Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The Care Programme Approach and Standard Care

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Contents

1 Introduction

Care Programme Approach (CPA) describes the approach used in secondary mental health and learning disability services to; assess, plan, review and co-ordinate care, treatment and support for people with complex needs, relating to their mental health or learning disabilities.

The term **Standard Care** is used in primary and secondary mental health and learning disability services to; assess, treat and review people with more straightforward needs relating to their mental health or learning disabilities.

This policy outlines the framework, principles and values of the Care Programme Approach (CPA) and Standard Care that apply to all services provided by Tees, Esk and Wear Valleys NHS Foundation Trust.

In order to provide safe, effective, person-centred and recovery focused services, it is crucial that Trust staff work in partnership with Local Authorities and other independent and voluntary agencies that support people with mental health and learning disability needs, and that health and social care is provided in partnership with service users, their carers, families and other supporters.

This policy is underpinned by, Refocusing the Care Programme Approach, Policy and Positive Practice Guidance, Department of Health 2008 London: HMSO

It supports the Trust Recovery Strategy 2014 and Harm Minimisation Framework 2014

2 Why we need this policy

2.1 Purpose

- To ensure a consistently high standard of practice in co-ordinating the care, treatment and support of people who access secondary mental health and learning disability services.
- To provide a framework and guidance for staff to aide clinical decision making about supporting people by CPA or Standard Care.
- To ensure staff are guided by the principles and values of person-centred care recovery and co-production in assessment, care planning and review, for people supported by CPA or standard care in ways that are proportionate to the person's needs.
- To set out the approach used to assess, plan, review and co-ordinate care and support for people accessing Trust services.

2.2 Objectives

- To set out the principles and values underpinning CPA and Standard Care.

- To set out the approach used to assess, plan, review and co-ordinate care and support for people accessing Trust services.
- To ensure CPA supports people individually, recognising them as a person and unique individual first, rather than a diagnosis, illness or set of problems.
- To make sure the people using Trust services are treated with respect, as partners in decision making and planning about their treatment, care and support.
- To ensure CPA is underpinned by recovery, wellbeing and harm minimisation.
- To ensure carers, family and supporters are identified, acknowledged, involved in planning care and have their own needs recognised and assessed.

3 Scope

3.1 Who this policy applies to

- All clinical employees where competency in practice of assessment, care planning and review is a requirement of their role.
- Employees whose roles include care co-ordination or lead professional and other members of the multi-disciplinary team.
- All employees in clinical services who have regular contact with service users, their families, carers or other supporters.
- Service users, their family, carers and other supporters as partners in their care.
- Other practitioners who work with service users, their families and carers through partnership agreements, interagency working arrangements, service level agreements and educational placements.
- Team managers and leadership teams who support the implementation of CPA and Standard care.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	• Ensuring there are effective arrangements for CPA and Standard Care within the Trust
Director of Nursing and Governance	• The development, monitoring and review of this policy and practice standards relating to it • Provision of appropriate training, education and supervision to support the policy standards
Senior Clinical Directors	• To support the implementation of this policy in their specialties
Directors of Operations	• Implement and monitor this policy in their areas of responsibility • Ensure that systems and processes are in place and are

	monitored to meet the standards and requirements outlined in this policy • Provide opportunities for training, development and supervision to support the policy standards
Clinical Team Managers, Ward Managers, Advanced Practitioners, Modern Matrons	• Ensure implementation of the systems and processes that are in place to monitor compliance with this policy in their areas of responsibility • Ensure all employees attend relevant training relating to this policy (section 7)
All clinical employees	• Ensure a personal awareness of the content of this policy • Implement the policy standards and procedures • Understand their role as care co-ordinator, lead professional or co-worker • Maintain individual competence in assessment, risk assessment, care planning, review, co-ordination of care or other supporting roles

4 Policy

To implement this policy Trust staff will work in partnership with Local Authorities and other agencies providing services and support to people with mental health and learning disability needs, living in County Durham, Teesside and North Yorkshire.

