The 5 key messages the reader should note about this document are:

1. The Care Programme Approach (CPA) is essentially a model of assessing, planning, implementing, delivering care and then evaluating the effectiveness of that care or intervention.

2. This Policy provides detailed guidance on all aspects of the CPA process, covering Assessment (including assessment of risk), Care Planning, Review, Transfer and Discharge.

3. The Policy and its associated procedures outline the Roles and Responsibilities of Care Co-ordinators and stresses the importance of undertaking this role at a consistently high standard.

4. The Policy also stresses the central role that service users and carers play in the CPA process and is designed to ensure that where possible, they lead the care planning process. Care Co-ordinators will also find procedures in relation to Personalisation and Self-directed Support.

5. The Policy also takes account of the transfer of community services from Bradford and Airedale Community Health Services (BACHS) to the new organisation and captures the requirements of Primary Care Mental Health Services in relation to their model of risk assessment.
This policy has been approved. Circumstances may arise where staff become aware that changes in national policy or statutory guidance (e.g. National Institute for Clinical Excellence (NICE) guidance, Employment Law) may affect this policy. It is the duty of the staff member concerned to ensure that the policy author is made aware of this change so that the matter can be dealt with through the policy review process.

NOTE: All policies remain extant until notification of an amended policy via Global e-mail and posting on the intranet.

<table>
<thead>
<tr>
<th>Document details:</th>
<th>CARE PROGRAMME APPROACH POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>8.1</td>
</tr>
<tr>
<td>Persons / committees consulted:</td>
<td>Deputy Directors, Heads of Operations, Team Managers, Professional Council, Service Governance Committee</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Professional Council</td>
</tr>
<tr>
<td>Date approved:</td>
<td>20/08/2012</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>Service Governance Committee</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>14/09/2012</td>
</tr>
<tr>
<td>Title of originator / author:</td>
<td>Care Programme Approach Lead</td>
</tr>
<tr>
<td>Title of responsible committee</td>
<td>Service Governance Committee</td>
</tr>
<tr>
<td>Title of responsible Director:</td>
<td>Chief Operating Officer/Director of Nursing</td>
</tr>
<tr>
<td>Date issued:</td>
<td>14/09/2012</td>
</tr>
<tr>
<td>Review date:</td>
<td>13/09/2014</td>
</tr>
<tr>
<td>Frequency of review:</td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All nursing and Social Care Staff</td>
</tr>
<tr>
<td>Responsible for dissemination:</td>
<td>Governance and Clinical Audit Manager</td>
</tr>
<tr>
<td>Copies available from:</td>
<td>Intranet and policy author</td>
</tr>
<tr>
<td>Where is previous copy archived (if applicable)</td>
<td>V drive (NHSLA)</td>
</tr>
<tr>
<td>Amendment Summary:</td>
<td>Additional text relates to 3 requirements for NHSLA updates: Clinical Risk – pages 8, 43,47 and 48 Review - pages 9, 68, 72, 73, 74, 75, 76 and 77 Clinical Transfer/Discharge - pages 9, 78, 81, 82, 85, 86 and 94</td>
</tr>
<tr>
<td>Chapter</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>Purpose</td>
</tr>
<tr>
<td>3</td>
<td>Definitions</td>
</tr>
<tr>
<td>4</td>
<td>Duties</td>
</tr>
<tr>
<td>5</td>
<td>Document Development</td>
</tr>
<tr>
<td>6</td>
<td>Equality Impact Assessment</td>
</tr>
<tr>
<td>7</td>
<td>Training Needs Analysis</td>
</tr>
<tr>
<td>8</td>
<td>Consultation, approval and ratification</td>
</tr>
<tr>
<td>9</td>
<td>Review of this Policy</td>
</tr>
<tr>
<td>10</td>
<td>Dissemination</td>
</tr>
<tr>
<td>11</td>
<td>Monitoring Compliance</td>
</tr>
<tr>
<td>12</td>
<td>References &amp; Glossary</td>
</tr>
<tr>
<td>13</td>
<td>Associated documentation</td>
</tr>
<tr>
<td>14</td>
<td>What is CPA?</td>
</tr>
<tr>
<td>15</td>
<td>Service User Involvement</td>
</tr>
<tr>
<td>16</td>
<td>Advocacy</td>
</tr>
<tr>
<td>17</td>
<td>Carer Involvement</td>
</tr>
<tr>
<td>18</td>
<td>Balancing the needs of Users and Carers</td>
</tr>
<tr>
<td>19</td>
<td>Equality of Opportunity and diversity</td>
</tr>
<tr>
<td>20</td>
<td>Communication</td>
</tr>
<tr>
<td>21</td>
<td>Principles underpinning CPA</td>
</tr>
<tr>
<td>22</td>
<td>CPA Policy</td>
</tr>
<tr>
<td>23</td>
<td>New Criteria for CPA</td>
</tr>
<tr>
<td>24</td>
<td>Personalisation</td>
</tr>
<tr>
<td>25</td>
<td>Single Assessment Process (SAP) and CPA for older adults</td>
</tr>
<tr>
<td>26</td>
<td>Mental Health Action Planning (MHAP) for people with a learning disability</td>
</tr>
<tr>
<td>27</td>
<td>Personal Service Planning (PSP) for people with a learning disability</td>
</tr>
<tr>
<td>28</td>
<td>Child and Adolescent Mental Health Services and CPA</td>
</tr>
<tr>
<td>29</td>
<td>The role and authority of the Care Co-ordinator</td>
</tr>
<tr>
<td>30</td>
<td>Changes of Care Co-ordinator</td>
</tr>
<tr>
<td>31</td>
<td>Allocation of Care Co-ordinators</td>
</tr>
<tr>
<td>32</td>
<td>Assessment of Needs</td>
</tr>
<tr>
<td>33</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>34</td>
<td>Care Planning</td>
</tr>
<tr>
<td>35</td>
<td>Choice</td>
</tr>
<tr>
<td>36</td>
<td>Access</td>
</tr>
<tr>
<td>37</td>
<td>Advance Decisions and Statements of wishes</td>
</tr>
<tr>
<td>38</td>
<td>Review and Evaluation</td>
</tr>
<tr>
<td>39</td>
<td>Outcomes</td>
</tr>
<tr>
<td>40</td>
<td>Outcome Measures</td>
</tr>
<tr>
<td>41</td>
<td>Criminal Justice and Assessment of Offenders</td>
</tr>
<tr>
<td>42</td>
<td>Discharge/Transfer/Leave</td>
</tr>
<tr>
<td>43</td>
<td>Confidentiality and Privacy</td>
</tr>
<tr>
<td>44</td>
<td>Caseload Management and Supervision</td>
</tr>
<tr>
<td>45</td>
<td>Care Co-ordinator Capabilities and Training</td>
</tr>
<tr>
<td>46</td>
<td>Care Co-ordinator Competencies</td>
</tr>
<tr>
<td>47</td>
<td>Audit</td>
</tr>
<tr>
<td>48</td>
<td>Assessment Procedure</td>
</tr>
<tr>
<td>49</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>50</td>
<td>Use of RiO Risk Assessment Tool</td>
</tr>
<tr>
<td>51</td>
<td>Clinical Risk Assessment and Risk Management within Primary Mental Health Care Services</td>
</tr>
<tr>
<td>52</td>
<td>Care Planning Procedure</td>
</tr>
<tr>
<td>53</td>
<td>Review of CPA Procedure</td>
</tr>
<tr>
<td>54</td>
<td>Transfer and Discharge Procedure</td>
</tr>
<tr>
<td>55</td>
<td>Criminal Justice and Assessment of Offenders Procedure</td>
</tr>
<tr>
<td>56</td>
<td>Carer Assessment Procedure</td>
</tr>
<tr>
<td>57</td>
<td>Care Co-ordinator Competencies Guidelines</td>
</tr>
<tr>
<td>58</td>
<td>Personalisation Information and Procedures</td>
</tr>
<tr>
<td>59-66</td>
<td>Personalisation guidance</td>
</tr>
<tr>
<td>66</td>
<td>References and Glossary</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>SDS process</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Standard Indicative Budget Letter</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Standard Self-Managed Actual Budget Letter</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>BDCT-Managed Actual Budget Letter</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Part-Managed Actual Budget Letter</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Overall Policy Equality Impact Assessment</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Compliance Checklist</td>
</tr>
</tbody>
</table>
1 Introduction

