CLINICAL POLICY
Assessment and Care Management (Incorporating the Principles of the Care Programme Approach)

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This policy is currently under review to align with new NHS guidance on the removal of CPA. While it may not fully reflect the latest guidance, the core principles of good practice, such as assigning a key worker (currently care coordinator) and carrying out regular reviews remain fully relevant and applicable. These fundamental practices will continue to be prioritised and incorporated into the updated policy once finalised. Thank you for your continued adherence to these essential standards and current policy during this transition period.

Policy Number	CLP247
Version:	V13.7
Purpose:	To provide a clear framework for assessment, care planning, care coordination and overall care management that complies with CPA guidance
Consultation:	Clinical Policy Group
Approved by:	Clinical Policy Group / QAG
Date approved:	April 2022
Author / Reviewer:	James Wright / Rob Newman
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Review date:	CURRENTLY UNDER REVIEW
Audience:	Mental Health / Learning Disability Staff
Dissemination:	This policy will be uploaded on the Trust intranet under Clinical Policies and publicised on the Clinical Policy News intranet page
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust

Version History

Version	Date Issued	Reason for Change
V1	14/02/2014	First Draft

V2	16/05/2014	Second Draft
V3	22/09/2014	LESTER TOOL Updates
V4	03/12/2014	Format Amendments
V5	21/01/2015	Update
V6	04/03/2016	LD Amendments
V7	20/03/2016	Ratified Final Version – Agreed at Governance
V8	24/03/2016	Ratified Final Version – Agreed at Governance
V9	03/07/2016	Appendix A Amendments + Page 32 Addition of 7.3
V10	14/07/2016	Core Assessment Part 1 + 2 Changes + Appendix A Update
V11	16/10/2016	Adjustment to guidance regarding Crisis and Contingency plans
V12	25/11/2016	Adjustment to Section 8 – Transfer between teams and to reflect the change to services around the Crisis Care Concordat (URT)
V13	05/01/2018	Adjustment to reflect Carers support and Primary Care and Perinatal MH assessment requirements
V13.1	Sep 2019	Format Update
V13.2	Mar 2021	MHST role and function update and removal of Herefordshire services
V13.3	Apr 2022	Review Date extended
V13.4	19/08/2022	Extension to review date by 6 months
V13.5	14/06/2023	Extension of 1 year to review date agreed by the Quality Assurance Group and Clinical Policy Group, amended to remove references to Hereford and 2G
V13.6	10/05/2024	Extension to review date – Policy confirmed as sufficient to meet the needs of existing practice by Associate Director of Patient Safety, Quality and Clinical Compliance
V13.7	10/12/2024	Extension to Policy of 12 months with statement added to top of the Policy

TABLE OF CONTENTS

ABBREVIATIONS

Abbreviation	*Full Description*
CAMHS	Child and Adolescent Mental health Services
CPA	Care Programme Approach
CQC	Care Quality Commission
CYPS	Children and Young People Service
EPR	Electronic Patient Record
GCC	Gloucester County Council
GHC	Gloucestershire Health and Care NHS Foundation Trust
HALO	Electronic Patient Record System
IAPT	Improving Access to Psychological Therapies
LD	Learning Disabilities Service
MH	Mental Health
MHARS	Mental Health Acute Referral Service
MHMDS	Mental Health Minimum Data Set
PMHS	Primary Mental Health Service
RiO / EPR	Electronic Patient Record System

1. INTRODUCTION

The assessment and care management of Trust service users will follow the key principles of the Care Programme Approach (CPA) and must have service users as its focus. These principles will apply to all services provided by the Trust. These include:

- All mental health in-patient and secondary care community services in Gloucestershire.
- Improving Access to Psychological Therapies services in Gloucestershire Primary Mental Health Services in Gloucestershire.
- Children and Young Peoples Services, Gloucestershire.
- All inpatient and community Learning Disability Services in Gloucestershire Mental Health Acute Response service (MHARS).
- Crisis Resolution and Home Treatment Teams (CRHTT).
- Managing Memory Assessment Service, Gloucestershire.
- Perinatal Mental Health Team.

The principles of Care Management, as set out in this policy; focus services on the strengths, needs and aspirations of service users, to assist in improving their outcomes. Care will sometimes be provided only by a single member of staff from the Trust, but often it will be provided through co-ordinated systems of multidisciplinary and joint agency assessment and care planning. The care planning process is fundamental to the care provided by our services. It places the service user at the heart of all care planned and delivered by the Trust.

Fundamental to effective care management is service user and appropriate carer involvement (where appropriate) and co-production in the care planning process. Service users should understand what they able to expect from our services and the key principles of effective care management. Reasonable adjustments should be made to ensure the information communicated/delivered wherever possible in a way that the service user would be able to understand.

2. PURPOSE

The Trust expects services to base all assessment and care planning on the following nationally agreed values and principles:

The approach puts the service user's strengths, goals and aspirations as well as needs and difficulties at the centre, builds confidence and promotes social inclusion and improved outcomes according to the Service User's health needs.

Care assessment and planning offers support to a service user considering their individual diverse roles and needs; including family, housing, employment, leisure and spirituality, with the aim of optimising physical and mental well-being.

Service users are supported to gain and maintain control over their own care and support wherever possible. Reasonable adjustments may be required to support a service user to achieve this.

Carers can be vital to a person's wellbeing and their own needs must be recognised and supported.

The quality of relationship/communication between service user and the lead professional / care coordinator is one of the most important determinants of success.

This policy has been written to provide a clear framework for assessment, care planning, care coordination and overall care management within the Trust. It complies with national CPA guidance as well as providing a framework for the provision of services not covered by the CPA national guidance. This policy outlines how these principles will be applied within the Trust, and provides benchmark for monitoring practice against standards. Where necessary this policy outlines the differing recording needs within both Primary and Secondary care. A list of services defined as functioning within primary care is included in Appendix 3.

3. SCOPE

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy.

- The contents of the policy are mandatory.
- This Assessment and Care Management Policy applies to all staff who are employed by the Trust, and they are responsible for adhering to this policy.
- It is the responsibility of all those providing care to service users and carers, not just the lead

professional or care coordinator to ensure that all others working with service users are kept fully informed of all significant changes or events.

- The Assessment and Care Management principles are applicable to ***all*** Primary and Secondary services provided by the Trust.

This Policy endorses that working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, disability, gender, sexual orientation, race and ethnicity and religious beliefs.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of, and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best

interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).

- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. POLICY DETAIL

This policy is based on an agreed pathway referred to as the Pathway to Care in this document.

This policy describes the recording of assessment and care management processes within the Trust's health and social care notes. The majority of service users' records will be recorded using the Trust's Electronic Patient Record systems (EPR) e.g. RiO, IAPTus. Staff are required to record information in all EPRs according to the latest training guidance and system update.

6.1 Assessment

Introduction

This section covers the standards associated with assessment. It describes what should be included in an initial screening and assessment, who can complete it and the time frame standards according to the Pathway to Care process map.

All screening will be undertaken by suitable trained staff and all assessments will be undertaken by a registered/qualified practitioner as detailed in Appendix 1. In the context of the Mental Health Support Team (within CYPS) the initial screening will be undertaken by senior clinicians to ensure the service users suitability for support in that context prior to further assessment and work being completed by the Educational Mental Health Support Worker (EMHP).

The 'Pathway to Care process map' sets out the process for all service users accessing Trust services from referral through to the completion of core assessments (part 1 and 2), following the first contact with the service user. The core assessment process can take up to a maximum of 28 days. This is detailed on the process map in this document.

The process of assessment is central to planning and delivering care. It is essential that an assessment is completed by a registered/qualified clinician or practitioner who examines all factors relevant to someone's wellbeing. These include health, social, vocational, emotional, developmental, educational, cultural and spiritual needs. It is also important to remember to focus on the service user's strengths, aspirations, hopes, individual preferences and goals, ensuring the care that we offer is person centred (This is sometimes called a 360° or 'in the round' assessment).

For adults with long term serious and enduring functional mental illness, a recovery focus to assessment and the ongoing coproduction of care planning is encouraged. Where an assessment has been completed and the service user enters services, the assessment should be added to and updated throughout the service user's journey through the Trust's services and not repeated. This is particularly important when the service user is assessed by one team, and then referred to another.

Prior to the Assessment

It is best practice to contact the service user being referred to arrange a time for the assessment appointment. Wherever possible, the service user should be offered some choice about the time and possible location for this appointment.

Where appropriate, a form should be sent to the service user being referred or be readily available in electronic form via an online source, in order to complete a 'self-assessment' prior to the appointment. This provides an opportunity for a service user to think about a range of issues and the capture of key data items. it is the service user's individual choice whether they wish to complete the self-assessment or not.

Where direct booking on psycho-educational courses takes place using the online booking system, the patient through the self-selection of courses available will complete a self-evaluation and therefore through informed decision making, enlist themselves on a pre-determined course outline which will inform their care. In such cases the service will ensure that any changes in their care needs that are brought to the attention of the course facilitator are responded to. Following the completion of the self-evaluation and direct booking requirements, the service user will have entered their pre-determined course and this will be the first stage of their treatment plan in primary care services.

Who to Involve in the Assessment?

The assessment will be undertaken as either a face-to-face meeting, telephone appointment or by the use of a self-assessment tool when referring themselves using the online facility for courses (IAPT). This can be in any location, but the staff member leading the assessment should ensure that the location offers privacy, and also minimises any risk to everyone involved. If it is appropriate, in terms of age and capacity to consent, and where it is therapeutically advisable, parents, carers and anyone else directly involved with the service user's care and welfare can be involved in the assessment. at all times, the service user's wishes must be carefully considered.

If the service user is known to be pregnant, the service user's midwife should be contacted wherever possible as part of the information gathering. If the service user has recently given birth, then the midwife or health visitor must be contacted. Consideration as to whether the Perinatal Mental Health Team needs to be involved should also occur.

If it is believed that there may be a number of different needs or issues, some of which are not within the expertise of the person leading the assessment, other clinicians, practitioners or other staff should be involved in the assessment. When this happens, all involved will contribute to the final assessment and formulation, but only one actual assessment will be produced. The lead professional or care coordinator is responsible for agreeing who will take the lead on the production of this joint assessment document and the timescale for production and review. For primary mental health and IAPT an internal referral will be made to the appropriate team.

If the service user has been referred to Trust services three times within a two month period and not accepted by the assessing service, community services manager should review the reasons and rationale for the team not accepting the referral. Again, reference should be made to interface guidance included within service operational policies.

Sources of Information for the Assessment

To ensure that the assessments are of the highest quality, staff must check and review all available information about a service user from their health and social care record prior to the assessment.

Where it is appropriate to do so and consent and capacity have been considered, talking to the service user's carers, close friends and family, as well as any other health, educational, voluntary sector or social care staff involved in the service user's care can be useful.

Where it is appropriate to do and consent and capacity have been considered check with Substance Misuse Services to see if the service user is known to or receiving treatment.

Where substance misuse services are provided by external organisations, contact should be made to ensure that key information is shared.

Where it is appropriate to do so and consent and capacity have been considered obtaining forensic / court liaison service information is advised where applicable.

Self-Assessment

In IAPT services, service users use an 'initial screening' tool to navigate to self-directed resources and psycho-educational courses. In such cases the service user undertakes a self-assessment of their needs and is directed to the most appropriate resource. This will be through the use of online prompts or contact with clinical staff. Clinical staff will have received relevant training in telephone-based engagements.

For online self-referral IAPT services, at initial screening, the basic demographics and patient declared needs will inform the direction for self-help/psycho-educational material and courses. Service users will make informed decisions based on their perceived needs and the content of the course/self-help material. The patient will manage their own risk assessment and self-evaluate their current mental health and suitability of interventions. For online self-referrals to the IAPT Service, the service user completes a self-assessment, following which; the IAPT Service can offer group psychological / educational courses.

It may be necessary at times for the IAPT service to re-engage service users who have previously self-assessed and may have dropped out of treatment. Although this would take the length of treatment above the 28-day threshold for completion of the core part 2 it will only be necessary for those clients to continue with the current level of assessment based on the understanding that should the service users' needs increase then a full assessment and completion of core part 2 would be undertaken where appropriate.

Skills and Competency of the Assessor

The core assessment is an initial primary or secondary care assessment. For it to be completed adequately the person completing a core assessment must be:-

- A health or social care clinician or practitioner who is qualified and registered with approved professional bodies.

- An Educational Mental Health Practitioner (EMHP) that has successfully completed the 12 month ‘PGDip Mental Health Practice in Education Settings’ course.