The detailed implementation of the principles and standards within this framework must be incorporated in each ward or team's local clinical operational policy.

This policy should be read in conjunction with any protocols developed within each locality outlining requirements specific to that area and speciality in agreement with Local Authority partnership arrangements.

4.1 Principles and values underpinning CPA and Standard Care

- Person-centred care with a genuine focus on the individual and their recovery.
- Value is placed on the therapeutic relationship between the person and the staff supporting them with recognition that they are unique with individual circumstances.
- Assessment and care planning is focused on the person's needs, strengths, preferences, aspirations and personal goals, reflecting their diverse roles and individual circumstances.
- Self-management is promoted and supported with a coaching and mentorship approach, wherever possible.
- Care planning is a shared process that involves the person in choices, decisions and supports them to seek a fulfilling life beyond their illness.
- Carers / family will be involved wherever possible in assessment and care planning (with the person's agreement) as they are usually crucial in supporting wellbeing, safety and recovery.
- The needs of carers, family and other supporters will be recognised and supported.

- Services will work in partnership with other statutory, independent and voluntary agencies to deliver care and support that is person-centred and recovery focused.
- Information will be shared but confidentiality respected at all times.
- People will be treated with dignity and respect at all times.

4.2 Care Programme Approach

There are NOT a minimum or critical number of characteristics that indicate the need for support by CPA.

The list should be used as a guide to support clinical and professional judgement when deciding who will need the support of CPA.

The rationale for decisions about CPA or Standard Care should be documented in the clinical record.

Characteristics to consider when deciding if support by CPA is needed

The person accessing services has a severe mental illness or a learning disability with a high degree of clinical complexity and support needs
There is a current or significant history of severe distress, instability or disengagement
There is co-morbidity e.g. dual diagnosis, substance and/or alcohol misuse, learning disability
There is multiple service provision from different agencies (requiring support and co-ordination); • Local Authority • Looked after Children, Child Protection • Housing • Physical care • Employment support • Criminal Justice • Voluntary and Independent sector
The person is currently or has been recently; • Detained under the Mental Health Act • Referred to Crisis services • Admitted to a Mental Health in patient ward • Subject to Supervised Community Treatment, Guardianship or Section 117 Aftercare under the MH Act 1983
The person experiences disadvantage or difficulties as a result of their; • Parenting responsibilities • Physical health problems or disabilities • Unsettled accommodation or other housing issues • Employment issues linked to mental illness • Significant impairment of function due to mental illness or cognitive impairment • Ethnicity, e.g. immigration status, race or cultural issues, language difficulties, religious practices, sexuality or gender issues

4.3 Standard Care

Characteristics to consider when deciding if Standard Care is appropriate

• The person has less clinical complexity and more straightforward support needs in respect of their mental health or learning disabilities
• The person has support from one agency e.g. the Trust and has no difficulties independently accessing support from other agencies or services.
• Risks to self and others are assessed as low
• The person is able to self-manage their health and wellbeing, either with or without support
• Agreed contact with the service for treatment or support is likely to be maintained
• People who have recovered from a complex episode of mental illness and are well supported in their community
• People who are engaged and responsive to their treatment, intervention and care plan

4.4 Role of the Care co-ordinator

This role co-ordinates the care, treatment, interventions and support for people on CPA.

A care co-ordinator is a registered health or social care professional that is competent in assessment, risk assessment and management, care planning and review of people with complex mental health or learning disability needs.

Critical functions of the care co-ordinator;

- Establish and sustain a professional relationship with the person and their carers, family or supporters, based on regular contact and partnership working
- Co-ordinate the assessment, risk assessment, care plan and delivery of treatment and support, as well as monitoring and reviewing the care plan and agreed outcomes.
- Broker partnerships between health, social care and other agencies who may offer and provide support to the person and their carer, family or supporters
- Provide interventions appropriate to the person's recovery and outcomes

Care co-ordination will be allocated to a member of the community team, who is competent to support the person's identified needs, goals and identified outcomes.

