Kent and Medway
NHS and Social Care Partnership Trust

Care Programme Approach (CPA) Policy

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DOCUMENT TRACKING SHEET

Care Programme Approach (CPA) Policy

Version	Status	Date	Issued to/approved by	Comments
4.1	Draft	June 2012	CPA Compliance & Development Manager	Review
4.2	Draft	July 2012	Trustwide consultation	Comments/ review
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5.0	Final	October 2012	Patient Safety Group	Ratified
5.0	Final	November 2014	TWH&SG Paragraph added, now at 7.2	Agreed
5.1	Draft	August 2015	CPA Compliance & Development Manager	Comments/ review
5.2	Draft	August 2015	Trustwide consultation	Comments/ review
6.0	Final	October 2015	Trustwide Patient Safety Group	Ratified subject to inserting a CPA Review Checklist
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7.1	Draft	August 2019	Advance Care Planning incorporated into the CPA Policy	Submitted for consideration and ratification at September 2019's TWPSMRG, no major changes.
8.0	Final	September 2019	Agreed at Trust Wide Patient Safety and Mortality Review Group	Ratified

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
Care Group Standard Operating Procedures (SOPS)
Safeguarding & Protecting Children & Young People Policy
Safeguarding Vulnerable Adults Policy
Clinical Strategy
Protocol for Confidentiality and Information Sharing between Agencies
NICE Implementation Policy
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
Advanced Care Planning (Advance decision/advanced statement guidelines)

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
09/08/19	Deputy Director of Nursing	4	Advance Care Planning Guidelines incorporated within policy

CONTENTS

1 INTRODUCTION

1.1 Kent and Medway NHS and Social Care Partnership Trust (KMPT) is required to provide mental health services using the Care Programme Approach (CPA). CPA requires trusts to provide assurance that all service users will have their mental health assessed and will be involved in developing a care plan that addresses identified needs and any assessed risks associated with their situation.

1.2 The term Care Programme Approach (CPA) has been used since 1990 to describe the recovery framework that facilitates a partnership between the trust and service users to work in partnership to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with KMPT who have complex presentations and in a framework to provide effective mental health care for people with severe mental health problems in secondary mental health services.

1.3 In 1999, there was a drive to bring CPA into mental health practice more robustly; aiming to embed this as a framework to support people's mental health recovery by helping people that use our services to understand their goals, strengths, support needs and address difficulties. The Department of Health reviewed CPA in 2008 and issued '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. This led to full CPA or a concise version of care, which we know as Non-CPA.

1.4 People subject to CPA are likely to have a range of complex characteristics and may present with high risks. This often means that people subject to CPA may also have social care needs that through referral to Social Services will be delivered within the Care Act 2014.

1.5 In contrast to CPA eligibility, 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 receive Non-CPA (please see Non-CPA Policy)

2 PURPOSE AND SCOPE

2.1 The purpose of this policy is to identify duties, responsibilities, training requirements of staff and Care Group responsibilities in relation to CPA practice.

3 DUTIES AND RESPONSIBILITIES

3.1 The identified member of the Trust Board is the Executive Director of Nursing and Quality, who is responsible for the strategic leadership and implementation of CPA. This responsibility is delegated to the Deputy Director of Nursing and Practice and Care Groups to ensure adherence to CPA practice.

3.2 A yearly audit of CPA practice is coordinated by the Deputy Director of Nursing and Practice and reported to the Clinical Effectiveness and Outcomes Group. This enables regular review of CPA care and agreement of required actions to support ongoing best practice.

3.3 Registered clinicians that assume the role of CPA Care Coordinators are responsible for ensuring that CPA policy is realised in practice.

4 DEFINITIONS

4.1 Non-CPA – a Framework for the service user who has been identified as having needs that can be met by a single mental health professional and does not need the more formal full framework of CPA. There are few if any other agencies involved. See Non-CPA Policy.

4.2 CPA – Some service users has sufficiently complex needs to require being on CPA. They are individuals with complex characteristics and risks, whose needs are met from a number of services and need a higher level of engagement, co-ordination and support.

4.3 Care Coordinator – the term given to the registered clinician responsible for overseeing CPA Framework for a given service user.

4.4 Lead Professional – the term given to the registered clinician responsible for overseeing patients in receipt of Non-CPA.

5 WHO SHOULD BE ON CPA

5.1 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 (See Appendix A). 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.

5.2 Due to the overall complexity and risk factors associated with inpatients, all mental health inpatients will be placed on the CPA framework upon admission. However, in exceptional circumstances and after assessment and review by the Inpatient Responsible Clinician, the service user may be changed to Non-CPA if their complexity and risks factors are assessed as assigned to a Non-CPA pathway (See Appendix A).

6 CPA ROLES AND RESPONSIBILITIES

6.1 CPA Care Coordinator

6.1.1 A registered professional who will lead and coordinate complex care plans for patients subject to CPA. The Care Coordinator will be the main point of contact for the service user and will help them to navigate services to achieve best possible recovery outcomes.

6.1.2 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 and their carers; and 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.