Must have completed, and be up to date with, the relevant Trust training in: -

- Assessment and Care Management
- Risk Assessment
- Child and Adult Safeguarding
- Mental Health Act (if relevant to the area of practice).

Precise details on roles and functions of different professional groups are listed in Appendix 1 of this document.

Pathway to Care

The Pathway to Care process map outlines the assessment and care management pathway for all service users referred to the Trust and contains key decision points and forms the basis of this policy.

Core Assessment Process

The assessment process contains two parts:
Core Assessment Part 1
Core Assessment Part 2

Within this assessment process, there are three care management decision points to decide whether the service user should undergo further assessment, go into treatment or whether the service user should be discharged, as detailed in the Pathway to Care process map in this policy.

Decision Point 1: At the first contact appointment, part 1 of the core assessment will be completed for all service users. In all services a decision will then be made as to whether further GHC services are required. If ongoing services are required, part 2 of the core assessment will be started and completed in line with the assessing service (i.e., primary or secondary care) however, primary care services will only complete the remaining aspects of core assessment where appropriate i.e. where it is in keeping with the service users’ needs and level of complexity.

Decision Point 2: Part 2 of the core assessment may also be completed at the first contact appointment and a decision made whether GHC services are still required.

Decision Point 3: Part 2 of the core assessment may take up to a maximum of 28 days following the first contact (to allow for further information gathering or additional appointments). At this point a decision must be made as to whether to discharge, or the service user will be deemed as being ‘in treatment’.

Following the completion of the core assessment, service users will be considered as ‘in treatment’ with GHC services, even if furthermore specialist assessments are required as part of the treatment plan. The process also identifies three decision points for clinicians, to further assess, to treat or to discharge. Following acceptance into GHC services, the pathway to care defines the process for review and discharge.

For CYPS, a full CHOICE assessment must be completed within 28 days of the first contact appointment. In the context of the MHST a suitable screening will have been completed to ensure that young people are suitable to be supported by the relevant EMHP's in a school setting.

The CHOICE assessment is equivalent to completing all of the first section of the core assessment, (part 1) and some of the second section of the core assessment (part 2) as detailed in table 2. This applies for service users accessing CYPS. The *CHOICE+* assessment is sometimes required to be completed where presenting clinical needs dictate that basic CHOICE information can only be gained over a 2-3 session assessment period,
the *Partnership Assessment,* following CHOICE will include additional areas of the core assessment part 2. PARTNERSHIP will be completed when the service user is accepted for a full core assessment and ongoing treatment with CYPS.

Core Assessments Part 1 and 2 Requirements for All Services Provided by the Trust
The Tables below set out the required information to be collected for service users accessing Trust services, excluding self-referrals to IAPT group psychological / educational courses.
IAPT Gloucestershire, PMHS Gloucestershire, Perinatal mental health team and MHARS will complete a Risk Screen for all service users. Where overall risk is LOW, no further risk assessment is required. Where medium to high risks have been identified' the completion of a FULL risk assessment will need to be undertaken. If following core assessment part 2, GHC services are not required, follow the discharge procedure as detailed in the discharge section of this policy.

TABLE 1: CORE ASSESSMENT PART 1

Core part 1	**Presenting Situation form** – Complete all sections. Include - reason and background for referral. Complete carers information form	**Mental State Examination form,** including Capacity if required	**Clinical Risk Screening**	**Full Clinical Risk Assessment** proportionate to risk and presentation including Safety issues around driving
IAPT on line self-referrals	***Self-referral includes GAD-7 and PHQ-9, alongside demographic information prior to attending a course***			
IAPT Services	√		√	**Where appropriate**
Urgent Response Team (URT)	√	√	√	**Where appropriate**
Primary Care Services	√	√	√	**Where appropriate**
CHOICE for CYPS	√	√		√
LD Services	√	**Where appropriate**		√
Secondary Care MH Services	√	√		√

TABLE 2: CORE ASSESSMENT PART 2

Core Assessment Part 2	**History form**	**Personal circumstances form**	**Formulation**	Presenting diagnosis (ICD10) or provisional diagnosis	Allergies	Complete baseline outcome measure and allocation e.g. HoNOS, ROM,HEF, & GAD7, PHQ-9	Collect PROM (Patient rated outcome measure WEMSEBS)	Consent to share	Care management in Mental Health Act status	Crisis Contingency Management plan
IAPT Services	√*	√*	√	√		√	√	√		√
Primary Care Services	+	+	+	+		+	+	+		+
CHOICE for CYPS	√					√				√
PARTNERSHIP for CYPS		√	√	√	√			√	√	√
LD Services	√	√	√	√	√	√		√	√	√
Secondary Care MH Services	√	√	√	√	√	√	√	√	√	√
	* Next of kin	* Gender & ethnicity								

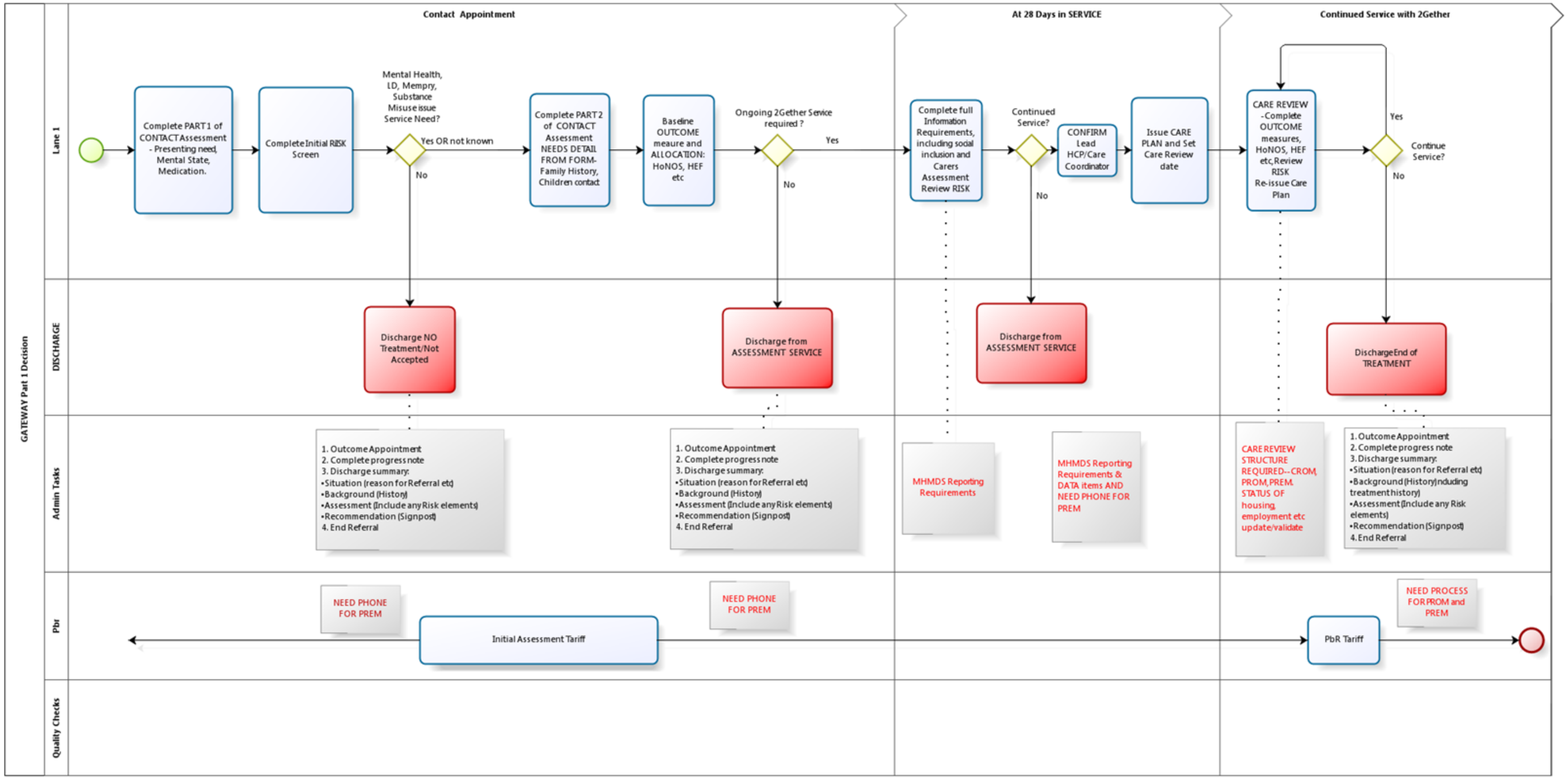
*Within IAPT services the above data is the minimum to be gathered within the respective sections in order to be compliant with the guidance included within this policy.

#Within all Primary Care and IAPT services the Crisis Contingency Management plan will be included within the Care plan letter sent to service users.

+Within Primary care services all information marked with + will be completed where clinically appropriate

NB. For details of which services are regarded as being primary care focussed, please see Appendix D. with the exception of CYPS and CAMHS

PATHWAY TO CARE



On-Going Services Required
With the exception of IAPT services, service users not discharged within 28 days of the first contact appointment will be considered to be 'In Treatment' with GHC services.

Following completion of the core assessment part 1 and where appropriate part 2, a lead professional/named worker (the latter for IAPT, PMHS, MHST and perinatal mental health) or care coordinator needs to be identified. At this point, a care plan is developed with the service user and they are given a copy. Where a treatment intervention does not have a fixed number of sessions (PMHS/IAPT short term engagement) or exceeds 4 weeks a care review date is set.

Consent to Sharing information
Effective, seamless care is based on all those involved with someone having access to the right information. The service user receiving support, and/or others may be put at risk if this information is not provided.

Where information is shared with others, they also have a duty of care to ensure that this information is protected. The Trust may ask for evidence that this has been done, and if dealing with a partner agency, may ask to see copies of their policies and procedures.

The Trust will ensure that service users are aware of how we hold their information, what we use it for and how they can have access to copies of it. (For further details, see the Trust policy on the Data Protection Act 6 and Subject Access request).

We often have to 'share' information about service users receiving services with a number of different people. These may include family, friends, neighbours, and professionals from organisations such as social services, schools or from the voluntary and community sector. It is important that the service user's views and wishes about what can be shared, and with whom, are properly recorded. This is called 'Consent to Share Information' and there is a distinction to be made between general information about the service user's wellbeing, information about the service etc and sensitive, confidential information about the service user's current mental health and progress.

The standard position with regard to sharing information with families and carers is that clinicians are expected to do this unless the service user withholds their consent. This is because sharing information and communicating effectively:

Helps families and carers to support the service user better and promotes their recovery and wellbeing.

- Creates relationships and communication channels that can improve shared understanding between teams and families, harnesses carer expertise and reduces the risk of relapse or harm for the service user.

- Supports carers and families to maintain their own wellbeing and reduce isolation, anxiety and exclusion.

Staff should discuss with service users how the Trust shares information with family, friends and carers, asking about:

- How they would like to be involved.

- What the family know already.

- Information that can’t be shared or concerns the service user may have about families having information.

Service users should know that clinicians will usually try to speak to involved families and carers about their own perspective of the situation and the family’s support needs for themselves. Clinicians will agree with the service user personal information that can be shared with carers in advance through the consent to share process.

Adult service users and those young people deemed to be Gillick competent, have a right to confidentiality. In principle, younger children also have the right to confidentiality but the parent(s) with legally defined parental responsibility are able to make decisions on their behalf. Information sharing with anyone not directly involved in the service user’s care, must be done in line with the principles outlined in ‘Confidentiality: NHS code of Practice’. This is shown below along with further information relating to sharing of information, from the leaflet ‘How we handle your information’. Individuals are entitled to be advised:-

- whether any personal data is being processed

- given a description of the personal data, the reasons it is being processed, and whether it will be given to any other organisations or people

- given a copy of the information comprising the data; and

- given details of the source of the data (where this is available).

Carers have their own right to confidentiality and can ask for information they provide to be kept confidential from the service user. Where a carer shares confidential information about themselves, this should be stored in a separate carer record (See section 6.5 below).

Documenting Consent to Sharing Information
A service user’s wishes, network and situation may vary on a regular basis. Therefore, consent to sharing information needs to be a dynamic rather than fixed-point process.

As a minimum, Information needs to be collected at the following points:-

- *When there is specific information to be shared, such as distribution of care plans, or sharing of information with other agencies.*

- *When someone is admitted to an inpatient setting, a signed copy will be saved within the health and social care records and reviewed regularly throughout the inpatient stay.*

This information needs to be checked and updated at each contact with the service user, with a minimum at cluster / care review.

This information needs to be clearly labelled as ‘consent to share information’.