When someone supported by CPA is admitted to hospital the care co-ordinator maintains their role and contact with the person and their carer / family or supporters. They will have a crucial role in planning and supporting leave and discharge from hospital and provide follow up review after discharge.

Any transfer of the care co-ordination role must be discussed and agreed with the person and where possible their carer / family in accordance with transfer or transition protocols.

Principles of practice of the care co-ordinator

• Works in partnership with the service user, their carers/family
• Gives the person the necessary information to be meaningfully involved in decision making, choices and the outcomes they want to achieve regarding their wellbeing and recovery
• Co-ordinates, navigates and supports the person's journey through the health and social care system
• Co-develops a person-centred care plan based on assessed needs, strengths, preferences and goals
• Ensures that care and treatment is evidence based
• Ensures the needs of carers / families are addressed
• Endeavours to work in partnership with all health, social care and other agencies involved in supporting the person and their family.

4.5 Role of the Lead Professional

This role leads on the care, treatment and interventions for people supported on standard care.
A lead professional is a competent practitioner from the multi-disciplinary team who is identified as the most suitable to provide and / or monitor and review the treatment and care of service users.

A key function of this role is:

- Care planning and delivery of treatment and support, as well as monitoring and review against agreed outcomes.

4.5.1 Additional Responsibilities

There are additional responsibilities expected of care co-ordinators and lead professionals linked to CPA and standard care e.g. timely completion of outcome measures e.g. MHCT/CROM, PROM and information required for reporting purposes.

4.6 Assessment

Assessment is a collaborative process that fully involves the person in decisions about their life and supports them to achieve the outcomes they want in order to find a fulfilling life beyond their illness.

The aim is to get a full picture of the person, what needs they have and what goals and outcomes they want to achieve and should not only focus on what professionals and services can offer.

To avoid duplication the assessment and care plan should follow the person throughout their involvement with Trust services, across a range of settings if needed.

It should be assumed that the person has mental capacity unless otherwise indicated and if not arrangements made for support either from an appropriate individual such as a carer or family member or an independent advocate.

A comprehensive assessment will be completed when the person is referred to our services.

What a Comprehensive Assessment should include

• The person's capacity to be fully involved in the assessment, understand information and express their needs and wishes
• A clear explanation of the nature and purpose of the assessment
• Assessment of the person's psychiatric, psychological and mental health needs
• Risks to the person or to others
• History of trauma, including violence and abuse
• Any co-morbidity and co-existing problems
• Physical health needs and disabilities
• Communication needs (including alternative formats, assistance or interpreters)
• Substance or alcohol misuse
• Current medication
• Social care needs, social circumstances, informal support networks
• Person's parental, child care or other caring responsibilities
• Details of the person's carers, family or other supporters
• The person's personal goals and what they want to achieve
• Housing status and needs
• Financial status and needs
• Religious, spiritual or cultural needs
• Leisure, vocation, employment, training and education
• Identify the need for further specialist assessment and refer/transfer appropriately to the relevant service, agency or profession
• The need or wish for advocacy
• Any Advance decision and /or statement of wishes in existence
• The service user's need for support by CPA, Standard Care or other agencies
• To know what help / support / treatment the person wants the service / Trust to provide
• How they would like things to be different as a consequence of working with us

4.7 Harm Minimisation and Risk Management

It is expected that risk information is co-produced with the person and involves and is shared with their carers / family or other supporters wherever possible.

A risk management plan does not prevent positive risk taking, on the contrary it should emphasise recovery and wellbeing.

Harm minimisation and risk management will be clearly documented and reviewed regularly as part of the review and care planning process.

Communication and sharing of the outcomes of clinical risk assessment, formulation and management plans, with all clinicians including the GP and others involved in the person's care, including carers and family is essential. Any risks identified should be clearly documented in the person's care plan with actions to reduce or mitigate the risk.

