation of the care plan in an interim situation.

16.6.2 A Crisis and Contingency Plan may contain the following:

a) Possible early warning signs of a crisis and coping strategies

b) How the service user usually presents

c) Protective Factors

d) Support available to help prevent hospitalisation

e) Where the person would like to be admitted in the event of hospitalisation

f) The practical needs of the service user if they are admitted to hospital (for example, childcare or the care of other dependants, including pets)

g) Details of advance statements and advance decisions

h) Whether (and the degree) to which families or carers are involved

i) Information about 24-hour access to services

Named contacts (crisis card)

16.7 Crisis and Contingency Plans will follow these principles:

16.7.1 The service user must be involved in the formulation of their crisis plan

16.7.2 It should be written in collaboration, negotiation and agreement with the service user.

16.7.3 The plan will be part of the CPA process and will be the responsibility of the care coordinator or lead professional.

16.7.4 With their consent, the service user's family or carer may be involved in the formulation of the plan.

16.7.5 The service user must receive a copy of the plan

16.7.6 With the service users consent, a copy may need to be sent to other professionals or agencies such as their GP.

17 PRINCIPLES OF RISK ASSESSMENT & MANAGEMENT:

17.1 The philosophy underpinning risk assessment and management is one that balances care needs against risk needs, and that emphasises: positive risk management; collaboration with the service user and others involved in care; the importance of recognising and building on the service user's strengths; and the organisation's role in risk management alongside the individual practitioner's. It emphasises the importance of the assessment of dynamic (changing) risk factors, as well as the more well-understood static ones.

17.2 Risk Assessment is an essential part of good quality care planning. It should be carried out in line with the KMPT policy, Clinical Risk Assessment and Management of Patients/Service Users). Each Service Directorate has a list of approved Risk Assessment Tools. Risk Assessment also includes Safeguarding Considerations and Safeguarding Children]. Risk is managed through the Care Pathways process, crisis planning, and contingency planning and relapse identification.

18 CPA REVIEWS

18.1 The purpose of CPA meetings is to review the care plan. As with the assessment and initial care planning process, most of this work should be done between the Care Co-ordinator and service user (and carer/s if appropriate) before the meeting.

18.2 When the service user is an inpatient, the care coordinator must continue to take an active lead in arranging, attending CPA reviews and recording CPA reviews in collaboration with the ward staff.

18.3 As good practice CPA reviews should adhere to the following guidelines:

18.3.1 Be more inclusive to service users.

18.3.2 Be more flexible regarding the location and time of the meeting.

18.3.3 The review will consider all health and social care needs, please refer to KCC Support Planning Policy for guidance on care planning social care needs.

18.3.4 Any member of the care team, the service user or carer must be able to ask for a review at any time.

18.3.5 All reviews must be planned in advance with the service user's care and expectations of the review being discussed with them prior to the review.

18.3.6 The Care Coordinator should discuss with the service user if they require an advocate and if required sign post the service user to the most suitable service.

18.3.7 All CPA reviews must be a face to face meeting.

18.3.8 The review may be part of a regular contact or consultation.

18.3.9 All professionals currently involved in the service user's care will be invited to the review.

18.3.10 Reviews should be chaired and led by the service user where the service user wishes and has capacity.

18.3.11 As a minimum the meeting must be attended by the service user and care coordinator, if other professionals involved in the service user's care have been unable to attend, the care coordinator will consult them on the content of the meeting before/ after the review occurs.

18.3.12 All opinions must be recorded and disagreement with care planning or assessment recorded.

18.3.13 After a review has taken place the care plan must be signed by the service user and distributed to all (with permission) within 7 days of the review taking place. This will be recorded under care plan distribution on RiO.

18.3.14 After every review for service users under CPA or Lead Professional Care, the service users GP must also be sent a copy of the CPA review/ current care plan.