1.1 The Care Programme Approach (CPA) is essentially a model of assessing, planning, implementing, delivering care and then evaluating the effectiveness of that care or intervention. It aims to promote effective liaison and communication between agencies, thereby managing assessed risk and meeting the individual needs of people with mental health problems so that they are better able to function in society.

1.2 Whilst CPA is ‘applicable to all service users in contact with the secondary mental health system’, ‘the principles of CPA are relevant to the care and treatment of younger people with mental health problems’ and those service users with a Learning Disability.

2 Purpose

2.1 The purpose of this Policy is to define clearly the Trust’s responsibilities with regard to The Care Programme Approach. It defines the role of Care Co-ordinator and sets standards of practice which we must aspire to and exceed.

3 Definitions

3.1 All terms are explained in the glossary at Section 48

4 Duties

4.1 The Service Governance Committee has the responsibility to ratify the Care Programme Approach Policy.

4.2 The Professional Council holds the responsibility to approve the Procedures which are associated with this Policy.

4.3 The Chief Operating Officer/Director of Nursing is responsible for ensuring this Policy and its Procedures are adhered to (delegated to the Care Programme Approach Lead).

4.4 The Care Programme Approach Lead is responsible for ensuring this Policy and its Procedures are up to date, properly disseminated and its use audited via the audit processes.

4.5 Responsibility of Line Manager. It is the responsibility of the Line manager to ensure that:

- Relevant training is identified for staff through the appraisal process.
- Staffs attend training and subsequent refreshers.
- New employees receive information on the Care Programme Approach Policy and its associated Procedures.

4.6 Responsibility of the employee. It is the responsibility of the employees to ensure that they:

- Follow the Care Programme Approach Policy and its associated procedures.
- Attend training and subsequent refreshers.
Put their training into practice

4.7 All Managers and Team Leaders, both in-patient and in the community, are responsible for ensuring that their teams are aware of the policy and are implementing it fully and correctly.

4.8 All clinical, social care staff and administrative staff are responsible for using the policy correctly to ensure Service Users, their families and carers receive the highest quality of service.

5 Procedural Document development

5.1 The Trust already had an approved Policy in relation to the Care Programme Approach. This revised Policy takes account of the requirements as outlined in the Refocused CPA Policy Guidance issued by the Department of Health in February 2008.

5.2 Development of this Policy has been the responsibility of the Care Programme Approach Lead.

5.3 This Policy links to the Trust’s Strategic Intents, in that it promote the delivery of an excellent care planning and review system, which puts Service Users at the heart of the process.

5.4 Version 8 (this version) incorporates changes to the Roles and Responsibilities of Care Co-ordinators, whereby Consultant Psychiatrists are not to act as Care Co-ordinators for service users on CPA (or CPA and Section 117).

5.5 This Version also makes provision for changes that are due to be implemented within the In-patient Care Pathway. The main change centres on In-patient nursing staff providing follow-up to discharged patients within 48 hours of leaving hospital, before handing over care to Community-based Mental Health Services.

5.6 The Policy also charges Care Co-ordinators with the responsibility of making every effort to obtain a copy of associated care records being held by the hosting authority, prior to transfer into BDCT services.

5.7 Implementation of this Policy will be via the routes of management dissemination, new training and via team briefings.

6 Equality Impact Assessment

6.1 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage to others. An assessment has been undertaken to consider the need and assess the impact of this policy and can be found in Section 7.
7 Training Needs Analysis

7.1 The Trust is committed to high quality targeted training to support this policy. The Trust recognizes that training capacity can fluctuate and will depend on resources available. As such based on an assessment of capacity and risk, the training needs analysis will identify the high priority groups for training. The objective of the training to implement this policy is to meet training to this group over the time frequency stated. The focus of Trust monitoring will be on this group over the agreed period or lifetime of the policy.

7.2 Issues relating to capacity to meet training needs for the high priority group will be escalated by the policy lead to the relevant Director for action to mitigate the risk and inclusion on the appropriate risk register.

7.3 For a detailed account of training numbers, costs and action plan please refer to Training and Development Policy within HR

7.4 The CPA Training Team operate a flagging system to check, monitor and re-invite non-attendees. This will be monitored annually through an annual report.