In some cases harm minimisation and risk management may involve public protection strategies e.g. Multi-Agency Public Protection Arrangements (MAPPA), Safeguarding Children and Adults, Multi-Agency Risk assessment Conference (MARAC). There are local interagency policies and protocols in place across TEWV partner Local Authorities

4.8 Care Planning

Care planning requires a thorough assessment of the person's needs and developing a care plan in collaboration with the person is part of the process of understanding their situation, strengths, and the outcomes they would like to achieve.

It is likely to involve consideration of:

- mental healthcare
- psychological needs of the person and, where appropriate, of their carers
- physical healthcare
- daytime activities or employment
- appropriate accommodation
- identified risks and safety issues
- specific needs arising from co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder
- any specific needs arising from drug, alcohol or substance misuse (if relevant)
- any parenting or caring needs

A care plan is an overarching summary of the identified needs and agreed interventions, outcomes and support for an individual. It is a formal written record setting out what is planned, the reason, when and by whom. It exists for the benefit of the person and must be written in a format that makes sense and is meaningful to them.

The care plan serves as a communication tool between the person, their carer, family or supporters, as well as professionals and other services involved.

A recovery focused care plan should be based on the person's own priorities and goals as well as the treatment and intervention goals which address any needs that may be impeding the person's wellbeing and recovery and support them to find a fulfilling life beyond their illness.

Harm minimisation actions are of course important and will feature in care plans where harm is a serious risk, whilst still ensuring that the bulk of the care plan is about treatment, goals, etc. as described above.

What the care plan should include;

- A written record of the identified needs from assessment, the person's personal goals, treatment, interventions and expected outcomes
- Psychological and other therapeutic support to promote recovery &/or prevent deterioration
- Details about prescribed medications
- Actions to address physical health problems or reduce the likelihood of ill health
- Any risks to self or others, including carers, family and anyone providing support
- Information and an out-of-hours contact number for services and guidance on actions in the event of a crisis
- Clear information for the person, their carer / family or identified supporter about what to do in the event of a deterioration in the person's presentation
- Any specific provisions and entitlements of after-care under section 117 of the Mental Health Act 1983
- Any provisions of Direct Payments or Individual Budgets (either fully or in part linked to the Local Authority support plan)
- Contact details for the named Care Co-ordinator or Lead Professional
- Contact information for all named parties involved in providing support
- Plans for discharge, transfer or transition
- The next planned review date

Copies of the Care Plan

The care plan will be co-ordinated by the care co-ordinator for people supported by CPA, who will send to the person, their GP and anyone else with responsibility for providing support to the person including, voluntary and independent sector providers. Any exceptions to this will be recorded in the clinical record with a clear rationale.

Anyone supported by **CPA** will be offered and provided with a copy of their care plan in an accessible format they can understand

With the person's agreement their carer, family or identified supporter may also have a copy.

People supported on **Standard Care** may receive their care plan in the form of a written statement within a letter.

With the person's agreement their carer, family or identified supporter may also have a copy of the letter

4.9 Intervention Plans

An intervention plan is a detailed professional or service specific plan of evidence based interventions to deliver treatment or therapeutic support. They may be profession specific e.g. nursing, OT, physiotherapy, psychology or relate to standardised practice for specific conditions e.g. Mental Health Act, CTO, physical health, medications e.g. Lithium. They may reflect parts of care pathways and be used in circumstances where there is a time limited intervention e.g. in-patient care, respite care.

Intervention plans must relate to and link with the person's overarching care plan though do not have to be replicated in full within the care plan.

4.10 Crisis contingency and staying well plans

- Contact details of the Care Co-ordinator/ Lead Professional/Community Team telephone number
- An Out-of-Hours urgent advice contact telephone number
- GP contact telephone number
- Family and friends to call contact telephone numbers
- Useful information and contact numbers
- Any caring responsibilities (children, family or pets)
- Medical conditions or allergies
- Medication
- Preferred languages (to communicate)
- Particular ways of behaving when distressed
- What helps or doesn't help in an emergency or crisis
- Early warning signs, relapse indicators and actions

4.11 Review

Review and evaluation of the person's needs and care plan should be an ongoing process every time the person has contact with clinical staff.