6.1.3 Refer service users and carers to Social Services for their social care needs to be assessed under the Care Act 2014.

6.1.4 Coordinate the formulation, monitoring and evaluation of the care plan and crisis and contingency plans in close collaboration with the service user. This will include facilitating access to whichever therapeutic interventions will best

meet the service user's recovery needs and may include talking therapies, peer support, defined social or medical interventions and physical health monitoring and interventions as some common examples.

6.1.5 Ensure that the service user is at the centre of their care, has choice and is supported to identify their recovery goals.

6.1.6 Maintain a minimum of monthly face to face contact with the patient (and where appropriate their carer), increased to weekly dependant on need, in order to support the care plan and monitor mental state and recovery. Organise and ensure that a 6 monthly CPA review takes place, and that all those involved in the care plan are invited, consulted and informed of any outcomes. Through CPA reviews, identify any unmet needs and build this into a reviewed and updated Care Plan. The patient's GP is to be invited to and communicated with, about the CPA review process.

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

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

7 RECORDING CARE

7.1 Please refer to the service's Standard Operating Procedure and professional codes of conduct for guidance on contemporaneous CPA practice recording.

8 ADVANCE CARE PLANNING (ADVANCED STATEMENTS AND DECISIONS)

8.1 Advance care planning is a voluntary process of discussion about future care between an individual and their care providers. It is essential to discuss with individuals their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future.

8.2 It can form either one or both of the following: Advance Decision and Advance Statement.

- An **advance decision** means a decision to refuse specified medical treatment made in advance by a person who has the mental capacity to do so. Advance Decisions to refuse treatment are legally binding. (The Mental Capacity Act 2005)

- An **advance statement** is an advanced expression of view, feelings or wishes. They may be about preferred medical treatment or other preferences and wishes not related to care, including their medical treatment, NRT Therapy if admitted to hospital, how families and carers should be involved, the steps that should be taken in emergencies and what should be done if particular situations occur (e.g. access to their keys, bank cards and who can care for their pets).

8.3 An Advanced Care Plan must be offered to:
All service users who:

- Have already had one hospital admission or are likely to be admitted into hospital.

- All service users under CPA
- Service users who are being discharged back to primary care
- Service users who may lose capacity

8.4 Advanced care plans are to be discussed with the service users, after discharge from hospital within the 72 hour follow up and at CPA Reviews.

8.5 Advanced Care Plans are recorded within the MCA and Information Sharing and Consent Section on RiO.

8.6 The fact that a patient has made an advance decision refusing treatment for mental disorder will be one of the reasons why a decision is taken to detain them under the Act. If this was to occur, clinicians must still try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision.

8.7 Patients should be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference. However, professionals should make all practicable efforts to comply with these preferences and explain to patients why their preferences have not been followed.

9 CRISIS AND CONTINGENCY PLAN

9.1 A crisis plan is a pre-agreed plan of action which is implemented in a crisis, ensuring that the patient, their carers and professionals know who to contact when they are in crisis.

9.2 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.

9.3 A Crisis and Contingency Plan may contain the following:

9.3.1 Possible early warning signs of a crisis and coping strategies

9.3.2 Protective Factors

9.3.3 Support available to help prevent hospitalisation

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

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

9.3.6 Details of advance statements and advance decisions

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

9.3.8 Information about 24-hour access to services

9.4 Crisis and Contingency Plans will follow these principles:

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

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

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

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

9.4.5 The service user must receive a copy of the plan.

9.4.6 With the service user's consent, a copy may need to be sent to other professionals or agencies such as their GP.

10 PRINCIPLES OF RISK ASSESSMENT AND MANAGEMENT

10.1 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.

10.2 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 and the Trust's Safeguarding Policy

11 CPA REVIEWS

11.1 The purpose of CPA review meetings is to review the care plan and the patient's current recovery indicators.

11.2 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.

11.3 As best practice, CPA reviews should adhere to the following guidelines:

11.3.1 Be inclusive of the service user and their carers.

11.3.2 Be flexible regarding the location and time of the meeting.

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

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

11.3.5 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.

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

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

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

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

11.3.10 Reviews should be led by the service user where the service user wishes.

11.3.11 As a minimum, the CPA review 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.

11.3.12 All opinions must be recorded.

11.3.13 After the CPA 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. If the patient declines to sign their care plan and agreement cannot be reached to enable the patient to wish to sign, this is to be recorded on RiO as such. A copy of the care plan will be shared with the patient's GP.

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

11.4.1 CPA Review

11.4.2 Care Plan

11.4.3 Risk Assessment

11.4.4 HoNOS

11.4.5 Needs Assessment.

11.5 **CPA Reviews for service users in the community must be held:**

11.5.1 At least every six months.

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

11.5.3 Before discharge from CPA or secondary mental health services.

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

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

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

11.6.2 During long admissions at least every 6 months

11.6.3 Before any Mental Health Act Review Tribunal

11.6.4 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 7 days after discharge. The patient must still have a care plan agreed with inpatient staff on discharge outlining clearly follow up care arrangements in place.