18.3.15 The absence of a CPA review should not prevent a service user's discharge.

18.4 Within 3 working days of a CPA review occurring, as good practice the following documentation must be updated and validated on RiO:

18.4.1 CPA Review

18.4.2 Care Plan

18.4.3 Risk Assessment

18.4.4 HoNOS

18.4.5 Needs Assessment

18.5 Where the client refuses to sign their care plan, this should also be recorded on RiO.

18.6 **CPA Reviews for <u>CPA</u> Service users in the community must be held:**

18.6.1 At least every six months.

18.6.2 If there is a significant change in the service user's circumstances

18.6.3 Before discharge from CPA or secondary mental health services.

18.6.4 Before transfer of care to another mental health service or team.

18.7 **Reviews for Service users under <u>Standard</u> in the community must be held:**

18.7.1 At least every year for service users with health needs.

18.7.2 After 12 weeks for service users with just social care needs and then yearly.

18.7.3 If there is a significant change in the service user's circumstances.

18.7.4 Before transfer of care to another mental health service or team.

18.8 **In-patient CPA review meetings must be carried out:**

18.8.1 The week before discharge for admissions of 3 weeks or more

18.8.2 during long admissions at least every 6 months

18.8.3 before any MHRT

18.8.4 For patients who have short admissions of less than 3 weeks a CPA review may not need to be held before discharge but should be arranged to be held in the community during the week after discharge. The patient must still have a care plan written by inpatient staff on discharge outlining clearly follow up arrangements in place

18.9 DNA of CPA Reviews

18.9.1 There will be occasions where the service user does not attend their CPA review; when this occurs staff must adhere to the following guidance:

18.9.2 Follow the DNA Policy

18.9.3 Contact the service user either by telephone and/ or writing

18.9.4 Arrange another review with the service user

18.9.5 Try arranging a review at alternative locations, such as the service user's home address, their GP surgery etc.

18.9.6 Escalate to their Senior Practitioner, Service Manager and the Consultant Psychiatrist if the service user will still not engage.

18.9.7 In exceptional circumstances after attempts to arrange a review or if the service user has DNA or refuses to attend the review, after Consultation with the Service Manager and Consultant Psychiatrist, it may be necessary to hold an urgent CPA Review in the service user's absence.

18.9.8 If this does occur; The Consultant Psychiatrist and Care coordinator/ Ward Manager must be present

18.9.9 The reasons why service user was not present and why a review was held in their absence must be recorded on RiO.

18.9.10 After the review, the care coordinator/ Ward Manager must still print off a copy of the revised care plan to the service user and arrange to give them a copy.

18.10 Please refer to Appendix B for good practice guidance on CPA Reviews.

18.11 Please refer to Appendix C for a checklist which must be followed for all CPA Reviews.

19 DISCHARGE/ TRANSFER FROM SECONDARY MENTAL HEALTH SERVICES

19.1 Please refer to the KMPT Policy entitled "Transfer and Discharge of Care- Service users Policy" which covers the transfer and discharge processes in full.

20 DOCUMENTATION AND RECORDING OF CPA

20.1 In 2011 the RiO electronic record system was introduced and all records related to service users must be recorded on this system.

20.2 Each service line has produced a RiO Standard Operating Procedure which clearly provides a summary of the expected standards and guidance to the relevant service line.

20.3 The headings outlined below are general guidance specifically related to CPA which work in conjunction with the service lines RiO Standard Operating Procedures.

20.4 **Recording of CPA Status:**

20.4.1 If a service user is on CPA, then the RIO CPA status must be set to CPA.

20.4.2 All service users under lead professional care must be recorded on RIO CPA status as Standard.

20.4.3 The recording of non applicable generally means non applicable to secondary mental health services which constitutes primary care services. The only exception to this would be for service users with social care needs who will would be under Cluster 1,2, and 3.

20.5 **Recording of Eligibility Criteria (Fair Access to Care Services):**

20.5.1 The eligibility criteria must be recorded on the Presenting Situation and Referral Outcome Decision section within in the Core Assessment section on RiO.

20.5.2 Clinician to complete care plan on RiO under Intervention Type SO Direct Payments detailing any Personal Budget interventions.

20.6 **Recording of Care Coordinator:**

20.6.1 If a service user is on CPA there must be an identified care coordinator recorded on RiO.

20.6.2 All other service users must have an identified lead clinician recorded on RiO entitled lead HCP (health care professional).

20.7 **Recording Assessments:**

20.7.1 All service users must have an assessment recorded on the Core Assessment section of RiO. The sub categories of assessment may vary depending upon the service lines RiO Standard Operating Procedures.

20.7.2 All service users must have a social inclusion assessment recorded on RiO.

20.7.3 All service users must have a relevant safeguarding assessment recording on RiO.

20.8 **Recording of the Care Plan:**

20.8.1 All service users under CPA must have an up to date care plan recorded on the relevant care planning sub category on RiO.