Any concerns should be relayed to the care co-ordinator or lead professional.

The person or anyone supporting them can request a review at any time. If the care co-ordinator/MDT decides that a review is not necessary the reasons must recorded and explained to the person and their family.

A review must always involve the person and where possible their carer / family or supporters.

For those on CPA a formal review must take place to ensure every perspective of care and support is reviewed.

When to hold a review:

- Before discharge from hospital, prison or other residential setting
- Within 7 days following discharge from hospital
- Minimum every **6 months** for **CPA**
- Minimum every **12 months** for **Standard Care**
- When there is a change to the person's needs and individual circumstances
- When there is a significant change in care or support provided either from carer's, family or other providers.

A formal review will focus on:

• Progress and achievements
• Needs identified and any changes
• The views of the person, their carers / family
• The person's personal goals and desired outcomes
• Sharing and updating of harm minimisation information
• An update from professionals or services involved in providing care or support
• Any commissioned care and support
• Any Advanced Statements, Staying Well Plans and Recovery Plans
• Social care needs
• The need for support by CPA or Standard Care and rationale for moving from one to the other
• Community Treatment Order where applicable including progress, outcomes and after-care services
• Any provisions of after-care services under Section 117 of the Mental Health Act, where applicable
• Updating of the care plan
• Highlighting any unmet needs
• Clear identification of what needs to be in place to facilitate discharge from secondary services
• Transfer or transition to another service or between levels of care
• Discharge from mental health services

It is important not to duplicate meetings where other care processes apply e.g. Safeguarding Adults, Safeguarding Children and Looked After Children reviews. All agencies need to work together to share information and avoid duplication.

4.12 Hospital Admission and Discharge

Anyone admitted to a mental health or learning disability assessment and treatment ward will automatically be placed on CPA.

For those supported by CPA prior to admission, the care co-ordinator will retain responsibility and continue to be involved in reviews and discharge planning, and will co-ordinate specific follow-up within 7 days after discharge.

For those previously supported on standard care or unknown to mental health services, a care co-ordinator will be allocated and will attend ward formulation meetings to provide duties relating to CPA and follow-up after discharge from hospital.

4.13 Discharge and Leave from Hospital

The person, their carers, family and supporters should be fully involved in planning any leave and discharge from hospital so that support and other practical arrangements can be made.

The period around planned leave or discharge from hospital is recognised as a time of elevated risk, particularly of self-harm, therefore assessment and review beforehand is essential.

It is expected that there is close liaison between in-patient and community staff during any leave and specific follow up within 7 days after discharge from hospital. The CPA Care Plan must be reviewed prior to discharge from hospital. Only in exceptional circumstances will a service user be discharged from hospital on Standard Care

4.14 Transfers and Transitions

People can experience any number of transitions during their contact with mental health and learning disability services including transfer between services, transition between CPA and Standard Care, transfer of care to another provider or complete discharge from services.

Examples of transitions and transfers include:

Admission to or discharge from hospital or other similar establishment
Move to a different geographical location within or outside of TEWV
Containment or release from prison or criminal justice system establishment
Transition from CAMHS to Adult services
Transition from Adult services to MHSOP
Change to level of support e.g. CPA to Standard Care or vice versa
Change of Care Co-ordinator or Lead Professional
Transfer to another mental health team
Referrals to or from other services e.g. Ministry of Defence, Local Authority, independent or voluntary sector

In response to the needs of individual service users and the service, the transfer process will be initiated following discussion and care plan review with the multi-disciplinary team members, service user and carers. It is the responsibility of the care co-ordinator or lead professional to co-ordinate this and planning should involve all relevant members of the multi-disciplinary team and other services or providers of support. Any referral made to an external or internal service should clearly indicate the level of urgency.

It is important to involve the person, their carers, family or supporters in any transition or transfer so they can express their views and make informed decisions and choices about their needs, care and support.