8 Consultation, Approval and Ratification Process

8.1 The following groups have and will continue to be consulted about the development and review of this Policy:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Level of involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Managers</td>
<td>Review and comment</td>
</tr>
<tr>
<td>CPA Policy Development Group</td>
<td>Review and comment</td>
</tr>
<tr>
<td>Facilities and Informatics</td>
<td>Revision of clinical information system descriptors for CPA</td>
</tr>
</tbody>
</table>

8.2 Procedural Document Approval Process
   - The CPA Policy will be approved and ratified by the Service Governance Committee. Associated Procedures will be approved in future revisions by the Professions Council.

8.3 Ratification Process
   - The CPA Policy will be ratified by the Service Governance Committee. Associated Procedures will be ratified in future revisions by the Professions Council.

9 Review of the CPA Policy

9.1 The Policy will be reviewed every 2 years. (interim NHSLA review in 2012 reduces this temporarily to 1 year)
10 Dissemination of the Procedural Document

10.1 Dissemination of this Policy will be the responsibility of the Care Programme Approach Lead. The Policy will be cascaded via management and Team meetings.

11 Monitoring Compliance and effectiveness of the Procedural Document

11.1 The Compliance Checklist has been completed for this Policy and is held in Appendix x. The monitoring of the compliance of this policy will be as follows.

11.2 In relation to Clinical Risk we will monitor the following:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Monitored by</th>
<th>Monitored when</th>
<th>Evidenced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>CPA Lead</td>
<td>Annual</td>
<td>Files Audit, SGC Minutes, Prof Council Minutes, Job Descriptions, Peer Group Audit, 6 monthly reports</td>
</tr>
<tr>
<td>Organisation’s expectations in relation to staff training as identified in the TNA</td>
<td>CPA Lead</td>
<td>Annual</td>
<td>Training records in ESR, Training Sheets, Feedback forms completed, 6 monthly report to SGC</td>
</tr>
<tr>
<td>Tools/processes authorised for use within the organisation</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Peer Group Audit, 6 monthly reports, 6 monthly report to SGC</td>
</tr>
<tr>
<td>How clinical risk assessments are reviewed, including timescales (pilot)</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Peer Group Audit, 6 monthly reports, 6 monthly report to SGC</td>
</tr>
</tbody>
</table>

In addition, we will monitor compliance through Agenda for Change approved Job Descriptions; audit reports mentioned above and through ESR.

11.3 In relation to Clinical Transfer we will monitor the following:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Monitored by</th>
<th>Monitored when</th>
<th>Evidenced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handover requirements between all care settings, to include both giving and receiving of information</td>
<td>CPA Lead</td>
<td>Quarterly</td>
<td>Peer Group Audit, 6 monthly reports, 6 monthly report to SGC</td>
</tr>
<tr>
<td>how handover is recorded</td>
<td>CPA Lead</td>
<td>Quarterly</td>
<td>RIo Progress notes, 6 monthly report to SGC</td>
</tr>
<tr>
<td>Out of hours handover</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Policy, 6 monthly report to SGC</td>
</tr>
</tbody>
</table>
process

| How the organisation monitors compliance with all of the above. | CPA Lead | 6 monthly | 6 monthly reports | 6 monthly report to SGC |

11.4 In relation to Discharge we will monitor the following:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Monitored by</th>
<th>Monitored when</th>
<th>Evidenced by</th>
<th>6 monthly report to SGC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Discharge requirements for all patients</td>
<td>CPA Lead</td>
<td>Quarterly</td>
<td>Peer Group Audit 6 monthly reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>b) Information to be given to the receiving healthcare professional</td>
<td>CPA Lead</td>
<td>Quarterly</td>
<td>RiO Progress notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>c) Information to be given to the patient when they are discharged</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>d) How a patient’s medicines are managed on discharge (pilot)</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Audit report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>e) How the organisation records the information given in minimum</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Audit report</td>
<td></td>
</tr>
<tr>
<td>requirements b) and c)</td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>f) out of hours discharge process</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>Audit report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 monthly report to SGC</td>
</tr>
<tr>
<td>g) How the organisation monitors compliance with all of the above.</td>
<td>CPA Lead</td>
<td>6 monthly</td>
<td>6 monthly reports</td>
<td></td>
</tr>
</tbody>
</table>
<pre><code>                                                                                     |                |                | 6 monthly report to SGC |
</code></pre>

12 References and Glossary

12.1 Document References and Glossary are listed in Chapter 65
13 Associated Documentation

13.1 This Policy now contains a number of relevant Procedures, references to which are listed under each relevant section. In conjunction with this policy, staff should also read:
- Incident Management Policy
- Risk Management Strategy
- Policy for Patient’s Leave of Absence
- Police Liaison Policy
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Mental Health Act 2007 Policies and Procedures

14 What is CPA?

14.1 The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 through a circular ‘The Care Programme Approach for people with a mental illness referred to specialist psychiatric services as the principal strategy for the provision of mental health services within the community. This was reinforced in ‘Building Bridges’ in 1995, and the National Service Framework for Mental Health and it continues to occupy a position of prime importance in supporting the delivery of care and treatment in specialist mental health services. The most recent update in England is ‘Refocusing the Care Programme Approach’ (2008).

14.2 This Policy covers all the main elements of the CPA, but focuses particularly on the role of the CPA Care Co-ordinator (originally the CPA Key Worker), which has long been recognised as the linchpin of the whole process. It is vital that Care Co-ordinators be given the necessary guidance and support to enable them to successfully undertake their responsibilities.

14.3 The Policy was updated in 2001 to take account of changes in policy and guidance, particularly in the ‘National Service Framework for Mental Health’ and ‘Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach and again in 2007 to take account of the National Health Service Litigation Authority (NHSLA) requirements.

14.4 The refocused CPA policy updates and develops practice in mental health services, focusing on:
- Values and principles for all service users
- Refocusing the (new) CPA on people in contact with secondary mental health services who have complex characteristics. For those no longer on CPA — national standards but local arrangements
- Assessment and Care Planning standards
- A whole system approach to care planning and delivery
- Support for the workforce
- Measuring and improving quality
15 Service User Involvement

15.1 To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start. Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers without over promising or under delivering. Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected.