20.8.2 All other service users as good practice should have a care plan recorded in the Care Planning Section on RiO. However as detailed within some of the service lines RiO Standard Operating Procedures, the care plan can be in the form of a clinician's letter. If it has been agreed within the service line that this approach is used within some teams, the letter must give a clear understanding of how care and treatment will be carried out, by whom, and when.

20.8.3 All service users must have their care plan or plan of care printed off RiO and given to them with a full explanation of the care they are receiving. The relevant care planning section on RiO should be completed which references that a Clinicians letter has been completed.

20.9 **Recording of the Risk Assessment:**

20.9.1 All service users must have a risk assessment recorded on RiO.

20.10 **Recording of CPA Review:**

20.10.1 All service users on CPA (CPA on RiO) must have a formal multi-disciplinary, multi-agency review at least 6 monthly but likely to be needed more regularly. This is to be recorded by the care coordinator within the Care Planning, CPA and Reviews Section on RiO and must be validated.

20.10.2 After the CPA review has occurred and the care plan has been updated the clinician will then record the distribution of the care plan on the Care Plan Distribution Section on RiO.

20.10.3 For service users who are not under CPA, the review may either be recorded within the progress notes or within a GP letter.

21 CARERS

21.1 The role that carers have in supporting service users is integral to recovery and is therefore an integral part of the CPA process.

21.2 Carers should be involved as much as possible throughout the service user's care and can be a valuable resource during an assessment, when formulating person centred care plans, at CPA reviews, and when conducting risk assessments and managing identified risks.

21.3 The issue of confidentiality and carer involvement should be negotiated with the services user as appropriate; and re-visited on an ongoing basis.

21.4 Carers should be identified on RiO, by making a Carers record and recording the appropriate assessment data within the Core Assessment on RiO, which will include 'Client and Carers Understanding of Assessment'. In addition, all therapeutic contacts that include Carers must be accurately recorded within the setting of appointments and in out-coming appointments.

21.5 Professionals should encourage service users to consider their carer to be active participants in the planning and delivery of care.

21.6 When a service user declines to have their carer involved, the carer should be informed of this decision and be provided with relevant information on whom to contact with their concerns, however the carer is entitled to a carers assessment.

21.7 A service user's refusal to involve carers shall be reviewed with them at regular periods.

21.8 Both client and carer have the right to expect that information they provide to mental health services will not be shared with others (or each other) without their consent. This can only be over-ridden if justified by risk or if law requires this. (For further guidance on this see "Protocol for Confidentiality and Information Sharing between Agencies" 2002).

21.9 All Carers are entitled to:

21.9.1 Have their views and concerns listened to and respected.

21.9.2 Have choice about whether to continue in the caring role.

21.9.3 Be given information about CPA and care planning.

21.9.4 Know who to contact in an emergency.

21.9.5 Receive prompt and positive responses to requests for help.

21.9.6 Be signposted to relevant authorities within public sector if applicable.

21.9.7 To be identified and told by the Care Co-ordinator/ named professional that they have a legal right to have their health and social care needs assessed (see No Health without Mental Health 2011).

21.9.8 When a carer has received a carers assessment to have formulated a Carers care plan detailing interventions which should help inform the service users care plan, recorded on Care- Planning Carer section on RiO.

21.9.9 For teams who are not within the Partnership agreement (Older Adults and Medway), a referral will be made to either Medway Council or KCC following current protocols and agreements.

22 ADVOCACY

22.1 All service users have the right to access advocacy services at any point throughout the care pathway. It is the responsibility of the Care Co-ordinator or Lead Professional to ensure that service users and/or carers are aware of the local advocacy services and that services users are aware of their right to access these services.

22.2 All service users should be encouraged to access peer support, including third sector support.

22.3 People who are detained under the Mental Health Act now have a statutory right to an Independent Mental Health Advocate (IMHA). An IMHA is a specialist advocate who will ensure that the person's voice is heard in all issues around their care and treatment under the Act. This will include those who are allocated a care co-ordinator under CPA arrangements.

22.4 Care co-ordinators have a responsibility to ensure that service users are aware of the services available in the local area and that IMHA are involved if the service user requests.