The person's clinical record must be up to date before a transfer or transition takes place including;

- Risk assessment
- Care Plan, detailing actions to support the transition/transfer
- Crisis and contingency arrangements
- Documented communication and handover of responsibility –name of new care co-ordinator, lead professional or other and date of transfer or transition agreed
- Core record keeping documents specified in operational policies

It is expected that the person and their carer, family or supporters will have an opportunity meet the new care co-ordinator and have contact details as soon as possible once a transfer or transition has been identified. The transfer timescale should be based on the person's needs and wishes and be negotiated between all relevant parties. The care co-ordinator will lead and facilitate the transfer or transition.

Existing Transitions protocols should be referred to where relevant, e.g. CAMHS to Adult, Adult to MHSOP.

4.15 Transfers from CPA to Standard Care or Discharge from Trust Services

It is essential to involve the person and their carer, family or supporter in discussions about the level of support needed and the outcomes they want to achieve.

Every formal review should consider whether support by CPA is still needed or if discharge from services is appropriate. It is expected that the person is involved in decision making about this.

It is important that support is not withdrawn prematurely as it may be that it is the support that is contributing to the person's wellbeing.

When there is no longer a need for the person to be supported by CPA or there is a planned discharge from secondary care mental health services there must be;

- A review and handover to the lead professional (for Standard Care support) or the individual's GP if discharged back to primary care services
- A plan for support and follow up as appropriate
- A clear statement about actions to take and who to contact in the event of signs of relapse or mental health crisis.

CPA is a process and not in itself a measure of eligibility under the national minimum threshold for eligibility (Care Act 2014), therefore transfer from CPA to Standard Care will not alter or remove an individual's entitlement to the services they are eligible for or need, either from local authorities or aftercare provisions under section 117 of the Mental Health Act 1983.

4.16 Involving and Supporting Carers, Family and significant Supporters

The Trust '*Carer Support Strategy' (*2014-2017), outlines the Trust's continued commitment to supporting and improving communication with carers, families and supporters of people accessing Trust mental health and learning disability services.

A carer is defined under the Care Act 2014 as 'someone who helps another person, usually a relative or friend in their day to day life.

Carers, families and other supporters are seen as partners and a vital support to the person in their recovery and wellbeing. There is evidence that outcomes are improved when they are appropriately informed, consulted and involved in decisions about the care and treatment of the person they support.

Carers, family and supporters should be identified through the assessment process at the earliest opportunity to;

- Ensure they receive timely and appropriate information about;
    - the service, team or ward including contact details
    - accessible information on mental health conditions and treatment options
    - CPA and Standard Care leaflets
    - confidentiality and sharing information
    - how to raise concerns including PALS
    - how to obtain an assessment of their own needs
    - details of carer support groups
- Involve them in decisions about treatment and care planning to support the person wherever possible
- Seek their views about risks and harm minimisation and how best they can support the person
- Identify any risks of harm or potential harm towards themselves

- Specifically identify young carers to ensure they are referred to an appropriate service for support
- Provide information about resources, services, facilities and support groups available to support carers, family and supporters
- Offer emotional support which may include signposting to other support agencies e.g. local authority, MIND, Alzheimer's society, peer support

Carers Assessments

Anyone who provides regular and substantial care, including young people, is entitled to have an assessment of their caring, physical and mental health, leisure and occupational needs, leading to provision of their own care and support plan which is reviewed at least on an annual basis.

Carers, family and supporters are entitled to an assessment even if the person they support refuses help form mental health services.

Carers assessments are the responsibility of Local Authorities under the Care Act 2014 and Trust staff should provide information about how to access this assessment and support in line with local protocols in their area of work

Carers are entitled to an assessment even if the person they support refuses help from mental health services

Refer to appendices for local protocols about cares assessments.

With the person's agreement carers, family and supporters may have a copy of the care plan and crisis contingency plan. Every effort should be made to gain consent from the person by explaining the benefits of sharing this information, whilst respecting the person's right to confidentiality.

If the person does not give their consent to share their care plan with their carers or family then general information in relation to support, safety and wellbeing should still be provided.