Consent to share will be recorded in the health and social care records, within the progress notes or a form can be used which may be signed by the service user if felt appropriate. If a form is used, a record of the consent must be recorded in the progress notes.

Where a service user states that information should not be shared with a close family member, agency or another person who has a legitimate need to be kept informed of some aspect of his/her health, mental health workers are required to: -

- Ensure that the person has considered the risks and benefit of the decision without seeking to influence;

- Regularly revisit the service user's wishes with them to ensure they reflect their current viewpoint;

- Document these discussions in the health record;

- Continue communicating with carers about their own needs and observations even when there is no consent to share about the service user.

NOTE: This does not prevent disclosures where we have legal duty to disclose and cooperate.

Consent to share is not only a dynamic process; it is also a nuanced term which should not be explored in an all or nothing context. It is good practice to differentiate sensitive information with the service user that they do not want to share and information which can be shared, often to the benefit of the service user. For example, it is not uncommon for service users to want to keep a period of substance misuse confidential from their family and carers but still be happy to include them in care planning to return home following an admission.

Where there are explicit instructions not to share sensitive information with a carer, the Trust will still offer (and document) the opportunity for carers to share information they see as important with clinicians and explain why information is not being shared. If it would compromise the therapeutic work being undertaken with the service user receiving treatment so that the lead professional or care coordinator cannot liaise with and support the carers, another member of the staff team should be identified to do this, as set out by the Mental Health Act Code of Practice.

Sharing Information and Issues of Capacity

There may be occasions when a service user may not be considered to have capacity to make a decision about the sharing of information. In these situations, it is possible to share information under the Best Interest principle of the Mental Capacity Act.

Where capacity issues exist relating to the sharing of information, Consent Guidelines for Learning Disability provide a useful guide to assessing capacity and relate to the Mental Capacity Act 2007.

A service user is presumed to have capacity unless he/she is:

- Unable to take in and retain the information especially the likely consequences of disclosing or not disclosing;
- Or is unable to believe the information;
- Or is unable to weigh the information in the balance, especially the likely consequences of disclosing or not disclosing, as part of a process of arriving at a decision;
- Is unable to communicate back in a way which demonstrates comprehension.

It must be remembered that:

- Any assessment to a service user's capacity has to be made in relation to a particular request to share information;
- Capacity in an individual can be variable over time and should be assessed whenever the issue of information is raised;
- Every effort should be made to ensure that the request for consent to share information was made using a range of communicable means;

All assessments of an individual's capacity should be fully documented in the health and social care record and clearly labelled 'consent to share information – capacity assessment'.

An advanced statement made when the service user has capacity, to indicate their wishes about information sharing should capacity be lost can be helpful to determine best interests. This should be uploaded to the relevant EPR and its existence recorded in the Personal Safety Plan. Further information can be found in the Trust policy 'Advanced Care Planning (CLG170)'.

Assessing Spirituality

Other aspects of assessment are outlined in specific policies; however, spirituality is not and therefore, guidance is included here as part of the assessment process.

There is evidence that people who have spiritual awareness have better mental health. Spirituality can play a part in helping service users live with disability or recover from mental health/substance misuse. It is important that staff understand how they can offer spirituality as part of the support for the service user.

One definition of spirituality is as follows:

"In Health Care, spirituality is identified with experiencing deep seated sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration and wholeness".

The Trust wants to help service users to recognise what gives them hope, value and purpose, to give them access to relevant and appropriate spiritual resources and enable them to explore spirituality as they choose.

To help the Trust meet its commitment, the following questions are to be asked of all service users, excluding CYPS and CAHMS. When a service user answers "yes" to question 4 contact is made with the relevant spiritual leaders.

Questions are as follows:

- Is faith (religion or spirituality) important to you in relation to the services you receive?
- Has faith been important to you at other times in your life?
- Do you have someone to talk to about religious/spiritual matters?
- Would you like to explore religious/spiritual matters with someone?

Other aspects of assessment are outlined in specific policies.

6.2 Care Levels

Introduction

There are two levels of care management offered to service users which is proportionate to the intensity and complexity of support required. These are detailed in Appendix 2.

Standard Care:
This is the care level where a lower intensity of support is needed; care will be facilitated by a lead professional/named worker (the latter for IAPT/SM services and MHST).

All service users accessing primary care will be managed by a lead professional/named worker.

For CYPS, children and young people accessing level 2 primary care services will be managed by a care coordinator.

On CPA
Where service users require more intensive support and / or there are medium or high levels of risk involved, they will be allocated a care coordinator who will manage their care. This level of care equates to 'on CPA'.

All service users admitted to any inpatient services will be 'on CPA' on admission and the level is then determined upon review prior to discharge'. (CPA and Care review handbook, 3rd Edition, 2008)

All individuals referred, assessed and accepted into the Trust's services for secondary care will be allocated either a lead professional or care coordinator.

Service users in secondary care may require either a lead professional or a care coordinator to facilitate their care depending upon complexity and level of risk.

All service users have a right to an assessment of needs, the development of a plan for treatment and care and a review of that care.

All service users should have access to high quality evidence-based services.

Lead Professional / Care Coordinator Allocation
All service users accessing primary care services or IAPT will be allocated a lead professional/named worker.

For CYPS/CAMHS, children and young people accessing level 2 primary care services will be managed by a care coordinator.

All service users accessing secondary care services will have either a lead professional or a care coordinator.

A band 5 or above clinician or practitioner; as detailed in Appendix 1, can act as either a lead professional and/or a care coordinator, depending upon the care level (e.g., 'standard care', or 'on CPA') of each service user on their caseload.

The criteria for allocation in secondary care is as follows:

Lead Professional – Standard Care:
The service user would be assessed as having:

- Minimal needs of low complexity in Mental Health Services

- Low risk to themselves or others
- Low intensity of support required from Trust services or support is easily organised and largely provided by a single trust worker.

The majority of service users supported within primary care would be generally on this level of care.

Care Coordinator – 'On CPA':

The service user would be assessed as having:

- Moderate to high levels of care needed from Trust services
- Require multi-agency support; active engagement; intense intervention; support with care coordinator is needed
- Severe mental disorder (including personality disorder) with high degree of clinical complexity meaning high support needed from Trust services
- Medium to complex mental health / learning disability needs meaning high support needed from the Trust
- Assessed as having medium to high risk factors
- Suicide, self-harm, harm to others
- Current or potential risk(s), including:
- Suicide, self-harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self-neglect/non-concordance with treatment plan
- Vulnerable adult; adult/child protection e.g. exploitation e.g. financial/sexual
- financial difficulties related to mental illness
- disinhibition
- physical/emotional abuse
- cognitive impairment
- child protection issues
- Current or significant history of severe distress/instability or disengagement
- 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 or referred to crisis/home treatment team

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

- Experiencing disadvantage or difficulty as a result of:
    - Parenting responsibilities
    - Physical health problems/disability
    - Unsettled accommodation/housing issues
    - Employment issues when mentally ill
    - Significant impairment of function due to mental illness
    - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices);
    - sexuality or gender issues
    - Significant barriers to health and wellbeing exist and significant support is needed.

6.3 Managing Care and Interventions

Managing and Co-ordinating Care

In all Trust services, including PMHS and perinatal mental health services, care will be managed or coordinated by either a lead professional or a care coordinator, or for IAPT and MHST a Named Worker.

Once a service user has been assessed and accepted into care, they will be allocated a lead professional/named worker or care coordinator in accordance with their allocated care level.

Under national guidance for mental health services in England, the publication, Refocusing the Care Programme Approach (2008)2, defines the term 'Care Coordinator' as applying to service users whose care level is 'on CPA', and the term 'Lead Professional' is used for someone on 'Standard Care' assessed as needing primary or secondary care services.

Role of the Lead Professional or Named Worker when Providing 'Standard Care'

The Department of Health's published National Guidance for Mental Health Services. The document named; 'Refocusing the CPA' introduced a new role of Lead Professional/ Named Worker for those who do not need CPA. The Lead Professional has: *'The responsibility for facilitating the delivery of care to the Service User who has been identified as having low complexity needs and has contact with only one agency; this will be the person identified as being most appropriate from that agency.'*

The lead professional can be a qualified registered clinician / practitioner or a non-professional practitioner in line with the details outlined in Appendix 1. Whilst an unqualified worker may carry out straightforward day-to-day care, the responsibility to assess, develop plans and review the care provided will remain with the lead professional as set out in Appendix 1.

The lead professional must document a plan of care in the health and social care notes. The information recorded should be proportionate to presenting need.

For service users accessing mental health services, where appropriate a copy of the electronic care plan should be given to service users on how their treatment and care will be carried out and delivered.

For other services provided by the Trust, (e.g., Primary Mental Health and Perinatal Mental Health Services), a letter to the service user will be copied to the GP/referrer and will suffice to communicate how treatment and care will be delivered, by whom and when. This should be offered to the service user with an explanation that sets out the plan for their care.

A review of all aspects of the individual's needs and risks, covering the same range of issues as the initial assessment, must take place annually and be recorded as such in the health and social care notes. At review, the lead professional will consider the following options:

- Discharge from services
- Change in care level
- Transfer to another team or agency

A summary letter of the review to the service user copied to the GPs/referrers will provide evidence that a review has taken place. This review will then be recorded in the health and social care record.

Where care is delivered subject to Section 117 of the Mental Health Act, it will commence with the care level of 'on CPA'. When it becomes established, is straightforward and involves only one agency, then following review, standard care may be appropriate. Any plan to discharge from Section 117 must be preceded by a review of both health and social care needs and must be agreed by both health and social care agencies in accordance with locally agreed procedures.

Role of the Care Coordinator when Providing Care for Service Users 'on CPA'

The term 'Care Coordinator' is specific to the service user who is 'on CPA'. The Care Coordinator coproduces and reviews regularly the care plan with the service user. Others who deliver elements of the care package must not be called Care Coordinators.

A service user 'on CPA' can only be care coordinated by a registered /qualified practitioner in line with the standards outlined in Appendix 1.

For all professions and job roles, the following key principles apply:

- The professional must have completed and be up to date with key Trust assessment and care management training
- They must receive regular clinical / professional supervision
- They will receive regular case load supervision
- If they are on a preceptorship or not professionally registered, they must have a named case supervisor who will oversee their work.

The Care Coordinator will:-

Carry out or co-ordinate the on-going assessment of the service user's needs and associated risks, involving the service user as fully as possible, in the co-production of the care plan, taking into account the views of carers and of other agencies e.g. probation, housing, voluntary sector;

Write a care plan; detailing the service user's needs and how they will be met service users must be included in the formulation of their care plans, which should be clear, intelligible with reasonable adjustments made. The service user should always be offered a copy, unless the service user does not have capacity to make decisions about their care or treatment; or if it is deemed not in the service user's best interest to be offered a copy of their care plan. This will be subject to regular audit.

Commission services and secure funding if appropriate. The option of direct payments as a way of meeting any eligible social care needs should be offered at every assessment and review meeting.

Act as a first point of contact for the service user, carer and other professionals.

Ensure that an out-of-hours contact number is specified in the care plan for service users and carers.

Be responsible for co-ordinating the efforts of others in delivering the care plan.

Ensure that regular contact is maintained with the service user and that the care plan is in operation and relevant to the service user's current needs.

Work with the service user to make contingency plans and implement as necessary, monitor the overall care plan and call reviews as agreed, or when the need arises;

Ensure that all relevant information is communicated to:

- Psychiatric inpatient health and social care professionals during admission
- Acute inpatient health and social care professionals during admission
- Wider health community where practicable
- Distribute the care plan details to independent sector providers as appropriate and agreed.

Maintain contact with the service user during any in-patient or CRHT episode and continue to act as care coordinator.

Share information with carers, having due regard to the service user's wishes.

Where possible, ensure that when a service user moves out of the area appropriate liaison with receiving authorities takes place.

Be responsible for maintaining an up-to-date risk assessment and management plan. It is a team responsibility to ensure timely and accurate information is communicated to the care coordinator to up-date the risk assessment and management plan.

Care coordinators are responsible for identifying any person who provides regular and substantial care to someone on CPA.

Care coordinators are responsible for advising people who provide regular and substantial care to someone 'on CPA' of their right to assessment in their own right.

Care Coordination in the Crisis Resolution and Home Treatment Teams (CRHT)
Under national CPA guidance, a service user accepted into treatment by a Crisis Team (CRHT), automatically moves to 'on CPA'.

If the service user is already 'on CPA', their existing care coordinator will remain unchanged.

If the service user is on ''Standard Care'', but the existing lead professional has the required qualifications to care coordinate someone 'on CPA' according to Appendix 1, the care coordinator role will be with them.