22.5 IMCA are also indicated if there is an issue or concern where capacity to make decisions regarding care or treatment is in doubt. The arrangements where this is an issue are outlined in the Trust policy Mental Capacity Act Policy and Guidelines.

23 MENTAL CAPACITY

23.1 All Health and Social Care Staff must have regard to the Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards. This is a legal duty. Staff must be aware of the code of Practice and be able to explain how they have a regard to the Code of Practice when acting or making decisions. Please refer to KMPT Policy 'Mental Capacity Act Policy and Guidelines' for further guidance.

23.2 Staff should be aware that the MCA details five guiding principles which underpin its fundamental concepts and govern its implementation.

The five key principles are:

23.2.1 Assume capacity unless it is established otherwise

23.2.2 Give all appropriate help before concluding someone cannot make their own decisions

23.2.3 Accept the right to make what might be seen as eccentric or unwise decisions.

23.2.4 Always act in the best interests of people without capacity.

23.2.5 Decisions made should be the least restrictive of their basic rights and freedoms.

23.3 Staff should routinely consider mental capacity issues as part of their assessment. Any assessment of capacity must be decision and time specific.

23.4 As the CPA process is a framework of shared decision making, when service users lack capacity, they must be encouraged to participate as much as possible during the CPA process. If a service user lacks capacity and is and has no family or friends to support them, a referral to an Independent Mental Capacity Advocate (IMCA) may be required for specific decisions.

24 SAFEGUARDING

24.1 Safeguarding must be considered during the comprehensive assessment of both needs and risk and an adult protection alert raised if appropriate. Where issues are identified then these and the risk management plan must be covered in the resulting care plan.

24.2 The Joint Agency Safeguarding Protocol will be referred to as guidance throughout the safeguarding process (http://staffzone.kmpt.nhs.uk/Safeguarding.htm).

24.3 If a client is a parent, the appropriate Safeguarding Children Nurse for KMPT must be invited to the CPA review. The Safeguarding Children Nurse will then have the opportunity to read the client's notes on RiO and decide whether she needs to attend the CPA review.

24.4 If the client's child/ren is subject to a Child Protection Plan, the child's social worker must also be invited to the CPA review.

25 SOCIAL INCLUSION AND CPA

25.1 Social inclusion is a priority for the Trust. This can be defined as people having the same opportunities to participate in, and contribute to society and community as the rest of the population.

25.2 Employment and accommodation issues therefore must be considered when deciding whether someone would benefit from CPA and should be clearly recorded on RiO during the CPA assessment, care planning and review.

25.3 Education and further educational issues should also be clearly addressed during the CPA assessment, care planning and review and documented on RIO.

25.4 Where presentation is complicated by other difficulties such as Learning Disability, Sensory Impairment, Family, Socio-environmental, Age or Cultural factors then additional support or advice maybe requested for the assessment and or treatment of these clients and their families, as good practice the health worker must consider:

25.4.1 Allowing longer session times for appointments.

25.4.2 Verbal language e.g. checking if the person understands, using open questions, not using jargon and consideration of use of alternative methods of communication.

25.4.3 Environmental factors such as noise, seating and if the environment has any adjustments such as hearing loops for service users who may be hearing impaired.

25.4.4 Capacity to consent.

25.4.5 Physical as well as mental health needs.

25.4.6 Inviting advocate or carer to assessments and interventions where service user consents.

26 TRAINING:

26.1 Training will be made available to staff to ensure that they have sufficient support to demonstrate the competencies to deliver the CPA.

26.2 The level of training will be determined by the roles that staff would be expected to undertake within the specific care pathways framework used in their directorate. This training will be identified by staff as part of their supervision and appraisal.

26.3 CPA training is an e-learning package accessed via learning space.

26.4 The trust in collaboration with KCC offers a variety of training which incorporates good CPA practice, which includes:

26.4.1 Clinical Risk Assessment Training

26.4.2 Person Centred Care Planning Training

26.4.3 RiO Training

26.4.4 Mental Capacity Act Training

26.4.5 Clinical Record Keeping

26.4.6 Care Coordination Training

26.4.7 Community Care Legislation Training

26.4.8 Section 117 Training

26.5 A training needs analysis can be found in Appendix D

27 PROCESS FOR MONITORING COMPLIANCE WITH THE REQUIREMENTS OF THIS POLICY:

27.1 In order to ensure the quality of the CPA Policy, the following methods will be used to monitor compliance with the requirements of this policy.