15.2 The approach to individuals’ care and support puts them at the centre and promotes social inclusion and recovery. It is respectful building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

15.3 Care Co-ordinators are crucial in supporting service user involvement. An effective Care Co-ordinator is one who keeps in touch, communicates regularly and devotes more time to those they are Care Co-ordinator for than to others.

The involvement of service users can be made more effective by the Care Co-ordinator:

- Being aware of boundaries and personal agendas;
- Recognising that care plans exist for the benefit of the person using the service, can be written by the person, and should be based around the needs of that person, not around the ability of the service to provide;
- Ensuring that the focus remains firmly on the individual and recognising that everyone has a role to play in his/her own care. ‘Consideration should be given, where practicable, to encouraging service users to write their account of their illness in their notes’;
- Recognising that: ‘people do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services’;
- Working, wherever possible, in a recovery-focused way with individuals, recognising that “recovery” will mean different things to different people and the concept of “person centred” or ‘personalised” services can change depending on an individual’s perspective’;
- Understanding that: ‘recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems’;
- Enabling the person to have a choice of worker wherever resources allow, particularly in respect of gender, ethnicity, culture, language, or religion. The person should feel able to ask for a change of Care Co-ordinator;
- If the service user does not have an advocate, considering (with them) whether an advocate should be sought to support them, and making sure they know how to contact advocacy services;
- Respecting the person’s choice of advocate;
- Involving the person in agreeing and writing the care plan as much as possible: Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No ‘one size fits all’;
- Ensuring that the review process is designed around the needs and wishes of the person, and recognising the disempowering effect of large meetings; Being flexible in your approach to the person’s involvement;
- Always checking the literacy skills of service users and carers. It may be necessary to get the care plan translated for people whose first language is
not English, or to use symbols for people with learning disabilities;
- Offering the person copies of care plans, review notes etc;
- Leaving contact cards (including alternative numbers) with the person;
- Arranging to meet at mutually convenient times;
- Spending time with the person;
- Explaining fully the CPA process;
- Establishing clear protocols for ‘deputising’ arrangements; and
- Accepting that reviews can be initiated by any member of the care team (including non-statutory services) or the service user or carer.

15.4 Our Choices in Mental Health’ outlines the key values underpinning choice for people who use mental health services and their carers:
- Living a normal life as far as possible;
- Being included in local communities and activities;
- Not being stigmatised or discriminated against on any grounds;
- Easy access to up-to-date and accurate information;
- Genuine options and/or choices of care available locally;
- Personalised care plans that are built around the wishes of each individual and their carer; and
- Services and staff that promote and enable recovery and well-being.

16 Advocacy

16.1 Many people experience difficulty in speaking up for themselves and expressing their needs, and there are ways of supporting them in this. One of the most effective is advocacy.

16.2 Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

16.3 Commissioners and services should recognise the positive role that advocacy can play in enabling effective service user involvement in the development and management of their care and the benefits that a skilled advocate can bring in helping service users engage with what can often feel like an overwhelmingly complicated and intimidating system.

16.4 Under the Mental Capacity Act 2005, Independent Mental Health Advocates (IMHA’s) have been introduced.

17 Carer Involvement

17.1 Carers often make a major and valued contribution to the support received by many people with a mental illness being treated in the community. Where a care programme depends on such a contribution, it should be agreed in advance with the carer who should be properly advised both about such aspects of the patient’s condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day-to-day basis.

17.2 Carers form a vital part of the support required to aid a person’s recovery. To effectively involve carers, Care Co-ordinators should:
- Be aware of who the main carers are, what their relationship is with the person, and how to contact them;
- Communicate with carer/s as far as possible; Be tactful where service users do not accept the involvement of their families, but recognise that conflict should
not be a barrier to carer involvement, carers still need information and other services in these situations;

- Make sure the carers are advised that they may be entitled to a carer’s assessment, and offer this;
- Consider the need for an individual support plan for the carer;
- Be aware of the carer’s needs;
- Make sure the carer knows how to contact the Care Co-ordinator; It is important that “Points of access” to mental health teams should be provided for families who are concerned about a patient’s risk’;
- Include the carer’s role in the care plan; Carers should be involved in care planning, particularly social care needs and crisis planning; and
- Staff should encourage carers to have direct involvement in key decisions e.g. CPA reviews, arrangements for discharge from in-patient units.

17.3 As ‘Standards for Better Health’ says in its Patient Focus domain: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

17.4 Carers and families should be advised of any risks to them or to the person using the services which may arise from the treatment/care plan. For example, the risk of not taking medication, or missing appointments with community mental health professionals.

17.5 Good practice recommendations from ‘Positive & Inclusive?’ suggest effective ways for professionals to involve carers in information sharing:

- Basic information on mental health problems;
- Carer education programme and peer support groups to empower and support their own recovery;
- Professional need to provide carers with opportunities to discuss information and listen to carer concerns;
- Where information cannot be shared (because of lack of consent) offer a supportive explanation rather than perceiving confidentiality as a block’ to engaging with carers;
- Respect for carers knowledge and experience; and develop a collaborative working culture in mental health.

18 Balancing the needs of Service Users and Carers

18.1 Where people’s choices conflict with those that carers or family members might have made on their behalf, it is important to balance both sets of needs and ideal’ find a resolution acceptable to all parties.

18.2 The challenge for services is how to support the interests of the individual and ensure that family carers are involved in decision making, are supported and valued, and that their issues and concerns are heard.

18.3 Carers of people with mental health problems who provide regular and substantial care for a person on CPA should:

- Be identified by health and social services ;
- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
• Have their own written care plan which is given to them and implemented in discussion with them;
• Have seen and had explained to them the care plan of the person for whom they provide care. In general, the service user’s consent should always be explicitly sought before information is passed on to their carer. If the service user is incapacitated, information may be passed to the carer if it is in the service user’s best interests;
• Be given information about the service user’s illness to help increase their understanding of the nature of the service user’s illness;
• Know how to contact services if they need to; and
• Have their care plan reviewed at least annually.

19  Equality of Opportunity and Diversity

19.1 The following equality issues must be considered throughout the CPA process: age, disability, gender, sexual orientation, race and ethnicity and religious beliefs.