If the service user is 'on CPA', but the lead professional does not have the required qualifications to care coordinate someone 'on CPA' according to Appendix 1, a new care coordinator must be identified. If the service user is: –

- Receiving care from a team that does care coordinate service users 'on CPA', a new care coordinator from that team will be identified as a matter of urgency, and the previous person should remain involved to ensure continuity of relationship.
- Receiving care from a team that does not care coordinate service users 'on CPA', then the CRHT will provide an acting care coordinator. In this case as soon as practicable, a discussion needs to take place between the CRHT and the referring team to identify whether the service user is going to need additional support from the referring team once the CRHT episode has been completed. If this is the case an urgent referral to an appropriate service will be made involving both the referring team and CRHT.

Where a service user is referred to the CRHT directly and is not open to another secondary care service, the CRHT must provide a temporary care coordinator. In all cases where the CRHT provides care coordination, this should not be for less than 7 days and never more than 14 days. This should be reviewed post 14 days.

Care Level and Mental Health Care Clusters

Adults receiving adult Mental Health Services from the Trust have a range of differing needs and conditions. The majority of these conditions are grouped together in a nationally agreed set of 'Care Clusters'. Each care cluster has had an identified, anticipated level of CPA. This is shown in Appendix 2 together with which professions and roles might care coordinate.

Care Planning

The care plan is an essential part of organising and delivering care and support to a service user receiving services. It identifies the range of strengths, hopes and needs that a service user may have the details of how these will be addressed, and who will be responsible for each item.

Care plans exist for the benefit of the service user using the service, and should be based around their needs, not around the ability of the service to provide the services.

Regardless of care level, everyone receiving care should have as part of their care plan, a crisis relapse and contingency plan; however, this will vary depending on where within the Trust the service user is currently being supported. Essentially, the following guidance will be followed in relation to this:

- All service users supported in primary care services will receive a care plan letter which will include a Crisis and Contingency planning section.
- All service users supported within secondary care will have a Crisis and Contingency form completed and saved within the Crisis and Contingency planning section of the electronic patient record. Completion of this will form the basis of a personalised Crisis and Contingency plan which will be included as part of the service users current care plans and recorded within the appropriate section of the care record.

Where a service users risk has been reassessed and it has been rated as moving from Low/Medium to High, consideration should be made as to whether this will have an impact on the current Crisis and Contingency plan. The Risk Management Care Plan should also be revisited to verify if there is a need for this to be adjusted in line with the current assessment.

For adult Mental Health Services (excluding PMHS and IAPT), care plans must also include the approved elements of what is required to meet the standards for the identified care cluster.

In Primary Mental Health Services depending on the duration of the treatment then it may be appropriate to provide a documentation plan of care or document the interventions in a letter to the service user.

Every service user who has been assessed and is currently receiving support and treatment must have a current care plan. This will be routinely monitored.

Where a Family and Household Form has been completed and a dependent child has been identified, a dedicated care plan needs to be created that outlines the support that the child and family will be provided with to ensure the needs of the child are met.

Service users must be offered a copy of their care plan in accordance with the service user's capacity, and if it is in the service user's best interest to do so. Where service users are judged to have capacity and it is deemed appropriate, the service user must also be given the opportunity to sign their care plan to show that they agree to it.

Where a service user is being treated in the community, the care plan should be written by the service user's lead professional / care coordinator with the involvement of the service user. The care plan should be sent to the service user's GP, and anyone else involved in the service user's care, subject to their agreement (see also section on sharing information and issues of capacity).

Where a service user is an inpatient, the care planning should be led by the service user's named nurse or other professional with involvement of the service user.

Care planning will be completed in the health and social care records.

As some service users may have differing communication needs, versions of the care plan can be produced in different formats according to the service user's communication needs in support of the main care plan. For example, the care plan could be produced in large print, easy read, picture format or in the service user's preferred first language.

In supporting patients to make informed decisions about their care, information regarding treatment options including risks, benefits and alternatives will be documented in their health and social care notes.

Consenting to Treatment and Care Plans
It is essential that as is clinically appropriate, we ensure that service users are involved in, and agree to their planned care. (This should not be confused with demonstration of consent under detention of the Mental Health Act).

Service users can be confident that their human rights are respected and taken into account.

Service users who have capacity to consent to mental health care and / or treatment as identified in their care plan:

- Should give consent to examination, care, treatment and the support they receive;
- Understand and know how to change any decision about examination, care, treatment and support that has previously been agreed.

Where a service user is assessed as not having capacity to consent, appropriate processes should be followed in line with the Mental Capacity Act or Mental Health Act as applicable. For children appropriate processes should be followed. Capacity assessment is incorporated within the care cluster care plans.

Content of the Care Plan for Someone with a 'Lead Professional'
The care plan for service users who have a 'Lead Professional' receiving standard care will reflect the type and duration of service provide.

In IAPT, the plan of care will be agreed as part of the agreed intervention e.g. Attendance at a group programme, Level 1 or Level 2 interventions.

In Primary Mental Health Services depending on the duration of the treatment then it may be appropriate to provide a documentation plan of care or document the interventions in a letter to the service user.

In other services, the provision of a detailed care plan or the documentation of the interventions in a letter to the service user needs to be proportionate to the treatment and its duration.

When a care plan is provided for an adult accessing secondary care mental health services, a template care plan with the recommended interventions and standards will be created and individualised as required.

Content of the Care Plan for Someone with a 'Care Coordinator'
All care plans must include the following, where appropriate:

- Name of their Care Coordinator and how to contact them
- The name of anyone else involved in their care and their contact details
- The Care Level
- The service user's strengths, hopes and primary needs, the interventions being planned together with the expected outcome
- Service user and if appropriate carer's view of the care plan
- A record of all the actions agreed to meet the goals
- A clearly description of the time scales for actions to be completed
- Details of any medication, dosage, frequency and method of delivery
- If appropriate any issues around supporting areas of life that matter to the service user, for example, parenting, vocation, finances, religion
- Any physical health concerns or disability
- The date of the next care review
- Details of any other agencies or staff involved
- Any early warning signs or relapse indicators
- Crisis and contingency arrangements, including who to contact in an emergency
- Any arrangement for managing risk
- How to respond if the service user misses an appointment or contact
- A crisis, relapse and contingency plan including –
    - who the service user is most responsive to and how to contact them
    - any strategies that have worked previously
    - any agreed strategies, interventions or advanced decisions including changes to medication, admission etc.
    - who will care for dependants and any animals
    - who can be involved and their contact details
- Additional support required for social inclusion and contributing to hope and well being
- Needs associated with faith, culture, gender, ethnicity or disability
- Referral to other interventions indicated for the service user/care cluster, such as psychological therapy
- Any specific issues around parenting/ caring the any needs of the child(ren) or those being cared for.

Adults accessing mental health services within the Trust will be allocated a care cluster. It is expected a template care plan with the recommended interventions and standards will be created and individualised as required.

The service user's consent should still be sought and documented in the usual way.

The care plan should include details of the interventions set out in the appropriate care package and the review date should comply with the relevant care cluster review date.

Care plans must be produced using the core care planning functions on the Health and Social Care Record(s). A copy will be given to the service user receiving care and support. Where appropriate to their needs, an easy read summary version of the care plan will be produced and given to the service user.

Care Plans and Copying Letters to Service Users
The initiative to copy clinicians' letters to service users is part of the government's policy to increase service user's involvement in their care and treatment. All letters written from one clinician to another should be copied to service users as of their right, unless there are strong and justifiable reasons not to do this. This applies to all staff.

For those service users who are seen only in an outpatient clinic or who have care provided by a lead professional where a care plan is not required, the letter written will be addressed to the service user, copied to the GP and will represent a care plan. A copy of this letter will additionally be recorded in the service user's health and social care record.

6.4 Care Review

Review of Care
One of the essential elements for the service user receiving prolonged treatment and support from the Trust is that their care be reviewed. Every time the service users' care is reviewed, and a new plan of care is developed, these should be recorded as a CPA review for service users whose care is managed by a care coordinator. For service users whose care is managed by a lead professional, this will be recorded as a care review.

In addition to the national mandated requirements for everyone receiving treatment to have a review at least once every 12 months; the Trust has a number of other standards as set out in appendices.

Copies of the review should be given to the service user unless there is a clear documented reason why this has not happened.

Purpose of the Review
The purpose of a Care Review or Cluster Review is to consider:

- Progress the service user has made
- The view of the service user, carer and professionals
- How the service user has responded to services being provided
- Reassessment of risk factors (completion of a full risk review as detailed in the Trust's Assessing and Managing Clinical Risk and Safety Policy)
- Ways in which their needs may have changed
- If the needs have changed, the extent to which the care plan (including the crisis and contingency plan) requires amending.

Frequency of the Review
The national minimum is that anyone receiving treatment must have their care reviewed at least once every 12 months (CPA national guidance). In practice, care is reviewed more frequently than this and at the following times: -

- If the service user requests it
- When the service user’s care cluster package indicates a review (see appendices)
- If there are significant changes in the service user’s mental or behavioural state – positive or negative
- Significant changes in their social or vocational situation
- Before discharge from an inpatient unit
- If a Community Treatment Order is being removed or section 117 aftercare is being discharged
- When transferring from one team to another
- When relocating out of area.

Conducting a Care or Cluster Review Meeting
A service user’s care or cluster review meeting can be informal or formal according to the needs of the service user being reviewed.

If the service user’s care is being managed by a care coordinator, they must have a review meeting that meets the national requirements in accordance with the Refocusing the Care Programme Approach (2008)2 National Policy.

The review of care / care cluster should follow the same principles whether on ‘Standard Care’ or ‘on CPA’.

If the service user is on ‘Standard Care’, the review process is still followed but can be carried out more informally or even completed as an ad hoc review following a discussion.

Formal Review
For a *formal* review the service user should be: -

- Consulted on who attends, offered the services of an advocate (where there are issues relating to the Mental Health Act)
- Involved in deciding the location of the meeting
- Involved in deciding the timing of the meeting
- Given a letter for the reason for the meeting and the place and time of its occurrence
- There may be occasions where this is not possible i.e.-
- If the service user’s mental health would be compromised
- Where there are legal obligations for certain people to attend
- There are obligations under the Mental Health Act e.g. Sec 117
- If significant risk issues are present
- When they are a young child without Gillick Competency.

Where the service user is not involved in the meeting, the lead professional or care coordinator must ensure that it is clearly documented why this was necessary, reasonable and in the best interests of the service user and or carer. Where a service user requires several meetings, every effort should be made to combine them e.g. MAPPA / CPA / Sec117 / Discharge from an Inpatient Unit / CAF / Statement preview. Prior to the meeting and where appropriate a copy of the current care plan should be given to the service user so that they can review it.

Involving Carers in Reviews

Wherever possible the service user's carer or parent/s if a child/young person, should be involved in the care review. Where the service user receiving support and treatment does not wish them to be involved, they can still be asked to contribute to the review in writing or another suitable way.

The care coordinator must ensure that carers and families should be advised of any risk to them, or to the service user using the services which may arise from the treatment / care plan.

Further guidance on working with carers please see part 6.5 of this policy.

Documenting a Care or Cluster Review

Details of the formal review need to be fully documented in the health and social care record.

The Care Review field in the health and social care record, must also be populated with a minimum of the following information:

- Location
- People present
- Time and date of meeting
- People invited but not able to attend
- People who contributed but did not attend
- The service user's view
- The carers view
- What worked well
- What didn't work so well
- Date of next review
- Any unmet needs
- Any other comments.

REVIEW OF CARE

Care and Cluster Reviews	Primary MH Services	Secondary MH Services	CAHMS / CYPS Services	LD Service	IAPT	MHARS	Perinatal MH
Marital Status	√	√	if appropriate	√	√	√	√
Social Inclusion	√	√	√	√	√	√	√
As relevant: Cluster assessment/Allocation (HoNOS) Outcome Measure (ROM's, HEF)	√	√	√	√	√	√	√
Consent to share	√	√	√	√	√	√	√
Risk Review	√	√	√	√	√	√	√

Allergies	■	√	√	√	■	√	■
Care Level	**If care level is changed**	√	√	√		√	**If care level is changed**
Review care plan	√	√	√	√	√	√	√
Outcome Care / Cluster Review	√	√	√	√	√	√	√
Outcome appointment in the health and social care records	√	√	√	√	√	√	√
Make a clinical entry in the health and social care record	√	√	√	√	√	√	√
Letter and copy of care plan to Service User and copy to GP	√	√	**Dependent upon Gillick Competency**	√	√	√	√
Presenting Condition	√	√	√	√	√	√	√

When Service Users Do Not Attend (DNA) and Approach to Missing Persons

Loss of Contact with a Service User Receiving a Service

As a routine part of the assessment and treatment of the service user, the lead professional/care coordinator should consider whether there are any indications that the service user may disengage from services. Any such concerns should be documented in the progress notes and a specific management plan including timescales should be developed and recorded in the Crisis and Contingency section of the service user's care plan.