11.7 **DNA of CPA Reviews**

11.7.1 There will be occasions where the service user does not attend their CPA review. When this occurs staff must adhere to the following guidance:

a) Follow the DNA Policy.

b) Contact the service user either by telephone and/ or writing.

c) Arrange another review with the service user.

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

e) Escalate to their Team Leader/supervisor, Service Manager and the Consultant Psychiatrist if the service user remains unengaged.

f) In exceptional circumstances after attempts to arrange a review or if the service user has DNA'ed or refused to attend the review, after Consultation with the Service.

g) Manager and Consultant Psychiatrist, it may be necessary to hold an urgent CPA Review in the service user's absence.

h) If this does occur the Responsible Clinician and Care coordinator must be present.

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

j) After the review, the care coordinator must print a copy of the revised care plan and arrange to give them a copy.

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

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

12 DISCHARGE/TRANSFER FROM SECONDARY MENTAL HEALTH SERVICES

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

13 DOCUMENTATION AND RECORDING OF CPA

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

13.2 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).

13.3 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.

13.4 Each Care Group has a RiO Standard Operating Procedure (SOP) which clearly provides a summary of the expected reporting standards. This is to be used in conjunction with professional code of conduct requirements.

13.5 Please see Appendix B for general reporting guidance, to be used alongside care group SOPs.

14 CARERS

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

14.2 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.

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

14.4 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.

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

14.6 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.

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

14.8 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).

14.9 All Carers are entitled to:

14.9.1 Have their views and concerns listened to and respected.

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

14.9.3 Be given information about CPA and care planning.

14.9.4 Know who to contact in an emergency.

14.9.5 Receive prompt and positive responses to requests for help.

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

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

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

14.9.9 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.

15 ADVOCACY

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

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

15.3 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 Coordinator under CPA arrangements.

15.4 Care coordinators 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.

15.5 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's Mental Capacity Act Policy and Guidelines.

16 MENTAL CAPACITY

16.1 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 the Trust's Mental Capacity Act Policy and Guidelines for further guidance.

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

16.3 The five key principles are:

16.3.1 Assume capacity, unless it is established otherwise.

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

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

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

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

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

16.5 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.

17 SAFEGUARDING

17.1 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, and in the appropriate section on RiO.

17.2 The Joint Agency Safeguarding Protocol will be referred to as guidance throughout the safeguarding process.

17.3 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 they need to attend the CPA review.

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

18 SOCIAL INCLUSION AND CPA

18.1 Social inclusion is a priority component in care planning. 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.

18.2 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.

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

18.4 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 may be requested for the assessment and or treatment of these clients and their families. As good practice the health worker must consider:

18.4.1 Allowing longer session times for appointments.

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

18.4.3 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.

18.4.4 Capacity to consent.

18.4.5 Physical as well as mental health needs.

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

19 TRAINING

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

19.2 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 Care Group.

19.3 CPA training is an e-learning package accessed via iLearn.

19.4 The Trust offers a variety of training which incorporates good CPA practice, which includes:

19.4.1 Clinical Risk Assessment Training.

19.4.2 Person Centred Care Planning Training.

19.4.3 RiO Training.

19.4.4 Mental Capacity Act Training.

19.4.5 Clinical Record Keeping.

19.5 A training needs analysis can be found in Appendix D.

20 PROCESS FOR MONITORING COMPLIANCE WITH THE REQUIREMENTS OF THIS POLICY

20.1 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.

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

20.3 The Trust's CLIQ check process will audit practice against a number of key CPA fields.

20.4 A yearly CPA audit is carried out across all community services in order to measure practice against this policy. Care Group action plans are reported and monitored through the Trust's Clinical Effectiveness and Outcomes Group. KPIs associated with the CPA process are monitored through the Trust's IQPR.

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

21 EQUALITY IMPACT ASSESSMENT

21.1 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. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages of the trust intranet.

22 HUMAN RIGHTS

22.1 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.

APPENDIX A WHO IS ELIGIBLE FOR CPA?

To provide clearer guidance to services so that they can better target engagement, coordination 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.

The list is not exhaustive and there are not a minimum or critical number of items on the list that should indicate the need for CPA. 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.

Indicators suggesting people are likely to need CPA are:

• **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 losses

• **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**

(Adapted from 'Refocusing the Care Programme Approach-policy and practice guidance' DH 2008)

Appendix A continued:

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 Coordinator (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
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 will be documented on a personal support plan document
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 via a social care referral. Agreed arrangements for carer involvement.	Carers identified and informed of rights to own assessment via a social care referral. Agreed arrangements for carer involvement.

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** _____

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		*

***** ***Means update RiO Records***

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		

***** ***Means update RiO Records***

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		

***** ***Means update RiO Records***

APPENDIX D TRAINING NEEDS ANALYSIS

Staff Group	**E- Learning CPA Training One off (unless in the case of changes to the national framework** **MANDATORY**
Registered Clinical Staff	Yes
Non registered clinical staff	Yes
Managerial, Admin, Domestic etc	Only for senior managers with direct client contact
Medical	Yes