19.2 Equality of opportunity relates to four main areas:

• The development of policy and procedures:
  ➢ The Trust is required to assess the impact of any policy proposals on different groups in the community in terms of equality of access and impact on the rights and needs of those groups

• The need for services;
  ➢ Mental Health Services need to develop and demonstrate cultural competence

• Access to services, resources etc.;
  ➢ An interpreter, or in the last resort a family member will be necessary when language is a barrier

• Treatment once within a service;
  ➢ To help ensure that quality mental health services are provided to all, appropriate to their needs, services must also pay attention to the potential for inequalities in outcomes of individual care assessment and planning, and the service they provide.

19.3 Important factors:

• The discrimination people experience may contribute to their mental distress and ill health;

• There have been ‘significant over-estimates of non-white patients assessed as being violent by mental health professionals compared to white patients in contrast to their subsequent behaviour’;

• There has been a tendency to organise services generally in ways which are ‘blind’ to the actual needs of such individuals and the groups to which they actually belong; and

• In relation to carers, services need to be sensitive to different cultural models,
particularly an appreciation of the role of kinship networks and extended families and to the impact of age e.g. young carers.

19.4 If a Care Co-ordinator/lead professional is to ensure that the needs of the people they work with are met then they have a duty to work in what has been called a critical way. This involves being sensitive to and continually questioning:
- Their own assumptions;
- Peoples’ interpretation of an individual’s language and behaviour; and
- The impact of discrimination on individuals.

20 Communication

20.1 All services should provide written materials in the language of the service user, and interpreters should be sought for people who have difficulty in speaking

20.2 There much good practice, but more needs to be done so that individuals directly feel the impact of policy advances in their daily interactions with services, and can recognise and realise the tangible benefits and outcomes from receiving them.

21 The Principles underpinning CPA

21.1 The Care Programme Approach is underpinned by Values and Principles for Mental Health Services. These are articulated in ‘Refocusing the CPA’ which applies specifically to England, but apply equally to any modern mental health service.

21.2 The approach to individuals’ care and support puts them at the centre and promotes social inclusion and recovery. It is respectful building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

21.3 Care assessment and planning views a person ‘in the round’ seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

21.4 Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

21.5 Carers form a vital part of the support required to aid a person’s recovery. Their own needs should also be recognised and supported.

21.6 Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the Care Co-ordinator is one of the most important determinants of success.
21.7 Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

22 CPA Policy

22.1 As ‘Effective Care Co-ordination in Mental Health Services’ says ‘The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a key worker [care co-ordinator] to keep in close touch with the service user and to monitor and co-ordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.

22.2 From October 2008, the term CPA relates to those service users who have complex characteristics (as outlined in Section 23). It describes the approach used to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services.

22.3 The Mental Health Act 2007 establishes a new simplified single definition of mental disorder, which does not distinguish between different categories of mental disorder, so the same criteria apply to all individuals. In particular, people with a personality disorder should be able to benefit from treatment and support, and this guidance applies to them just like anyone else.

22.4 The policy mainly covers adults of working age, but the principles should be applied to any individual receiving specialist mental health services regardless of their age. Guidance is given where other systems also apply including for:

- Older adults
- CAMHS
- People with learning disabilities
- Offenders
- Substance misuse

23 Criteria for CPA

23.1 The Refocusing of CPA has introduced a wider set of inclusion criteria, which Care Co-ordinators and multi-disciplinary teams must use to determine the appropriate level of support a Service User requires.

Characteristics to consider when deciding if the support of CPA is needed:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity.
- 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 the 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.

**Key groups who would normally need the support of CPA are service users who:**

- Have parenting responsibilities.
- Have significant caring responsibilities.
- Have a dual diagnosis (substance misuse).
- Have a history of violence or self harm.
- Are in unsettled accommodation.
- Are subject to Supervised Community Treatment (SCT) or Guardianship (s.7) under the Mental Health Act 1983.

If these service users are not supported through CPA, the reasons must be clearly documented in the records.

**23.2 Service users who don’t need the support of CPA (Standard Care)**

Those service users with more straightforward needs: one agency or no problems with access to other agencies support. Services should consider at every formal review whether the support provided by CPA will be needed, As a service users’ needs change or the need for co-ordination support is minimised. Moving towards self directed support will be the natural progression

**23.3 The additional support of CPA should not be withdrawn without an appropriate review and handover (e.g. to the lead professional or GP).**
24 **Personalisation**

24.1 All Local authorities have a statutory duty under the NHS and Community Care Act (1990) and the National Assistance Act (1948) to assess and provide services to people with social care needs who are eligible for funding under Fair Access to Care Services. In mental health services, these duties are discharged through the Care Programme Approach. Traditionally these services have been offered through block contracted services such as mental health day services, supported accommodation, respite care and residential and nursing home placements. Such services at times can provide limited choice and flexibility to meet service users’ individual needs and preferences.

24.2 Social care policy has now changed with a move towards more personalised services and self directed support. New policies such as Putting People First (2007) sets out the vision of transforming social care from a service led system of assessment and provision to one of self directed support. Self directed support puts service users at the centre of the support planning process and allows them greater choice and control over how their social care needs are met and ultimately how they live their lives. Self directed support provides the opportunity for service users to have greater autonomy and self determination through the use of individual budgets.

25 **Single Assessment Process (SAP) for Older Adults**

25.1 The aim of the Single Assessment Process (SAP) is to ensure a person centred approach to assessment and care planning for older people, regardless of operational boundaries. SAP provides a platform to reduce unnecessary duplication or repetition by a variety of health and social care agencies, with its tiered assessment model of:
- Contact
- Overview
- Specialist
- Comprehensive

25.2 Where the older person’s needs are being met and managed mainly in primary care and social care, and they have a mental health problem which is neither complex nor includes significant risk, care will be co-ordinated through existing SAP Care Managers.

25.3 When an older person’s mental health and social care package is complex, predominantly mental health-related, and the person meets the criteria for CPA, they will normally require the support of CPA, and will have a mental health Care Co-ordinator.