If a service user does not attend an arranged appointment simple steps such as, attempting to contact the service user by phone must be taken. If there is still no contact, the lead professional / care coordinator and the team manager must decide whether there are any risks or concerns relating to the individual or others.

If there are no Risks or Concerns

Where a service user's care is being managed by a lead professional / named worker, a letter should be sent to the service user asking them to contact the lead professional / named worker to discuss further involvement. This letter must be sent within 48hrs of the missed appointment/contact. If the service user does not contact the team within 14 days, the team leader will have the discretion to discharge subject to previous history of engagement.

Where service user's care is being managed by a care coordinator, letter should be sent to the service user asking them to contact the care coordinator to discuss further involvement. This letter must be sent within 48hrs of the missed appointment/contact. If the service user does not contact the team or the care coordinator within 7 days, they should: -

- Document all actions taken to re-establish contact
- Inform their supervisor /manager
- Contact the referrer/ GP to discuss the case and decide if any action is required or the service user should be discharged.

Within IAPT, as a result of the 14 day target set by commissioners, an opt in process has been established which includes sending letters to service users within the 14 day time period. This generally follows a nursing triage If the service user does not respond to an initial phone call following triage, then a 7 day letter will be sent requesting opt in. If the patient has not opted in within that 7 periods the service user will be discharged. Although not strictly DNA it does reflect the need for service users to opt in.

If there are Risks or Concerns to Self or Others then the Following Should Occur:
Follow the agreed service user's Crisis and Contingency plan.

The Missing Person's procedure (CLPr102) should be referred to and used if the service user is an inpatient, a child or a vulnerable adult.

The service user's last known address should be visited. If unsuccessful the service user's regularly visited places should also be visited.

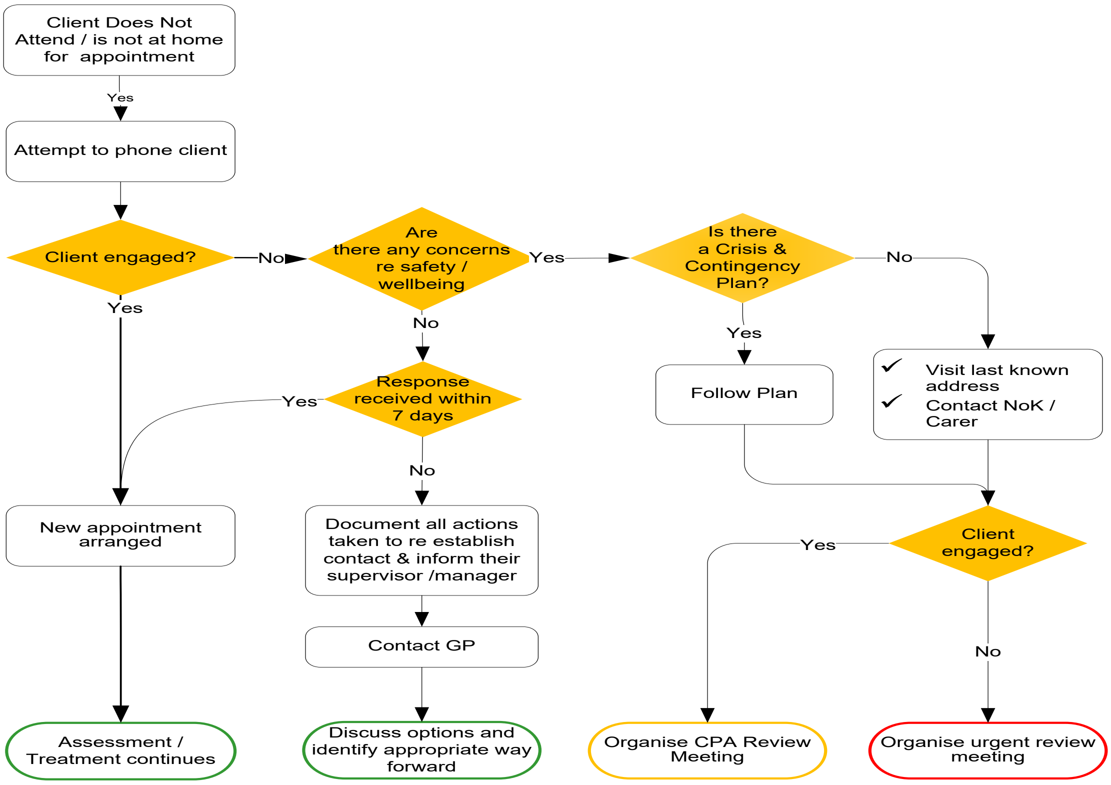
Contact should be made with the service user's nearest relative and/or friends (as appropriate, using principles on sharing information as outlined in this procedure).

If contact is re-established, Care review should be considered. It is important to document the outcome of any remedial and/or crisis and contingency planning that will be required in the future.

If, having taken all reasonable steps, contact is not re-established; the lead professional / care coordinator must convene an urgent review meeting. This will establish: -

- What the nature of the concerns or risks are
- What action should be taken
- Who will complete each action
- Who needs to be informed about the loss of contact
- At this stage, consideration should be given to using the missing person's procedure (if not already applied), and utilising Safeguarding Adult's procedures.

Loss of contact with a Service User Pathway



Sending a Missing Person's Alert
Having followed the process above, it may be considered necessary to issue a missing person alert. These alerts can be sent to other NHS organisations, where it is appropriate to do so. It should be recognised that by sending an alert the service user's confidentiality will have been breached in a significant way, and this should only be done in rare and exceptional circumstances.

The circumstances where this can used if the situation meets the following test: -

The Service User affected is either –

- a significant current risk to themselves or others
- is likely to present a significant risk to themselves or others from discontinuing treatment.

And both of the following –

- It is likely that they have travelled outside of the county of Gloucestershire
- All other reasonable steps have been followed to find and engage with the service user.

If it is appropriate, then the following must happen: -

- The care coordinator must discuss this with their team manager
- They should discuss this with the Trust Local Security Management Specialist and follow the agreed processes
- The team responsible for the service user's care will discuss this with the service user's carer or nearest relative to check that they are happy for the alert to be sent

- The care coordinator will complete a copy of the missing person's alert form. A progress note should be made in the service user's record stating what has happened
- A copy of the original, unprotected document must be uploaded to the service user's file
- A copy of the email with the alert, clearly identifying the address of who the email has been sent to, should also be uploaded in PDF or similar format.

6.5 Carers and Families

The Trust recognises that informal carers are respected and vital "Partners in Care" of the service users we support. It is recognised that carers have their own experience and key knowledge of the service user to contribute to effective support and best outcomes and that carers have skills and relationships with service users that can strongly enhance Recovery and Wellbeing plan. The Trust is therefore committed to working in partnership with the service user to be defined as a carer. It is the nature of the support they offer that determines this.

Definition of a Carer

"A Carer is a person who provides unpaid help and support on a regular basis to a partner, child, relative, friend or neighbour, who is frail or has a physical or mental illness, disability or substance misuse issues. The carer is not employed to provide this help but does so to improve the quality of that person's life" (Carers Gloucestershire).

Parents who have school age children that are frail or have a physical or mental illness, disability or substance misuse issues, are also carers Where additional responsibility or concern to support health needs are identified.

A 'Young Carer' is a child or young person under 18 who takes on responsibility at home or offers emotional support because a family member, usually a parent or sibling, suffers from an illness, disability, mental ill health or substance abuse. Young adult carers are aged 16 – 25 and take on this responsibility.

Rights of the Carer

Whatever the views of the service user, anyone identified as a carer is entitled to:

- A proactive response from clinicians/practitioners to speak to or meet professionals without the service user present.
- Continuing support in their caring role.
- Where there is an appearance of need, carers must be offered an assessment of their needs taking a whole family approach, which considers the physical and emotional wellbeing of carers, their opportunities to take part in a life outside of the caring role, their willingness and ability to continue in a caring role and their support needs. This should be revisited If reasonable adjustments are required for families to engage in the carers assessment these should be put in place by provider agencies including the Trust. These are legal requirements.
- Their own written support plan, implemented in collaboration with them.
- Request a review of their support plan at any time (Care Act, 2014).

Young Carers have their own rights. These include the right to:

- An assessment of their own needs. This should be suggested by teams where an appearance of need remains for a young person once a "whole family" approach has been taken to caring needs. Young carer's assessments are provided by specialist organisations locally.
- Identify whom they wish to be involved in their assessment, including health staff.

- Request an assessment of need if it is not offered.
- Assessment Information and advice during the transition from being a young carer to being an adult carer.

Support if they are eligible in their own right, irrespective of whether they person they care for is eligible for support.
Remember the fundamental principle that "No care package should depend on the inappropriate caring role of a child." (Children and Families Act, 2014)

Carer's Assessments
Carers of people receiving Trust services should be offered the opportunity to talk to a senior member of the care team about their own needs, including how the team can support the carer in their caring role using their professional experience alongside of how the carer wishes to be involved in the care offered by the team. This discussion should take into account whether the carer appears to have needs – if they do they should be offered the chance to access a formal Carer's Assessment.

Those entitled to a Carers Assessment include:

- Adult Carers (over 18)
- New Carers who will be providing care in the near future
- People whose caring responsibilities have changed (review)
- Young carers.

Identifying Carers
Regardless of whether the care we are providing is 'Standard Care' or 'on CPA', assessments should always review the social and family network around each service user to identify anyone who provides regular unpaid practical and/or emotional support and who's caring may have an impact on their own lives which creates a need.

Caring arrangements can change and should be reviewed regularly, particularly during the care review.

When a service user is referred to the Trust as part 2 of the Core Assessment we will ask if the service user has a carer. Where a carer is identified, and there is an appearance of need they will be contacted and, informed by the lead professional or care coordinator of their right to a formal stage 1 carers assessment under the Care Act 2014 and the Children and Families Act 2014 and generally made aware of the services that are commissioned from carer and community organisations. Most carer support is already commissioned, and carers do not need to have an assessment to access it. However, where the carer is eligible for support and funding is sought from the local council, this requires a stage 2 FACE Assessment and support plan to be put in place. Practitioners are advised to speak to a member of Social Care staff if they are in a team which conducts the carers assessment if they need advice on this process. Reassurance should be offered, that a Carers Assessment does not involve an assessment of the person's capability to care and is not an assessment of finance and savings.

Clinicians should record in part 2 of the Core Assessment within the Carer Information section of EPR:

- If there is a carer and who that is.
- Their relationship to the service user and any other relevant detail, for example that the carer

themselves is disabled in the free text box provided.
- Whether or not they have been offered and are accepting a formal Carers Assessment (this should be reviewed periodically).
- Who is providing the assessment if the offer is taken up.
- Where a service user or family states that there is no-one fulfilling a regular care role this should be regularly reviewed as caring roles are not always recognised or acknowledged at the outset.

If the carer accepts the offer of a formal assessment the care coordinator will ensure that this is completed. This can be completed either by the clinician or referred to another agency commissioned to do it (see table below “Responsibilities of the Care Coordinator”). To meet the requirements of the Data Protection Act, carers must have their carer record in EPR in which to store all confidential information relating directly to themselves as carer’s. Carer’s assessments are stored in the carer’s records and must not be stored in the health and social care record of the service user they care for. Further information is available on how to set this up in EPR helplinks within the Trust Intranet. Where carers provide information about the service user but request that this is not shared with the service user, this should be reported as third-party information Needs Assessment may identify a range of needs within the remit of the Trust and partner organisations commissioned to support carers. Services should ensure that where it is the Trust’s responsibility to facilitate this, appropriate partner agencies are involved during or after assessment to ensure effective follow up of identified carer need. This will form part of the support plan, which is appended to the Carers Assessment form. The support plan will be reviewed on at least a yearly basis or at the request of the carer. Where a a partner organisation may be involved care coordinators should seek written permission from the carer to liaise with them to assist in formulating and implementing a care plan.