Carers / families and supporters should be advised of any risks to themselves or to the person they are supporting. They should know who and where to contact if they have concerns about risks.

4.17 Advocacy and Support

It is important that a person is fully involved as far as possible in the assessment, care planning and review process within CPA and standard care. In this context this is about people understanding and retaining information, securing their rights, expressing their views, needs and wishes and being involved in decision making about their care, treatment and support.

If the person does not have capacity or cannot be fully involved in their assessment, care plan and review then appropriate support should be sought from an appropriate person or independent advocate.

Appropriate person;

- any carer or family member (who is not professionally engaged or remunerated)
- a friend
- an interpreter to address language or communication issues

If there is no one available to offer this support then an independent advocate may support and represent the person.

Section 30 of the Mental Health Act 1983 gives detained patients and those on a Community Treatment Order access to independent advocacy services, delivered by Independent Mental Health Advocates (IMHAs) and the Mental Capacity Act places a legal duty on staff to give patients who do not have capacity access to Independent Mental Capacity Advocates (IMCAs).

Advocacy services are available within local areas to assist carers in their role supporting service users accessing mental health services.

4.18 Mental Health Act 1983: Code of Practice (2015)

Support by CPA will include;

- most people who are entitled to after-care under section 117 of the Mental Health Act
- Everyone subject to guardianship
- Everyone subject to a community treatment order (CTO)

People who have Section 117 eligibility may be subject to standard care rather than CPA provided that this is indicated by their needs, progress and support.

Ref: Trust policy: Inter-Agency Section 117 Mental Health Act 1983

Because of specific statutory obligation, it is important that anyone entitled to after-care is identified and that records are kept of what is provided to them under that section of the Mental Health Act.

The ultimate aim is to maintain people in the community with as few restrictions as necessary wherever possible, to reduce the risk of deterioration of their mental health and reduce the risk of requiring further admission to hospital.

After-care services should not be withdrawn solely on the grounds that the person has been discharged from the care of specialist mental health services or the person is no longer on a CTO as may still need after-care services to prevent relapse or deterioration of their mental health condition.

For further guidance refer to the Mental Health Act 1983: Code of Practice

https://www.gov.uk/government/news/new-mental-health-act-code-of-practice

Trust policy: Inter-Agency Section 117 Mental Health Act 1983

5 Definitions

Term	Definition
Care Programme Approach (CPA)	Care Programme Approach (CPA) describes the approach used in secondary mental health and learning disability services to; assess, plan, review and co-ordinate; care, treatment and support for people with complex needs, relating to their mental health or learning disabilities.
Standard Care	Non CPA care for people accessing primary care and secondary mental health and learning disability services whose clinical needs are more straightforward and have a greater degree of self-management in their recovery and wellbeing.
Care co-ordinator	A named health or social care professional that has responsibility for the co-ordination and overview of the assessment, risk management, care plan, monitoring and review of care and support for people accessing secondary mental health or learning disability services.
Lead professional	A named competent practitioner (any member of the multi-disciplinary team) who is identified as the most suitable to lead, monitor and review the care of people accessing primary or secondary mental health or learning disability services.
Assessment	A core activity of health and social care professionals to identify a person's needs, strengths, goals and outcomes they want to achieve.
Harm Minimisation and Risk Assessment	Involves working with the service user and where possible their carer, family or supporters to help understand; history of violence, self-harm or self-neglect, their relationships, any recent losses, problems, adverse effects of hospitalisation, employment and any recent difficulties, housing issues, their family and the support that is available, and their more general contacts which could be all relevant (Best Practice in Managing Risk, 2007)
Clinical Risk Management	Involves developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. (Best Practice in Managing Risk, 2007)
Care Plan	A single overarching plan that records an overview of the total care and support agreed with the person and provided across all services, measuring and reviewing specific outcomes as well as the person's own goals for recovery and wellbeing,
Intervention plan	A detailed plan of specific evidence based interventions, agreed between the person and professional to deliver care or treatment in support of the person's care plan. Intervention plans may be profession specific; Nursing, OT, Psychology or reflecting care pathways. An intervention plan may be used initially until an overarching care plan is developed and agreed with the person.
Review	The standards set out to re-assess needs, risks, monitor progress, commissioned services, personal goals and plan ahead, in collaboration with the person and where-ever possible their carer, family or supporters; **CPA-every 6 months** or sooner if indicated or requested **Standard Care- every 12 months** or sooner if indicated or requested.