26 **Health Action Planning (HAP) for people with learning disabilities**

26.1 This is an action plan offered to people with learning disabilities to describe the health services being provided to support them. It is a written plan which forms part of the person centred plan. It is produced and co-ordinated by the health facilitator in partnership with primary care nurses and GP’s. It is reviewed at the following stages of people’s lives:
- Transition from secondary education with a process for ongoing referral;
- Leaving home to move into a residential service;
- Moving home from one provider to another;
- Moving to an out of area placement;
- Changes in health status, for example as a result of a period of out-patient care or in-patient treatment;
- On retirement; and
- When planning transition for those living with older family carers.

27 Person Centred Planning (PCP) for people with learning disabilities

27.1 Person centred planning is a mechanism for reflecting the needs and preferences of a person with a learning disability and covers issues such as housing, education, employment and leisure.

27.2 This is a plan which starts with the wishes and aspirations of the individual with learning disabilities, and which should help the person exercise choice about housing, education, employment, support, and leisure.

28 CAMHS and CPA

28.1 The NSF for children, young people and maternity services makes it clear that CPA is the system to be used when children and young people are discharged from in-patient services into the community, and when young people are transferred from child to adult services, as it ensures continuity of approach.

28.2 Where a criterion of complexity applies in CPA, there is theoretically no lower age limit for the use of CPA.

29 The Role, Authority and Responsibilities of the Care Co-ordinator and Lead Professional

29.1 This policy outlines the revised roles to be undertaken by both Care Co-ordinators (supporting service users on CPA) and Lead Professionals (supporting Service Users with Standard Care needs)

29.2 Lead Professional. This is a new role introduced in ‘Refocussing the CPA for people who do not need CPA. As part of their role, the lead professional will therefore need to:

- Conduct a full needs assessment, which must include a comprehensive risk assessment, which will determine the nature of the clinical care to be delivered;
- Agree with the service user a statement of care (care plan) which must be documented in clinical or practice notes. This needs to be in a transferable format accessible to the service user such as a letter;
- Ensure that the care plan, including crisis and contingency planning is formulated, updated and circulated;
- Review the person’s progress on a regular basis with view to determining whether CPA is required or not;
- Identify and liaise with carers with regard to ensuring that any care that they may need is accessible from the appropriate agency;
- Maintain accurate record keeping;
• Maintain appropriate liaison with others involved in the person’s care to ensure continuity of care; and
• Inform the person of the availability of advance statements should they wish to utilise them.

29.3 For older adults who have complex physical health, mental health and social care needs, where a variety of services are being provided, any one of those agencies may be managing the person’s care, and the person may or may not require a lead co-ordinator from mental health services.

29.4 The Care Co-ordinator

The Care Co-ordinator has: responsibility for co-ordinating care, keeping in touch with the service user, ensuring that the care plan is delivered and ensuring that the plan is reviewed as required.

29.5 The Care Co-ordinator's core functions are to carry out:
• Comprehensive needs assessment;
• Risk assessment and management;
• Crisis planning and management;
• Assessing and responding to carers’ needs;
• Care planning and review; and
• Transfer of care or discharge.

29.6 As part of their role the Care Co-ordinator will therefore need to:
• Ensure a comprehensive, multi-disciplinary and multi-agency assessment of the person’s health and social needs is carried out (including an assessment of risk and any specialist assessments);
• Ensure that all service users for whom they are Care Co-ordinators, have an up to date HONOS and have been initially “Clustered” by 31 December 2011, with on-going clustering occurring according to cluster review requirements;
• Co-ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them. Ensure that the care plan is sent to all concerned;
• Arrange for someone to deputise if absent, and pass on the Care Co-ordinator role to someone else if no longer able to fulfil it;
• Familiarise themselves with past and present records about the service user. both paper and electronic;
• Ensure that crisis and contingency plans are formulated, updated and circulated;
• Ensure that the person is equally involved and has choice, and assist him/her to identify his/her goals;
• Ensure that carers and other agencies are involved and consulted where appropriate;
• Ensure that the person understands the role of the Care Co-ordinator;
• Ensure that the person knows how to contact the Care Co-ordinator, and who to contact if the Care Co-ordinator is not available;
• Ensure that the person is registered with a GP, and that s/he is involved and informed as necessary;
• Maintain regular contact with the person and monitor his/her progress,
whether at home or in hospital, regardless of setting. If a person who remains vulnerable refuses to take part in the CPA process, all steps should be taken to find out why, and to continue to attempt to engage him/her;

- Maintain regular contact with people who have been sent to prison (including face-to-face contact where possible), and liaise with mental health staff working with the person in prison, in order to provide continuity of care. It is vital to be aware of any changes in location within the prison estate and likely release dates. so that proactive care can be planned for their release. In this situation, contact with and support for carers should also continue.
- Organise and ensure that reviews of care take place and that all those involved in the person’s care are invited, consulted, and informed of any outcomes. Chair the reviews if appropriate;
- Explain to the person, their relatives and informal carers what the CPA process is and make them aware of their rights and roles;
- Consider the need for advocacy for the person, or carers if appropriate, and make them aware of any advocacy or self-advocacy schemes taking into account the Mental Capacity Act 2005;
- Identify unmet needs and communicate any unresolved issues to the appropriate managers, through the appropriate systems;
- Ensure that other care systems requirements are met where necessary including consideration of local eligibility criteria in respect of FACS (Fair Access to Care Services), Person Centred Planning (PCP), Single Assessment Process (SAP), Health Action Planning (HAP) and Children’s Assessment Framework (CAF);
- Consider and explore Direct Payments with eligible persons and carers, with the aim of promoting their independence;
- Take responsibility for ensuring continuity of care, using home visits (including visits to prisons), repeat appointments etc. Providing clear written instruction on how to contact team members responsible for aspects of the care are made available to all those who need them; and
- Have face to face contact with the service user within a week of discharge from in-patient care.

29.7 However, follow-up should be within 48 hours for persons who have been at high risk, with a more intensive provision of care in the first 3 months after discharge.

29.8 The complexity of the Care Co-ordinator’s role in any person’s case will reflect the complexity of that individual’s needs and risks. The role is essentially one of co-ordination and communication. As professionals, Care Co-ordinators are responsible for actions within their own sphere of responsibility. They should:

- Be clear about where their role starts and ends;
- Be clear about the role of others involved in the care; and
- Communicate concerns, risk factors and changes to everyone involved.

The common law duty of care is a duty to take care, that is, not to be negligent.