Appearance of Need :

The Care Act 2014 aims for more carers to access an assessment. Previously stated that to be eligible for an assessment, carers had to offer ‘regular and substantial’ care has now been removed. When ascertaining the “Appearance of Need” the Trust expects staff to use a broad definition of caring needs recognising:

- Caring includes practical care and support, such as personal care, preparing meals, looking after the home, shopping, laundry, paying bills etc.
- Caring includes emotional care and support.
- Caring is not just about how much time is given to caring activities - the impact of being a carer fluctuates over time and can be affected by other circumstances affecting the carer.
- Carers may still continue to provide commitment and emotional support when a service user needs little practical help, or practical help is provided by paid homecare workers or residential services, or the service user lives elsewhere from the carer. For example, carers who provide necessary support for a relative in a care home may still be eligible for an assessment if they have an “Appearance of Need”.
- Service users will sometimes have more than one carer. Young Carers needs should not be overlooked even if there is another adult in the home.
- Carers may have more than one role as a carer, for example as a parent of young children and the carer of an older relative.
- Service users being cared for by Mental Health Services may also have needs as a carer. In this case they should be recorded as both a service user and a carer in the same EPR record with entries clearly differentiating which role an entry is about.

Provision of Carers' Assessments

A variety of commissioning arrangements are in place to conduct formal carers assessments. The following table provides some guidance.

Service	Intermediate Care Team	Secondary Mental Health Services	CYPS	LD	SM	Young carers
Carer's Assessment Provider XXXXX	All: Carers Glo'shire	Adults with functional conditions in services of all ages using adult teams (Recovery, Crisis, AOT etc) Trust responsibility to conduct the assessment Organic Conditions all ages Carers Glo'shire Adults with Functional Conditions using Later Life Services (no social care provision) Carers Glo'shire	• Parent Carer assessments are provided by carers Gloucestershire and can be requested by a professional of the parent • If the child is having a social care assessment through My PlanPlus the lead worker may recommend a parent Carer assessment direct as part of the process	Carers Glo'shire	N/A	Glos Young Carers (where a support need not addressed by whole family approach is identified)
Service	**Lets Talk/PMHS**	**Secondary Mental Health Services**	**CAMHS**	**Learning Disability**	**DASH**	**Young Carers**

Responsibilities of the Lead Professional / Care Coordinator

The Care Coordinator will know:

- who the service user's main carers are and any young carers involved
- what the carer's relationship to the service user they care for is
- how to contact the carer

The Lead Professional or Care Coordinator should:

- Ensure that the carer knows who they are and how to contact them and how to get support in an emergency or out of hours.
- Offer to meet or talk with the carer to discuss their understanding of the situation and share their views and/or concerns regarding the service user they care for, to introduce the service and discuss the carer's perception of their own needs, having an understanding of what the carer has already been told is helpful in determining what can be spoken about as information the carer already has e.g. a known diagnosis, can be discussed in general terms. Ensure that, with service user consent, the carer is provided with the relevant information about the care management process and the particular care, diagnosis and medication needs of the service user they care for. They should be invited to be involved in the service user's care planning, treatment, review and discharge planning. The care coordinator has a key role in

acknowledging and coordinating the important role that carers can play in working alongside the Service User and professionals to promote good physical and mental health and in the prevention of deterioration or relapse.

- Offer the carer a carer's booklet or information on how to access resources from the Trust website in a timely way. (Carers Act, 2014)
- work with other agencies in a co-ordinated way to support carers to access commissioned carer support.

Carers should be advised of any risk to them associated with the care provided and have the chance to express any concerns they have about risk; carers should be involved in risk management plans that involve care provided by them and support for the carer should be included in the risk planning.

Involvement of Others in Service User's Care

The service user should always be involved in the planning and provision of his or her care where capacity allows. Relatives and/or others important to the service user should also be involved wherever possible, with the agreement of the service user. When the service user does not have capacity, it is usual to involve carers, families and friends in decision making unless there is a documented good reason not to do so.

The obligation to maintain confidentiality must not prevent staff asking relatives and others for information or for their opinions and concerns, on care planning, which should always be documented. The Trust expects that carers will usually be involved in service users support as "Partners in Care". Where carers and others are identified, staff should engage proactively in discussion with the service user regarding how they would like them to be involved and what level of information may be shared and with whom. Such information should be recorded and regularly revisited. In the case of no disclosure carers can still be treated with respect and dignity and offered their own support and general information (See information sharing section).

The service user has a right to confidentiality; this must always be seen in the context of not only the interests and safety of the service user but others too. A decision to consult others, against the expressed wishes of the service user, for example to prevent serious harm to a service user or carer, will be taken by the care coordinator / lead professional and recorded in the service user's clinical record together with the reason why it was necessary to do this. Team involvement in this discussion should also be sought. The service user should be told this is happening and why.

Where best interest procedures are followed and agreement about a course of action cannot be reached between the care coordinator and relevant others, a discussion with the multi-disciplinary team or team manager must take place and a team decision reached. The nearest relative (as defined in the Mental Health Act 1983) of a service user being assessed for compulsory treatment must also be consulted under Section 11(4) of the Act. The service user should be informed of this, although sensitivity around where consultation takes place should be exercised.

How we Can Best Help Carers

Carers are usually doing the best they can in difficult circumstances. Stress and distress might make it hard for them to communicate clearly what they want to say or need from clinicians. The burden is on staff to make sure that they have understood and that the right information is given at the right time to support carers. Carers have indicated that they require information on:

- How the service works
- Information on mental health issues – the Royal College of Psychiatrists website has useful information advising carers how to ask professionals about mental health.
- Information on their rights
- Information on carer support both in and outside of the organisation
- A person to talk to if there is information carers want to share or understand
- What to do in a crisis.

The Trust carer’s booklet and service specific materials hold much of this information, but it is not a substitute for approachable, compassionate staff who engage well with carers and offer them the chance to speak.

Transfer to and from Another Team

Transfer Between Trust Teams

Dependant on the needs of the service user it is often necessary for care to be transferred to another team within the Trust. Any transfer of care should be sensitive to the individual’s needs. As the period around transfer can cause uncertainty and anxiety and therefore increased risk, the process should be transparent and reflect best practice in providing consistent care management. It is important to remember that the service user’s needs are paramount and that the care we provide should not be subject to unreasonable restrictions because of the service user’s age. Clinicians should at all times be mindful of the information provided within the interface guidance included within service operational policies.

The reasons for transfer to a different team should be discussed with the service user. Any subsequent professional discussions about service provision must be based on service user clinical need. It should be clear that cluster profiles are not exclusive and should never be used to deny a service user access to a service.

Where a service user is in a primary care service, the lead professional along with the team manager will be responsible for contacting the other team and informing them of the impending transfer.

Where a service user is managed by a care coordinator, in conjunction with the MDT the care coordinator will identify which team would be most appropriate to provide care. The team manager or designated person will contact the other team and work with them to establish a ‘person centred’ transfer process working around the needs of the service user.

Where a referral has been made, the team receiving the referral (the ‘receiving team’) must ensure that all appropriate details are available and are in keeping with the information listed below. The ‘receiving team’ will be responsible for ensuring that the appropriate action (i.e. assessment) is undertaken or that a more appropriate team is informed to ensure that they in turn accept the referral. There may be times where teams co-work with service users. This principle applies to all teams.

The current care coordinator or lead professional will be responsible for ensuring that the following information is up to date in the service user’s case record: -

- Demographic and contact details
- Outcome measurements
- Carer contact information

- Core Assessment
- Risk Assessment
- Risk Incident log/Alerts
- Safeguarding Information
- In the progress notes – including a summary of the service user’s progress to date and reason for transfer request.

Until the ‘receiving team’ accept and confirm responsibility either verbally or in writing the current ‘host’ team must retain full responsibility for the service user. All decisions to this point must be documented within the electronic clinical record in the progress notes.

During patient transfer and potential re-clustering (which should be documented as a CPA review) all transitions must be completed in a timely way to best meet the needs of the service user.

In the case of transfer from PMHS / Let’s Talk and MHST to other Trust services; until the receiving team has undertaken the additional assessment the responsibility remains with the transferring team. After assessment has confirmed the need for specialist care that responsibility will transfer to the receiving team. This is normally within four weeks. In all other cases, until the receiving team has identified a new care coordinator and has completed the handover of the service user, responsibility remains with the current team and care coordinator / lead professional.

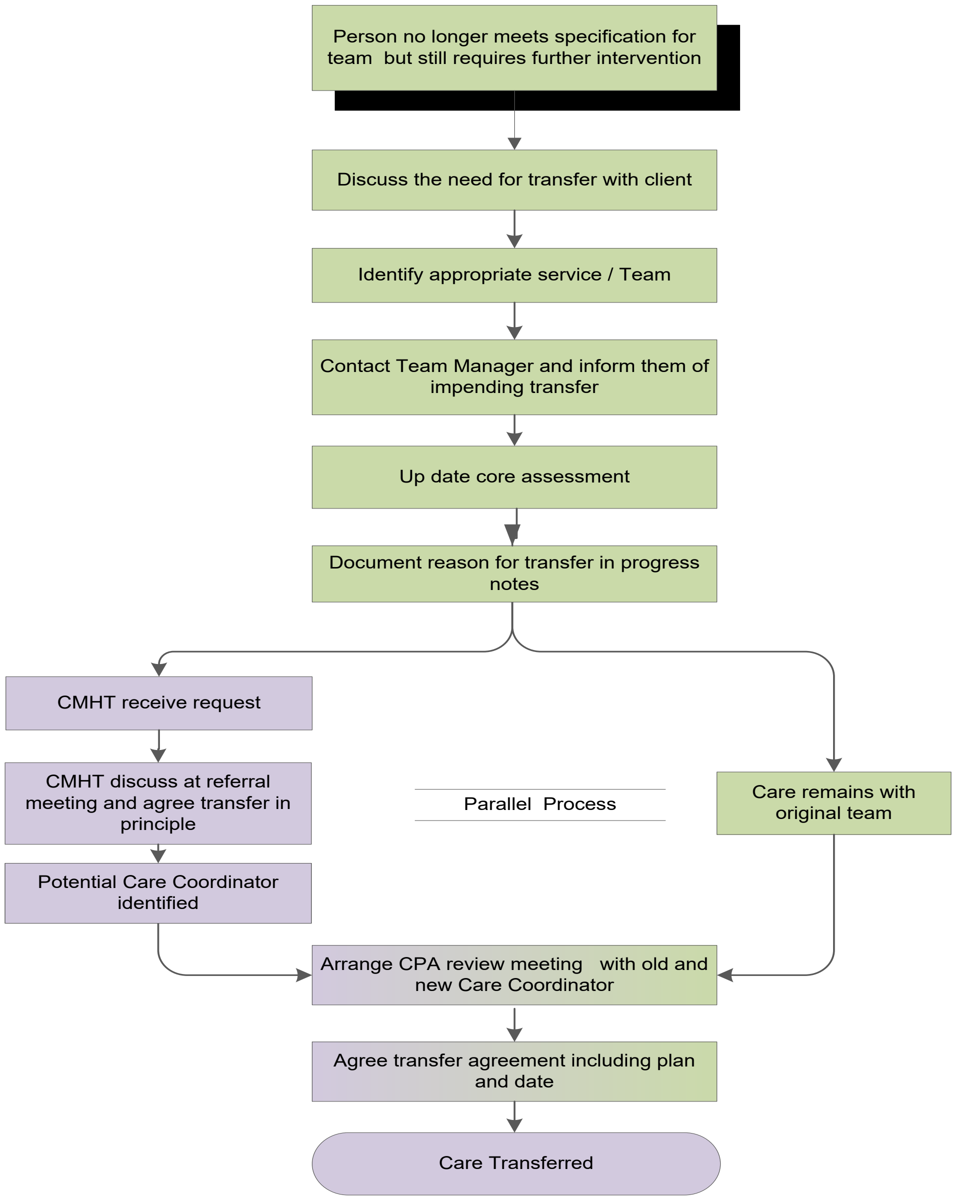
Where there is uncertainty regarding who should provide ongoing care both the ‘host’ and receiving teams should consider joint assessments to ensure a service is identified to meet the service users’ needs.

Any disputes about the transfer process or who the care coordinator will be, must be resolved in the first instance by team managers. Failing a satisfactory resolution, the community service managers must intervene and resolve the issue by appointing a care coordinator. This should occur the same day for emergency and urgent referrals and within 3 working days for referrals requiring routine assessments between 2-4 weeks. A table which outlines individual service response times can be found in the appendices.

The team receiving the request will review the service user’s care record and allocate an appropriate care coordinator. Following this a joint CPA review will be held with the current and future care coordinator when a clear plan for transition, including dates and any actions will be developed. This information will be clearly communicated to everyone involved in the service user’s care (including their carer if consent is given) and GP.

Where a service user is transitioning to another team, the receiving team should not place any unnecessary barriers in the way of transfer and service users should not be allowed to ‘fall’ between services. At no point should a referral be sent back to a referrer with a suggestion that it should be resubmitted to another service within the Trust. Once referred to the Trust it is the receiving team’s responsibility to manage the service user’s best interests.