27.2 Recording of attendance at training provided for care co-ordinators and e-learning training.

27.3 A rolling programme of audit is carried out within service lines between four week and every six weeks. The audit monitoring will include:

27.3.1 Assessment

27.3.2 Risk Assessment and Management

27.3.3 Care Plans

27.3.4 Contingency and Crisis Planning arrangements

27.3.5 Reviews

27.3.6 Allocation of Workers and contact arrangements

27.4 All clinical audits carried out, will be implemented according to the practice and procedures as detailed in the Trust Quality Improvement Policy

28 RECORD KEEPING

28.1 A service user's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council 2006, the Royal College of Psychiatrists 2009 and Nursing and Midwifery Council 2009 Standards and NHS Record Keeping - NHS Code of Practice for Record Keeping 2006).

28.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money and manage risks (Information Governance Toolkit, Essential Standards). Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record, RiO.

28.3 For full details of the specific information needed to ensure compliance with this policy see the RiO training guides and the Service Line Standard Operating Procedures

29 EQUALITY IMPACT ASSESSMENT

29.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

30 HUMAN RIGHTS

30.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

APPENDIX A ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
CPA	Care Programme Approach
KMPT	The Kent and Medway NHS and Social Care Partnership Trust
KCC	Kent County Council
SAP	Single Assessment Process
PCP	Person Centred Planning
SDS	Self Directed Support
DH	Department of Health
FACS	Fair Access to Care Services
HoNOS	Health of the Nation Outcomes Scales
PbR	Payment by Results
IMHA	Independent Mental Health Advocate
NCISH	National Confidential Inquiry into Suicides and Homicides
ACP	Advanced Care Planning
CRHT	Crisis Resolution and Home Treatment Team
SG1	Safe Guarding Alert
DOLS	Deprivation of Liberty
DCA	Department for Constitutional Affairs

Kent and Medway NHS
NHS and Social Care Partnership Trust

APPENDIX B CARE PROGRAMME REVIEW GUIDE

A Care Programme Approach Review Guide

What is the Care Programme Approach (CPA)?

The term Care Programme Approach (CPA) has been used since 1990 to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. In 2008 the Department of Health issued national guidance in the form documentation entitled 'Refocusing the Care Programme Approach' with the aim of providing a wider focus for all service users which ensures consistency and ensuring that the focus is centred upon a good quality of care.

What is a CPA Review?

A CPA Review is the means of checking a service user's progress and agreeing any changes to their care plans.

The meeting ensures that the service user and all the people involved in the service user's care have a say about what they are doing or what they are going to do.

The review should be person centred and should not be seen as a review of their medication.

The meeting can be either formal or informal depending upon the service user's preferences and needs.

The CPA review should be well planned in advance with the service user's current progress, their care plan, risk factors and expectations of the review being discussed with them beforehand.

The review may be part of a regular contact or consultation.

How often should a CPA Review be held?

A CPA review should be held as a minimum of every six months, CPA reviews may be needed more frequently depending upon the services users individual circumstances. Examples of the need for a review may be admission/ discharge from hospital or services, a change in care including medication, a change in social circumstances or a transfer to another health care provider.

The CPA review should be planned in advance. The care coordinator should aim to meet the service user before the meeting to discuss the CPA review and gather their opinions on their care and recovery. These are then to be recorded on RiO, enabling the other professionals involved to view the documentation prior to the meeting.

Where can CPA Review be held?

A CPA review can be held in a location which meets the needs of the service user and professionals involved in their care. Depending upon individual circumstances, this could be on an inpatient ward, at the community mental health base, their GP's surgery or where the service user resides such as their own home or a nursing home if applicable.
The review should be held in a comfortable environment which promotes confidentiality.

Who attends a CPA Review?

The emphasis of a CPA review is being person centred so the people who attend the CPA review should be who the service user wants involved in their care.

The care coordinator is a pivotal part of the CPA process and should be present at all CPA reviews. The care coordinators role is to ensure a comprehensive, multi disciplinary and multi-agency assessment of a service user's health and social care needs is carried out in partnership with the service user. Ensuring the coordination, the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them

.A Psychiatrist's involvement at a CPA review is important to help explain the service user's diagnosis, discuss their medication, indications, dosages, side effects and special precautions, explore with the service user their physical health monitoring and promote good health and participate in the HoNOS PbR Clustering review.