29.9 This is not the same as a statutory duty, and specific legal issues relate to particular legislation. Care Co-ordinators should make themselves aware of how it relates to them and their role. If in doubt, they should seek advice from their manager, their professional organisation, and/or the Care Trust’s Human Resources and/or Legal departments.
29.10 The Care Co-ordinator must have the authority to:
- Monitor the care plan being provided;
- Co-ordinate the delivery of the care plan;
- Call a review;
- Access resources;
- Accept or refuse the role of Care Co-ordinator based on their appropriateness; and
- Access directly other members of the person’s care team.

29.11 The Care Co-ordinator may also take on other roles, such as Guardian under the Mental Health Act 1983, and must be aware of how these impinge on the role of Care Co-ordinator.

30 Change of Care Co-ordinator

30.1 Where there is the need for a change of Care Co-ordinator, this can be a very disruptive event in the life of someone using mental health services, and must be handled with care. The key points are to:
- Discuss the reasons for the change with the person and the care team;
- Secure the agreement of all concerned and ensure a smooth handover;
- Consider any funding issues e.g. s.117 of the Mental Health Act 1983;
- Ensure the new Care Co-ordinator receives appropriate information e.g. case summary, assessment, risk assessment, needs statement and care plan; and
- Good practice would suggest that there is a handover meeting from one care team to another to share relevant information and introduce the person and/or carer.

30.2 Whilst it is good practice to involve the person and his/her carer in all facets of care, refusal of consent for information sharing with relevant others can be overridden by the clinical team where there are issues of risk to self or others, risks to children and vulnerable adults.

31 Allocation and Choice – who should be the Care Co-ordinator or Lead Professional?

31.1 The CPA Care Co-ordinator should be trained. It should be part of their job description and co-ordination support is recognised as a significant part of their caseload.

31.2 In general, the following will not usually be identified as a CPA Care Co-ordinator:
- Consultant Psychiatrists
- Support Treatment and Recovery (STR) workers;
- GP’s; or
- Unqualified/unregistered health or social care workers.
31.3 **Who should be lead professional?**

The worker taking lead responsibility for the person’s treatment and care, when the person has been assessed as not needing the support of CPA, should undertake the role,

31.4 **Who should be the Care Co-ordinator?**

The role of care co-ordinator should usually be taken by the person who is best placed to oversee care planning and resource allocation and can be of any discipline depending on capability and capacity.

31.5 The Care Co-ordinator should have:
- Competence in delivering mental health care (including an understanding of mental illness); 
- Knowledge of the service user/family (including awareness of race, culture and gender issues);
- Knowledge of community services and the role of other agencies; Co-ordination skills; and
- Access to resources.

31.6 The decision on who should be the Care Co-ordinator should take into account:
- The person’s needs and choice;
- The worker’s experience, training and qualifications;
- The worker’s level of input to care and relationship with the person;
- The worker’s current caseload size; and
- Their level of authority.

31.7 However, it is not the intention that the Care Co-ordinator necessarily is the person that delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required. This approach supports the principles of New Ways of Working, which aims to use the skills of all in the most appropriate, effective and efficient manner.

31.8 **Points to Note:**
- Choice of gender of Care Co-ordinator or lead professional may be a crucial factor in the development of a therapeutic relationship with those people who have experienced sexual abuse or violence.
- In response to a Serious Incident Review, the Policy has been revisited to ensure that Consultant Psychiatrists are not named Care Coordinators for service users who are high risk and subject to Section 117 of the Mental Health Act.
- Persons accessing mental health services should also be afforded a choice of the most suitable Care Co-ordinator or lead professional which takes into account cultural or religious needs. This does not necessarily mean that the Care Co-ordinator or lead professional has to come from the same religious, cultural or racial group as the service user. The issue of choice must not be used to support discrimination such as racism, misogyny or homophobia.
- A Care Co-ordinator or lead professional must be agreed as soon as practicable after the service user is first in contact with services.
• Persons accessing mental health services with the greatest level of need should usually have the Care Co-ordinators with the most skill and experience.
• The proposed Care Co-ordinator or lead professional must be aware of, and have agreed to take on this role.
• A worker should be able to refuse to take on the role of Care Co-ordinator or lead professional for a person, e.g. if they do not have the appropriate skills.
• Care Co-ordinators can be from the third sector (independent/voluntary), but this must be by local agreement or commissioning and take into account all the aforementioned factors and audit issues.

32 Assessment of Need

An individual service user’s care plan must be based on a thorough assessment of their health and social care needs. This assessment will involve the user and carer, where appropriate, as central participants in the process.

32.1 Purpose of assessment

Assessment is a core activity of all workers in mental health services. Its purposes are to:
• Provide an initial assessment of mental health needs and where they may be met;
• Evaluate the individual’s strengths;
• Identify the service users goals, aspirations and choices; Identify areas of need;
• Assess the level of risk;
• Identify the need for specialist assessment, i.e. personality disorder, substance misuse, etc, and where appropriate refer to a relevant service, agency or profession;
• Determine whether intervention from mental health services is appropriate; Identify the person’s need for CPA; and
• Establish an information base.

32.2 The Assessment Procedure can be found at Section 48

33 Risk assessment

33.1 The best quality of care can be provided only if there are established links between the need assessments of service users and risk assessment. Risk assessment is an essential and on-going element of good mental health practice and critical and integral component of all assessment, planning and review processes. Risk Assessment is an essential and ongoing part of the CPA process. Risk assessment is about weighing up both the possible beneficial and harmful outcomes and stating their likelihood.

33.2 Modern risk assessment and management should be based on the principle that the assessment of risk is structured, evidence based and as consistent as possible across a range of settings and across service providers. This consistency is essential for good communication between practitioners and agencies and will contribute to improved care. In England, any locally agreed policies and procedures in relating to the management of risk should be informed by ‘Best Practice in Managing Risk’.
33.3 Risk assessment tools however can only contribute one element to a broader overview of the risks presented by a particular individual; they should only be used as part of a general clinical risk assessment conducted with the service user. The findings of tool-based assessments must always be combined with information on many other aspects of the person’s life and current situation.

They are an aid to clinical decision-making, not a substitute for it.

33.4 Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgement.

33.5 Within the Trust, we currently use the RiO Risk Profile to assess risk and develop plans to manage any identified risks. The Procedure for using RiO can be found in Section 50. In addition to the RiO Risk Profile, Low Secure Services also carry out additional assessments using HCR-20.