TRANSFER PATHWAY



Transfer to Another Provider

Where a service user is to be transferred to another provider, the lead professional or care coordinator should ensure that the following occurs: -

The lead professional or care coordinator or consultant proposing the transfer identifies the appropriate provider or service. The prospective service is contacted and the situation explained.

If the service user is subject to Section 117 or Guardianship the Adult and Community Care Directorate (formerly Social Services, should also be contacted). Reference should be made to the local authority website for guidance regarding Section 117.

Where possible, a meeting will take place with the lead professional or care coordinator, the service user being transferred, and the new care provider. If an inpatient, it may also be appropriate for the service user to visit the new provider unit.

It is agreed when and how the transfer will take place. Identify responsibility for commissioning arrangements. A minimum requirement for the transfer of information to the proposed provider is:-

- A covering letter from the lead professional or care coordinator or Mental Health Act responsible clinician
- Up to date demographic information
- Outcome measurements and if applicable HoNOS cluster
- Copy of the most recent Core Assessment
- Copies of the last 3 months of community progress notes and or/ last 4 weeks if inpatient notes
- Copies of any care plans
- Copies of the risk Incident log and alerts
- Copies of any safeguarding information
- Copies of risk assessment and management plans
- Copies of any medication cards or prescriptions.

Transfer from Another Provider

Where a request is received from another provider to transfer a service user's care to the Trust the following should happen: -

The team receiving the request will check that the service user is appropriate for our service sand in the right geographic area. In addition, using responsible commissioner guidance the funding stream and governance structure should be established. The timely acceptance of service users in need of healthcare should override debates about ultimately who should pay for treatment.

If the service user is subject to Section 117 or Guardianship, the Adult and Community Care Directorate (formerly Social Services) should also be contacted. Reference should be made to the local authority website for guidance regarding Section 117.

Where possible, a meeting is arranged with the current lead professional, or care coordinator and the service user being transferred.

If the proposed transfer is appropriate all parties will agree when and how the transfer will take place.

Minimum Information Required from Another Provider:

- A covering letter from the care coordinator or if Mental Health Act applies, a responsible clinician
- Up-to-date demographic information
- Outcome measurements and if applicable HoNOS cluster
- A copy of the most recent Core Assessment
- Copies of the last 3 months of community progress notes and or/ last 4 weeks if inpatient notes
- Copies of any care plans
- Copies of the risk Incident log and Alerts
- Copies of any Safeguarding information

- Copies of risk assessment and management plans
- Copies of any medication cards or prescriptions.

Breakdown of a Relationship Between a Patient and Their Treating Team

Patients sometimes request a change of consultant or team. This wish will always be considered carefully and particular consideration given to whether a transfer would be therapeutic or not. The dissatisfactions a patient may be experiencing with a consultant or team may mirror relationship difficulties in other areas of their life and working these issues through may be a core therapeutic task. However, on occasions the relationship between a patient and their therapeutic team may deteriorate to the point that it is not consistent with the safe or appropriate provision of care. If this is the case, the patient should be offered alternatives to their current care. Equivalent standards of service may not be available in this case (for example in the case of specialist services with no local equivalent) and the patient should be informed of this.

For those subject to the provisions of the Mental Capacity Act 2005 where a Lasting Power of Attorney is in place and covers the provisions of personal welfare and healthcare decisions the appointed attorney can likewise, acting in the client’s best interest, request a second opinion (MCA Code of Practice 7.21).

Ideally, the care package should be transferred to another single locality team. Occasionally this may not be appropriate, and it may not be possible to access a care package shared between teams. This situation poses further risks in that some formal and informal communication mechanisms within teams are important aspects of patient safety. Shared care should be the exception.

Any subsequent transfer between teams in this situation should follow the same standards laid out within this section of the policy to ensure that seamless transfer of care occurs and that no gaps are created in the pathway.

6.6 Discharge

Background

The period around discharge of care from services can be an uncertain and worrying time and a period of increasing risk. It is, therefore, essential that this is well planned and coordinated.

Discharge following Core Assessment – Part 1 or / and Part 2

If after an initial assessment on-going GHC services for mental health or learning disability are not required the service user will be discharged or, if required, signposted to external services. This marks the end of the assessment, and the referral will be closed.

A number of administration tasks will be completed by the assessing clinician or practitioner at this stage.

These include:

- Outcome an appointment in the health and social care notes
- Documentation of assessment within the Health and Social Care Notes
- Complete brief progress note
- Complete discharge summary to include:
- Situation (reason for referral)
- Background (History)

- Assessment (include any risk elements)
- Recommendation (signposting)
- End referral
- Send a copy of the discharge summary and the agreed actions to the service user copied to the referrer/GP.

Discharge from Community Teams

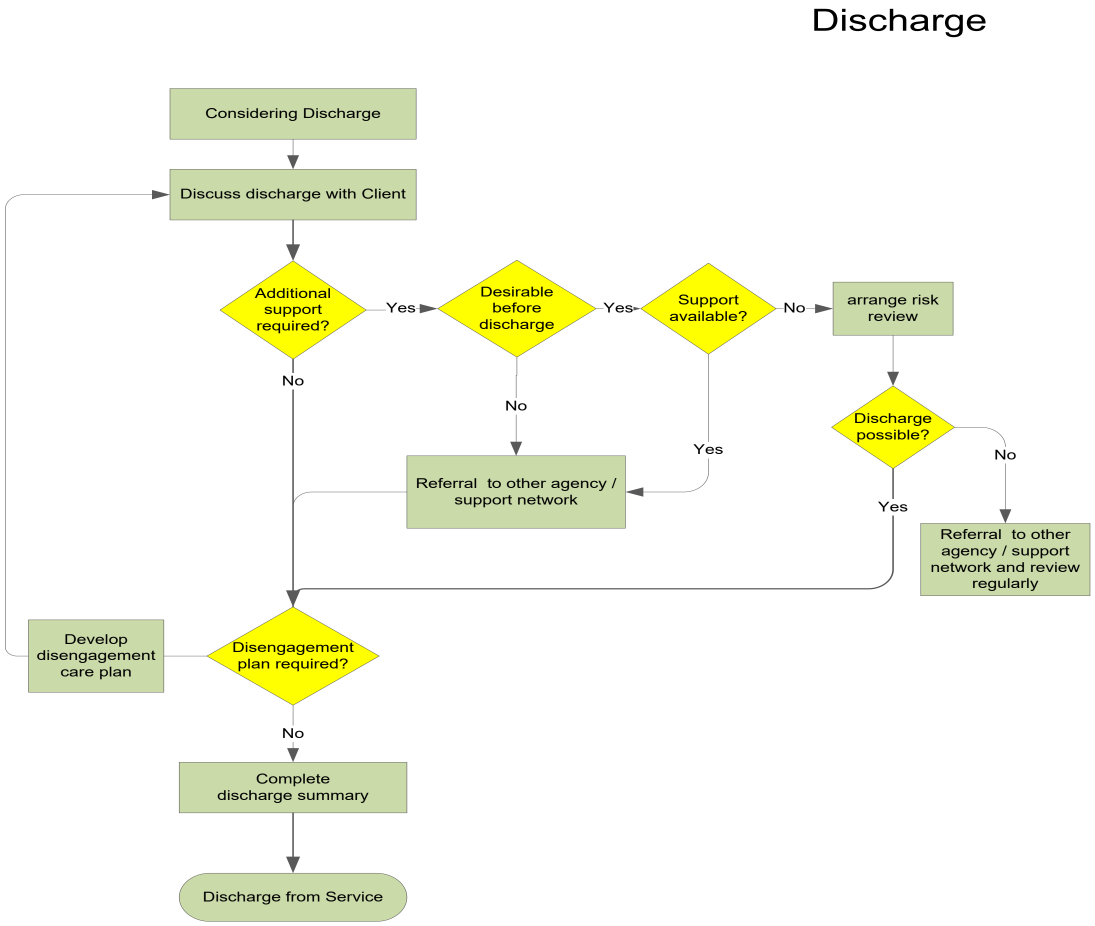
If the lead professional/care coordinator in conjunction with the service user believes that treatment and support is no longer required, then it is time to consider discharge. Before this can happen, the following things should occur: -

- The discharge process should be discussed with the service user receiving treatment
- If the service user's care is managed by a care coordinator, then there must be a full care review meeting held to consider discharge
- It should be considered if any additional input is required from the service user's support network or local community or another agency to facilitate discharge and whether this is possible
- Any specific risks associated with discharge should be identified and transparently discussed with the service user and carer
- If for any reason the service user has disengaged with our services in an unplanned way it will be important to follow this up and try and find out if we can do anything to support re-engagement. If not then a summary of the care offered to date will be produced, including the actual date of discharge, any potential areas of risk to self or others and any handover of pertinent information to other professionals still involved such as a Social Worker, or GP.

Once discharge has been agreed then –

- An appropriate review and handover to primary care worker / GP is arranged
- Plans for review, support and follow-up are produced as appropriate
- A clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that service user's mental well-being
- A discharge summary completed to the approved Trust format is sent to the GP within 5 days (10 days for CYPS)
- The case is closed on Trust clinical systems
- All inpatient care plans will be closed within 7 days of discharge from an inpatient stay in addition to completing the other tasks associated with this.

DISCHARGE PROCESS



Discharge from Inpatient Services

Once an inpatient, and before the service user reaches the end of their inpatient episode, detailed preparation for the discharge needs to commence-

- The discharge should be discussed with the service user receiving treatment
- Unless there is clear justification otherwise the service users care will be managed by a care coordinator for at least 6 months post discharge, and thus a CPA review meeting should be held
- A Care coordinator must be identified before the service user leaves the ward
- A ‘Discharge from Inpatient Care Plan’ must be produced before discharge in practice this will be a revised CPA care plan
- Consideration must be given to whether any additional input is required from the service user’s support network or local community or another agency to facilitate discharge and whether this is possible.
- Any specific risks associated with discharge must be identified
- The follow up arrangements for not later than 48hrs after leaving the ward must be agreed and documented
- A discharge summary must be completed and sent to the service user and copied to the GP **within 24hrs** of discharge (see section below) this should be completed jointly by the ward staff and a doctor.

Discharge Summary

The Trust uses an approved format for discharge summaries that meets the requirements of the C.C.G. as well as other safety and best practice issues. The discharge summary provides a clear summary of the events relating to the admission, and key information for the GP and other staff involved with a service user's care post discharge.

The minimum content is:

- A clear label of 'Discharge Summary'
- The service user's name
- The service user's date of birth
- The service user's consultant and their care coordinator if different.
- Their NHS number
- Their primary diagnosis
- Their treatment and rational for significant changes in treatment
- Any risk or safety issues
- Significant investigations and results
- Date of referral and date of discharge from service
- Details of other agencies involved
- Further action recommended to the primary care team
- Information given to the service user / carer / family
- If the service user is being discharged from inpatient care the following additional items are required:
- Date of admission
- The ward they were admitted to
- Date of discharge
- The ward they are being discharged from
- Where the service user is being discharged to, and if this is not the normal address, provide address details and phone number
- Details of when and where they are being followed up and by whom
- Medication details.

7. DEFINITIONS

Primary Care Services: Primary Care Services include Primary Mental Health Services and IAPT in the current structure within the Trust. Other Trust services are also regarded as being Primary care focussed and these are outlined in Appendix 3.

Choice and Partnership Approach (CAPA): The Choice and Partnership Approach (CAPA) is a nationally recognised child mental health clinical system which ensures services are delivered in collaboration with children, young people and their parents/carers. CAPA defines the initial assessment process according to specific terminology: Choice' and 'Partnership' assessments:

Choice: A CHOICE appointment is the CAPA term for the first contact the client has with CYPS. The aims of the Choice appointment are to build a therapeutic alliance with the child or young person and develop a joint understanding of the presenting emotional or mental health well-being need with consideration to possible risk and safeguarding issues.

Choice plus*:* A CAPA term where there is a clinical need to complete the first CHOICE assessment across 2-3 sessions in order to have sufficient time to build a therapeutic rapport and gain a clear clinical understanding of the presenting emotional or mental health need (s).

Partnership*:* Following CHOICE, a PARTNERSHIP appointment is a CAPA term to describe a detailed full CYPS mental health core assessment where CPA responsibilities commence. At the first partnership assessment, a detailed mental health assessment is completed including clinical formulation and a CPA care plan will be developed in collaboration with the child or young person. Subsequent PARTNERSHIP sessions (usually 7-10) offer core CAMHS treatment which aim to meet objectives outlined in the CPA care plan. Once the core PARTNERSHIP sessions are completed and further clinical intervention is indicated, the child or young person will receive further specialist intervention in accordance to the CPA framework.