Other people who the service user (with their consent) may want to attend their review could be:

- A carer
- An advocate/ IMHA
- The GP
- An interpreter
- Another professional within the team who provides care for them, e.g. a psychologist/ psychotherapist, an Occupational Therapist, a Social worker, an Art Therapist, and STR worker or a chaplain.

As a minimum the meeting must be attended by the service user and care coordinator, if other professionals involved in the service user's care have been unable to attend, the care coordinator will consult them on the content of the meeting before/ after the review occurs

Who chairs the CPA Review?

The CPA review can be chaired by anyone who participates in the service user's care.

The service user should be encouraged at all times to chair the CPA or part of the CPA Review if they feel comfortable doing so as they are the best person to review their own care.

What is discussed at the Review?

The CPA Review is the means of checking a service user's progress and agreeing any changes to their care plan. Therefore a variety of topics could be discussed at the review; these could include:

- Their Recovery- What worked well or perhaps what does not work within their current care and care plan. .
- Recovery STAR Domains
- Psychological factors

- Biological factors e.g. medication, physical health monitoring and health promotion
- Social factors e.g. housing needs
- Legal factors e.g. any statutory obligations under the Mental health Act e.g. Section 117/ CTO
- Psycho-education e.g. their diagnosis
- Risk factors, including early warning signs and crisis plan
- Spiritual needs
- Vocational activities

At the end of the review as good practice, the next review date can be set.

What to record after a CPA Review.

Within 3 working days of a CPA review occurring, as good practice the following documentation must be updated, validated and outcomed on RiO by the care coordinator:

- CPA Review
- Care Plan
- Risk Assessment
- HoNOS PbR Cluster
- Needs Assessment (if applicable)
- Advanced Care Planning

The care coordinator should also outcome the CPA Review in their RiO diary.

After a review has taken place the care plan must be offered to the service user to sign and distributed to all (with permission) within 7 days of the review taking place. This distribution may be in the form of an email informing clinicians within KMPT that the care plan has been reviewed. Any distribution will be recorded under care plan distribution on RiO. Where the client declines to sign their care plan, the care coordinator would try to explore the reasons for this and feedback to the other professionals involved. All views must be recorded and disagreement with care planning or assessment recorded on RiO.

After every review the service users GP must also be sent a copy of the CPA review/ current care plan.

Discharge CPA's and RiO

When discharging a service user from the service they must have a CPA review, this must again be a face to face meeting which can be part of a routine appointment.

- In order for a care coordinator to discharge a service user from their caseload on RiO, they must go through the process of recording and validating a CPA review.
- The care coordinator must record the date of the review as being when the CPA occurred (which is usually the last contact) and not the date they were discharged from their caseload.
- They must also be careful to ensure that only the people who attended the review are documented as attended, therefore they must ensure that any clinicians who did not attend are uninvited from RiO.

- For service users who have deceased, in order for the care coordinator to discharge them from their caseload on RiO, again they must go through the CPA Review Process.
- As good practice the clinician should record that a CPA did not actually occur due to the service user being deceased but happened due to RiO process. The RiO help desk are happy to support clinicians within this process.

APPENDIX C CPA REVIEW CHECKLIST

CPA Checklist

Care Coordinator _____ **Client** _____ **CPA Date** _____

- **Means update RiO Records**

Before CPA Review	Please Tick	Update RiO
1. Discuss with the service user if they would like to lead the CPA review and if they need support in doing this		
2. Discuss upcoming CPA with client and anything that they wish to raise		
3. Give the service user, the "I have had my say form"		
4. Ensure the service user receives a copy of previous CPA Review/ Care Plan		
5. Give CPA Review Guidance		
6. Encourage service user to access the patient portal to review their current care plan		
7. Community Support Team – obtain feedback, if involved, and invite to CPA		
8. Advocacy/IMHA referral/involvement/attendance – discuss with client		*
9. Recovery Star – Use Recovery Star to inform core assessment/care plan		
10. Explore the views of Carers (if applicable)		*
11. Consider any safeguarding needs		*
12. Physical Health Check/Needs. Consider need for physical health investigations prior to CPA Review (e.g. blood test; EEG). Offer Physical health check		*
13. Medication – discuss any medication issues with client including concordance/side effects		*
14. Social Care Eligible Needs – complete assessment and paperwork		
15. Discuss KCC charging and provide KCC information booklet (if applicable)		
16. Crisis and Contingency plan with client – review with client and update		*
17. Discharge CPA? – Liaise with GP. Consider holding CPA at GP surgery; GP input plan, if they are unable to attend CPA		
18. Consent to Sharing Information form – discuss and complete with client		*