6 Related documents

- Refocusing the Care Programme Approach, Policy and Positive Practice Guidance 2008 Refocusing the Care Programme Approach Policy and Positive Practice Guidance
- TEWV Harm Minimisation Framework (draft 2014)
- TEWV Carers Support Strategy 2014-2017http://flc-intouch:35000/Docs/Documents/Strategies/Carers%20Strategy%202014-2017.pdf
- Safeguarding Adults Protocol TEWV Safeguarding Adults protocol
- Safeguarding Children Policy TEWV Safeguarding Children policy
- Confidentiality Code of Practice TEWV Confidentiality and Sharing Information policy
- Mental Health Act 1983 Mental Health Act 1983
- https://www.gov.uk/government/news/new-mental-health-act-code-of-practice
- TEWV policy Inter-Agency Section 117 Mental Health Act 1983, Ref MHL-000-000-00x
- Mental Capacity Act policy Mental Capacity Act policy
- Advanced Decisions to refuse treatment and statements made in advance TEWV Advance decisions to refuse treatment and statements made in advance policy
- Admission and Discharge of Patients from Hospital and Residential Setting Policy
- DNA Policy TEWV Did not attend (DNA) policy
- Information Governance
- Data Protection Policy 2013 TEWV Data Protection policy
- MAPPA TEWV MAPPA policy
- MARAC

7 How this policy will be implemented

• This policy will be published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing.
• To be reinforced by Heads of Service, Locality Managers, Team Managers and leadership teams for the implementation and monitoring via audit, supervision and operational management processes.
• Clinical staff will demonstrate compliance with this policy and competence in the component parts of CPA and Standard care, undertaking relevant training.
• Through coaching as part of the local induction programme for new staff.

8 How this policy will be audited

There will be an annual trust-wide audit of CPA across all specialities; this will also include an audit of transfers and transitions of care.

9 References

Refocusing the Care Programme Approach: Policy and Positive Practice Guidance. Department of Health 2008:HMSO

The Mental Health Act 1983 (amended 2007) Mental Health Act Code 1983 of Practice2008, and Mental Health Act 1983

National Service Framework for Mental Health

Effective Care Co-ordination in mental Health: Modernising the care Programme Approach 1999 Department of Health

Supporting People with Long Term Conditions: Commissioning Personalised care Planning, a guide for Commissioners 2009 Department of Health

Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services 2007 Department of Health

Care Coordination-an at a glance guide for healthcare professionals: improving care for people with long term conditions 2010 Department of Health

10 Document control

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Next review date:	30 September 2023	
This document replaces:	Care Programme Approach Policy. A framework for Multi-Agency working in Mental Health and Learning Disability Service Promoting Recovery. IA/002/v5(1) Aug 2013	
Lead:	Name	Title
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	CPA Project Steering Group	
This document has been agreed and accepted by: (Director)	Name	Title
	Brent Kilmurray	Chief Operating Officer
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	6 April 2016
An equality analysis was completed on this document on:	19 April 2016 IA-0002-v6 EA The Care Programme App	

Change record

Version	Date	Amendment details	Status
6.1	14 Mar 2018	Minor amendment to wording at top of p.15	Published
6.1	15 Mar 2019	Document under review, review date extended from 6 April 2019 to new date of 6 April 2020 to allow review work to be done.	Published
6.1	15 Apr 2020	Review date extended from 06 April 2020 to 06 October 2020.	Published
6.1	15 Mar 2021	Review date extended to 06 October 2021	Published
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