A Professional: A health or social care clinician or practitioner who is qualified and registered with approved professional bodies.

Lead Professional / Named Worker: The clinician or practitioner who has lead responsibility for a service user's treatment and care, in their ordinary professional role. (NB this term denotes a specific role in relation to children when capital letters are used).

Care Coordinator: The clinician or practitioner who, irrespective of their ordinary professional role, has responsibility for co-ordinating a service user's care, keeping in touch with the service user, ensuring the care plan is developed, delivered and reviewed as required. This can often mean working as part of a multi-disciplinary team or ensuring that the care the Trust provides is coordinated with the care delivered by other agencies or care providers.

AHP: Allied Health Professional

Standard Care: This refers to the treatment facilitated by a lead professional / named worker. It can be provided within primary or secondary care services for those who require less intensive involvement from the Trust.

'On CPA': This refers to treatment facilitated by a care coordinator. It will be treatment and care provided within secondary care services, for those who require more intensive or complex involvement from the Trust.

Electronic Patient Record (EPR): Electronic health and social care record system.

First Contact Assessment: Telephone or face to face contact with service user.

Core Assessment: An initial primary or secondary care assessment when the service user is referred to the Trust, undertaken in conjunction with the service user and/or parents and carers where appropriate.

Outcome Measures:_ Are measurement tools to help assess impact of the care provided to a service user.

Health Equalities Framework - HEF: This is an outcome measure tool used in Learning Disability services referred to as the HEF.

HoNOS:_ Health of the Nation Outcome Scale, which is the Clinical Rated Outcome Measure

(CROM), used in adult mental health care packages.

Treatment Outcome Profile (TOPs): This is a drug treatment outcome measurement tool which is equally appropriate for use in alcohol services. The tool covers four domains, substance misuse, injecting behaviour, crime and health and social functioning.

Advance Decision: This is a decision to refuse specified treatment made in advance by a person who has capacity to do so, to apply at a future time when that service user lacks capacity.

Reasonable Adjustment: Work undertaken to improve **other** services (through reasonable adjustments) for people with learning disabilities, either relating to an individual or for the wider learning-disabled population.

Recovery: 'Is about building a meaningful and satisfying life, as defined by the service user themselves, whether or not there are on-going or recurring symptoms or problems.'

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	**Frequency**	**Further Actions**
A programme for auditing and monitoring will be carried out each year, as agreed by the Governance Committee. This will include the following: - • all teams audited against core standards and practises outlined in this policy at least twice a year • focused audits exploring specific standards and aspects of this policy as applied in practice, these will include: o The duties of clinicians and practitioners in relation to the policy o The compliance with training as laid out in the Trust training policy Documentation and provision of information to service users	Annually	The Governance Committee will be notified of any changes to this policy. They will also receive copies of any reports and audits relating to standards and practises in this policy, as a minimum, this must include an annual report.
This policy will be reviewed every 3 years to ensure that it continues to meet the needs of the Trust, by the Assistant Director of Quality, Assurance and Transformation, under the authority of the Director of Quality, though a review can be completed sooner if any of the following are identified – • There is a significant change in national guidance or policy • There is a significant change in best practice • Local practice issues are identified that are not adequately covered by this policy and need addressing.	3-yearly	

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident

Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

Training and information for staff will be given initially on induction to the Trust. Line managers should ensure all appropriate staff members are aware of the local implementation of the policy.

11. REFERENCES

The Care Programme Approach for people with mental illness, Joint Health and Social Services Circular — HC (90)23/LASSL(90)11, Department of Health 1990

Refocusing the Care Programme Approach Department of Heath 2008

Supplementary guidance issued to 'Refocusing CPA' DH 2008' relating to Implementation of Violence and Abuse policy by CPAA, June 2008

CPPA Handbook 3rd edition, Care Programme Approach Association 2008,

Best Practice in Working with Carers, Royal Collage of Psychiatry, 2006

The Data Protection Act 1995

The Mental Capacity Act 2005

A national Service Framework for Mental Health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf

Mental Health Act 1983 (amended 2007)

Royal College of Psychiatrists Mental Health Information. http://www.miepvideos.org/RCP%20spirituality%20and%20MH.pdf

Mental Health Act Code of Practice (2008).

NHS Code of Practice (2003)

Healthcare Commission No voice, no choice (2007) Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England (December 2009)

Carer's (Recognition and Services) Act 1995

Carers and Disabled Children's Act 2000

12. ASSOCIATED DOCUMENTS

This policy should be read alongside the Trust's policies and procedures relating to: -

Safeguarding Children Policy (CLP071)
Safeguarding Adults Policy (CLP101)
Missing Persons (AWOL) within Mental Health and LD inpatients (CLPr102)
Assessing and Managing Clinical Risk and Safety Policy MH/LD (CLP249)
The Data Protection Act
Health Records and Clinical Record Keeping Policy (CLP005)
The Carer’s Charter
Diversity and Inclusion Policy
Interface Policy
Policy on Recording Information in Electronic Patient Records (EPRs)
Consent - Recording Consent to Share Information in RiO
The Mental Capacity Act
The Mental Health Act Policies

Appendix 1

A	Can Assist but Not Validate
Y*	Yes if the person holds a registered and relevant qualification
Y^	Once assessed as Competent
Y+	Yes can create care plan where risk screen is sufficient
Y	Yes

	B2 HCA Support Worker	B3 HCA	B3 Support Worker AHP	B 4 HCA	B4 Support Worker AHP	B5 & above Nurse MH	B 5 & above Nurse Learning Disability	B5 & Above OT	B5 & Above Physio	B5 & Above Health & Exercise practitioner	B4 & Above Social Worker	Unqualified Psychologist or	B5 CYPS PMHW	B5&6 S&LT	B6 CYPS PMHW	B6 Health & Exercise Practitioner	Trainee Psychologist or Psychological	Qualified / Registered	Band 7 S&LT	Doctor (all grades	Band 4 Education Mental Health	Band 4 Assistant Psychological Wellbeing	Band 5 Education Mental Health Practitioner	Band 5 Psychological Wellbeing Practitioner
Core Assessment						Y	Y	Y	Y	A	Y		Y	Y	Y	Y	A	Y	Y	Y		Y	Y	Y
Clinical Risk Assessment						Y	Y	Y	Y	A	Y		Y	Y	Y	Y	A	Y	Y	Y	A		Y^	Y
Complete Honos Cluster						Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y
Care Manage / Standard Care				Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	A	Y	Y	Y	A	Y	Y	Y
Care Coordinate "on CPA"						Y	Y	Y	Y	A	Y	A	Y	Y	Y	A	A	Y	Y	Y			Y	Y
Write Care Plan				Y*	Y*	Y	Y	Y	Y	A	Y	A	Y	Y	Y	Y	A	Y	Y	Y	A	Y+	Y	Y
Write 'on CPA' care plan						Y	Y	Y	Y	A	Y	A	Y*	A	Y*	A	A	Y	Y	Y			Y	Y
Support care plan delivery	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Complete Carer Assessment				A	A	Y	Y	Y	Y	A	Y	A	Y	Y	Y	A	A	Y	Y	Y	A	A	Y	Y
Review Core Assessment				A	A	Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y	A	A	Y	Y
Review Honos Cluster				Y	Y	Y	Y	Y	Y	A	Y	Y	Y*	Y	Y*	Y	A	Y	Y	Y		Y		Y
Risk Screen				Y	Y	Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y	A	A	Y^	Y

Review Risk Assessment				A	A	Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y	A	A	Y^	Y
Discharge From Service						Y	Y	Y	Y	Y	Y	A	Y*	Y	Y*	Y	A	Y	Y	Y	Y		Y	Y
Complete ICD 10 Diagnosis						Y	Y	Y	Y	A	Y		Y*	Y	Y*	A			Y	Y				
Supervise Bands Below						Y	Y	Y	Y	Y	Y		Y*	Y	Y*	Y		Y	Y	Y				Y
Validate Own Notes	Y^	Y^	Y^	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y^	Y^
Validate Notes Of Others						Y	Y	Y	Y	Y	Y		Y*	Y	Y*	Y		Y	Y	Y				

Appendix 2: Mental Health PbR Care Cluster, Expected CPA Level and Review Frequency

Cluster Number	Cluster Description	Care Management Levels	Maximum Review Period (weeks)
21	Cognitive Impairment or Dementia – High physical or engagement	Care Coordinator	52
20	Cognitive Impairment or Dementia – Complicated high need.	Care Coordinator	52
19	Cognitive Impairment or Dementia – Complicated moderate need.	Lead Professional	52
18	Cognitive Impairment – low need.	Lead Professional	52
17	Psychosis and Affective Disorder – Difficult to engage	Care Coordinator	26
16	Dual Diagnosis	Care Coordinator	26
15	Severe Psychotic Depression	Care Coordinator	4
14	Psychotic Crisis	Care Coordinator	4
13	On-going recurrent Psychosis – high symptoms and disability	Care Coordinator	52
12	On-going or recurrent Psychosis – high disability	Lead Professional or Care Coordinator	52
11	On-going recurrent Psychosis	Lead Professional	52
10	First Episode Psychosis	Care Coordinator	52
9	Blank cluster	9. Blank cluster	
8	Non Psychotic chaotic and challenging disorders	Care Coordinator	52
7	Enduring Non Psychotic Disorders high disability	Lead Professional or Care Coordinator	52
6	Non Psychotic disorder of over-valued ideas	Lead Professional or Care Coordinator	26
5	Non Psychotic Disorder very severe	Care Coordinator	26

4	Non Psychotic severe	Lead Professional or Care Coordinator	26
3	Non Psychotic moderate severity	Lead Professional	26
2	Common Mental Health Problem (low severity with greater need)	Lead Professional	15
1	Common Mental Health Problem (low severity)	Lead Professional	8**
0	Cluster 0	Lead Professional	52**

Appendix 2: Care Cluster Expected CPA Level And Review Frequency – LD Services

Cluster Number	Cluster Description	Care Management Levels	Maximum Review Period (weeks)
1	Anyone seen only for purpose of review (e.g. review of medication, or postural management)	Lead Professional	52 weeks or when clinically significant
2	Communication / Capacity Issues / understand the Learning Disability	Lead Professional or care coordinator	As above
3	Dysphagia	Lead Professional or care coordinator	As above
4	Epilepsy	Lead Professional or care coordinator	As above
5	Memory Assessment / acquired cognitive difficulties	Lead Professional or care coordinator	As above
6	Mental Health (not clusterable on MH PbR)	Lead Professional or care coordinator	As above
7	Mobility	Lead Professional or care coordinator	As above
8	Support for Physical health needs	Lead Professional or care coordinator	As above

9	Postural issues	Lead Professional or care coordinator	As above
10	Problems shown through Behaviour	Lead Professional or care coordinator	As above
11	Sensory Issues	Lead Professional or care coordinator	As above

Appendix 2: Care Cluster Expected CPA Level And Review Frequency – CYPS and CAMHS Services

Tier	Details	**Care Management Levels**	Maximum Review Period (weeks)
Level 2	Primary Mental health	Lead Professional	12 months
Level 3	Secondary Mental Health	Care Coordinator	12 months
Level 3	Secondary Mental Health	Care Coordinator	12 months
Level 4	Inpatient	Inpatient provision is provided by out of county adolescent units and will therefore adhere to their local Trust CPA Policies	

Appendix 2: Drug and Alcohol Services

Tier	Details	**Care Management Levels**	Maximum Review Period (weeks)
Tier 1	Non Drug Treatment Specific Services	Lead Professional	3 monthly
Tier 2	Open Access Services	Lead Professional	3 monthly
Tier 3	Structured Community Based Services	Lead Professional or Care Coordinator	3 monthly

Tier 4	Residential and Inpatient Services	Care Coordinator	3 monthly

Appendix 3 - List of Services Regarded as Being Primary Care Focussed

Service line	Director	Primary care	Secondary care
Gloucestershire Locality	**Steven Holmes**	MHICT - PMHN	GRIP
		MHICT – IAPT	Recovery
		ADHD (Attention Deficit Hyperactivity Disorder Service)	Assertive Outreach Team (AOT)
		ASC (Autistic Spectrum Clinic)	CMHT (Later Life)
		MAS (Memory Assessment Service)	CLDT (Community Learning Disability Team)
		CDN (Community Dementia Nurses)	CPI (Complex Psychological Interventions)
		CHST	Perinatal Service
Countywide	**Kerry Jones**	Mental Health Liaison Teams	CRHTT
		Liaison and Diversion Service	
CYPS and CAMHS	**Mel Harrison**		