During CPA Review	Please Tick	Update RiO
1. Care Plan – review previous care plan and identify any new actions		*
2. Relapse signature and crisis plan - review		*
3. HoNOS - assess and update HoNos		*
4. Clustering – discuss and agree cluster		*
5. Diagnosis – Discuss diagnosis and provide information leaflet if needed		*
6. Medication – Explain medication and provide information leaflet if needed		*
7. Mental Health Matters – provide information leaflet		
8. Recovery – provide KMPT Recovery Leaflet		
9. Patients Rights to Correspondence – check with client		
10. Make service user aware of Patient Portal/ Buddy App		
11. Ensure that a draft is shared with the service user		
12. Set next Review date		

After CPA Review	Please Tick	Update RiO
1. Update Care Plan		*
2. Update Core Assessment and Risk Assessment – review with client and update		
3. Schedule and outcome CPA review		*
4. Update HoNOS and Cluster		*
5. Update Social Inclusion Data (if applicable)		*
6. Outcome appointment in RiO diary		*
7. Complete Progress note – complete re CPA Review		*
8. Review Section 117 (f client is subject to Sec 117 enter decision re 117 review)		*
9. Book next review		*
10. Care plan – provide draft copy, agree and sign (recorded under Care Plan Distribution)		
11. Care plan – distribute to client and GP and others as agreed in Review		

APPENDIX D TRAINING NEEDS ANALYSIS

Staff Group	E- Learning CPA Training 3 yearly MANDATORY	CPA Care coordination Yearly
Registered Clinical Staff	Yes	All staff undertaking care coordination role to initially complete all modules and then update two yearly.
Non registered clinical staff	Yes	
Managerial, Admin, Domestic etc	Only for senior managers with direct client contact	
Medical	Yes	

APPENDIX E FULL EQUALITY IMPACT ASSESSMENT (EIA) TOOL

If you prefer not to use this tool – you can create a separate document that answers the following questions:

- What is being assessed and what are the intended aims and outcomes?
- Are there any partners/contractors (internal and external) that will be involved in implementation?
- Which groups are currently affected and could be affected in the future (stakeholders)
- Have you got data on staff, service users, clients, carers and families by equality strand in relation to the policy?
- Which groups (internal and external) have been consulted?
- Could the policy directly/indirectly discriminate? (refer to definitions in EIA guidance document)
- Is there an opportunity to promote equality and diversity?
- What actions will you take to remove any potential discrimination?
- How will the EIA be monitored?

General Information		
1.	Name/s of policy, procedure, or practice:	CPA policy
2.	Directorate:	Nursing and Governance
3.	Policy Owner:	CPA Lead
4.	EIA Lead:	CPA Lead
5.	Lead Manager/Director:	Guy Powell/ Pippa Barber
6.	Date of screening:	2015
7.	Is this a proposed or existing policy, procedure or practice:	Updating new principles within existing policy
8.	What are the overall aim/s or purpose of the policy, procedure or practice?	To outline the arrangements and standards for CPA in the Trust
9.	Which groups of people will be affected by the policy, procedure or practice? E.g. particular service users, staff groups	All those involved in direct care including clinicians, service users and carers.
10.	Are any other Directorates/teams involved in the delivery of the policy, procedure or practice?	Yes Yes all Operational Service Lines
11.	Are any partner agencies involved in the delivery of the policy, procedure or practice?	Yes KCC, Medway council

<table>
<tr><td colspan="4">Data and Consultation</td></tr>
<tr><td>12.</td><td>Do you monitor the policy, procedure or practice in relation to any of the following?

Yes</td><td colspan="2">☐ Complaints ☐ Eligibility criteria
☐ KPI's ☐ Service Uptake
☐ User Satisfaction ☐ Other MONITOR Target</td></tr>
<tr><td>13.</td><td>If you answered yes to any of the above, do you collect this data broken down by any of the following?

Not currently</td><td colspan="2">☐Age ☐ Disability ☐ Gender
☐Faith ☐Race ☐ Sexual orientation
☐Other_____</td></tr>
<tr><td rowspan="9">14.</td><td rowspan="9">What consultation with service users taken place on the policy, procedure or practice within the last two years?</td><td>Who was consulted?</td><td>Summarise the findings</td></tr>
<tr><td>Race</td><td rowspan="9">Initial Policy in 2011 was..
- Circulated to Experts by Experience mailing list
- Published on Trust external web page
- Presented at locality PCC meetings
- Presented at Patient Experience Trust wide group

Update 2012 was…
- Circulated via PALS to Service User/ Carer Forums.

2015- Not circulated as no major changes.</td></tr>
<tr><td>Gender</td></tr>
<tr><td>Disablity
Age</td></tr>
<tr><td>Sexual orientation</td></tr>
<tr><td>Relgion and Belief</td></tr>
<tr><td>Transgender</td></tr>
<tr><td>Carers</td></tr>
<tr><td rowspan="10">15.</td><td rowspan="10">What consultation with staff groups has taken place on the policy, procedure or practice?</td><td>Which groups?</td><td>Summarise the findings</td></tr>
<tr><td>Race</td><td rowspan="10">- Staff groups were involved in the development of the 2011 policy through Clinical effectiveness and Outcomes Group.
- 2012 Policy was circulated globally to all Service Line Managers for comment .
- Policy was published on Trust webpage and a bulletin sent to staff to ask for them to review and comment on the policy.
- 2015 Policy was circulated to service managers for dissemination to staff.</td></tr>
<tr><td>Gender</td></tr>
<tr><td>Disability</td></tr>
<tr><td>Age</td></tr>
<tr><td>Sexual orientation</td></tr>
<tr><td>Religion and Belief</td></tr>
<tr><td>Transgender</td></tr>
<tr><td>Carers</td></tr>
<tr><td rowspan="6">16.</td><td rowspan="6">Is there any other evidence to support this EIA that suggests any group may be affected differentially by this policy, procedure or practice?</td><td></td><td>Summarise and reference the evidence</td></tr>
<tr><td>Research reports</td><td rowspan="6">None known</td></tr>
<tr><td>Consultations and surveys</td></tr>
<tr><td>Demographic data</td></tr>
<tr><td>Equalities monitoring data from local bodies (e.g. KCC or PCTs, charities)</td></tr>
<tr><td>PALS and complaints data</td></tr>
</table>

		Audits and research reports	
		EIAs completed by national bodies and partners	Single Equality Impact Assessment Report 2007 CSIP

Conclusions			
17.	Will the policy, procedure or practice affect any group differently? No		If yes – can this be legally justified? (explain)
		Race	
		Gender	
		Disability	
		Sexual Orientation	
		Religion and Belief	
		Age	
		Caring	
		Transgender	
18.	Does the policy, procedure or practice miss any opportunities to promote equality?	Yes (see action plan)	
19.	Does the policy, procedure or practice encourage disabled people to participate in public life?	Yes	
20.	Does the policy, procedure or practice promote positive attitudes towards disabled people?	Yes	
21.	Is there a need to gather more information than is currently available to assess the impact of the policy, procedure or practice	Yes	
22.	Is it possible to easily modify this policy, procedure or practice to address any issues highlighted above? Please give details of how and when this could implemented	Yes Changes can be made through the relevant policy processes and are flexible enough to incorporate changes in a timely manner. Changes can be made within one month.	

23.	The EIA has identified: (please tick)		No adverse impact (EIA complete)	Adverse impact that can be mitigated (detail in improvement/equality action plan)	More research/ consultation needed (detail in improvement /equality action plan)	Adverse impact that cannot be mitigated or legally justified (policy must be cancelled)
		Race	Yes			
		Gender	Yes			
		Disability	Yes			
		Sexual Orientation	Yes			
		Religion and Belief	Yes			
		Age	Yes			
		Transgender	Yes			
		Caring	Yes			

24. Additional comments

25. Improvements/Equality Impact Action Plan

Issue	Action Required	How will the impact/outcomes be measured in practice	Completion Date	Responsible Officer

SIGNED (or name if electronic):

EIA Lead:

Head of Department/Directorate:

Equality & Diversity Team member:

Completion Date:

Send the Full EIA to the Equality and Diversity Team equalities@kmpt.nhs.uk