33.6 From 1 April 2011, Primary Care Mental Health Services form part of the range of services offered by Bradford District Care Trust.

33.7 Whilst the principles of CPA will not usually apply to service users accessing this service, there may be circumstances where referral into secondary mental care will occur and an understanding of the requirements for assessing risk in both services is required. Primary Care Mental Health Services use the Threat Assessment Grid (TAG) to assess the risk of service users harming themselves or others.

33.8 The Risk Assessment Procedure is detailed in Section XX

33.9 Primary Care Mental Health Services Risk Assessment Policy and guidance to staff can be read at Section 51.

34 Care Planning

34.1 A care plan is a record of needs, actions and responsibilities written in an accessible and jargon free way. Care plans exist for the benefit of the person using the service, and should be based around their needs, not around the ability of the service to provide.

34.2 Devising a care plan is part of the process of understanding a persons’ situation and deciding a way forward. It has several functions:
  - It is a description of the process of care planning;
  - It summarises identified needs and how they are to be met: and
  - It is a formal record setting out what is going to be done, why, when, and by whom.

34.3 Principles of care planning:

Care planning is defined as:
  - A multi-agency endeavour;
  - Meeting the requirements of CPA (and the Single Assessment Process, Person Centred Planning and Health Action Planning where relevant);
Being co-ordinated by the Care Co-ordinator/Lead professional who should make sure that everybody who needs to know about the care plan gets a copy. This will include everybody who has been part of the planning process and who have responsibilities for delivering services to the person;

Being based on a thorough assessment of an individual’s health and social care needs;

Focusing on service user’s strengths and seek to promote their recovery;

Recognising the diverse needs and preferences of service users, reflecting their cultural and ethnic background as well as their gender and sexuality;

Being done in the most appropriate forum. In arranging and agreeing someone’s care it is important to recognise that it may be neither possible not appropriate for everyone involved to sit down together and discuss how to meet the service user’s needs. The most important thing is to get everyone’s views and agreement, and other methods of planning should be considered;

Detailing the formal interventions that are necessary. Only when all appropriate informal community options have been explored should specialist options be turned to;

Taking account of any risk to the person, their carer, any worker involved in delivering the plan, and the wider community; and

Being based on a collaborative approach, involving the service user, and where individuals have advance decisions or advance statements agreed copies should be attached/included in the care plan.

34.4 All people on CPA have a right to:

- The development of a care plan;
- Sign the care plan;
- A copy of the care plan;
- Develop their own care plans.

34.5 The Outline Procedure for Care Planning can be found in Section 52

35 Choice

35.1 Choice is a basic tenet of the Care Programme Approach. ‘Our Choices in Mental Health’ establishes the core principles for promoting choice, in acknowledging that people have the right to choose their treatment, and that choice applies across the spectrum of care and settings. It emphasises the increasing importance of:

- Direct payments
- Individual budgets
- Statements of wishes and advance decisions

36 Access

36.1 All members of the multi-disciplinary team must be able to access the latest care plan during and out of office hours. There should be 24 hour access to services for all service users on CPA and care plans must be held centrally within a database that is regularly updated. Within appropriate confidentiality and securing protocols, information of each service users assessments, care plans, and progress will be available, to read or add to, wherever staff are delivering care.
37  Advance Decisions and Statements of Wishes

37.1 Encouraging patients to set out their wishes in advance will often be a helpful therapeutic tool. Encouraging collaboration and trust between patients and professionals. It is also a way in which patients’ expertise in the management of crises in their own conditions can be deployed.

37.2 Part of the assessment process should be to enquire whether the service user has either an advance statement or advance decision.

37.3 When assessing a service user’s needs the Care Co-ordinator should check with them, and on any records, to identify if an Advance Decision/statement exists. This is an important factor to take into account if a service user has transferred from one service to another.

37.4 The Care Co-ordinator will have to take into account the information expressed in the Advance Decision/Statement when drawing up the care and crisis plan. Where a decision is taken to act contrary to the wishes expressed in an Advance Decision/Statement, the Care Co-ordinator must record the clinical justification e.g.

- The decision is necessary
- The decision is reasonable
- The decision is in the best interests of the patient

37.5 Provisions under the Mental Health Act take precedence over any wishes expressed in an Advance Statement. However, the care team should still discuss the wishes expressed and that they are considered as part of the care planning process.

37.6 Care Co-ordinators and Lead Professionals can find further information on Advance Decisions and Advance Statements on the CPA section of the Intranet. This Intranet also holds the updated information leaflet and relevant forms to use.

38  Reviews Outcomes and Evaluations

38.1 The purpose of Reviews is to consider:

- Any progress the service user has made.
- The views of the service user, carer, and professionals.
- How the service user has responded to the services being provided.
- Ways in which their needs may have changed; and as a result:
  - The extent to which the care plan requires amending.

38.2 Reviews should always take account of the needs of individuals in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs, housing, stigma and discrimination, as well as medication issues.

38.3 It is important to check with the service user whether they have or want to change or amend their Advance Statement. This may have an impact on the crisis and contingency plan, which may need amending in light of any changes to the Advance Statement.

38.4 The Review Procedure can be found in Section 53.
39 **Outcomes**

39.1 Assessments and care plans should routinely include arrangements for setting out, measuring and reviewing specific outcomes. An outcomes focus can help to improve understanding of the impact of services on the lives of people who use them; give assurance that treatments and care provided are producing results; and ensure that outcomes related to treatment, care and support are monitored on an on-going basis.

39.2 The desired outcomes should be explicitly agreed with the service user and carer(s) at the beginning of the care process so that the plan is personalised to the service user.

39.3 Outcomes set should be realistic and achievable. Service user defined outcomes are particularly valuable.

39.4 Possible Outcomes of Reviews may be to:

- Highlight unmet needs;
- Change the amount of support required, and update the care plan;
- Move from or to CPA/change the level of CPA
- Discharge from services;
- Update the risk assessment, crisis or contingency plan
- Transfer to another system of care, either in another provider area

40 **Outcome Measures**

40.1 Measuring the outcome of the CPA is not a simple task, as many other factors will affect the outcome for an individual. The Care Co-ordinator has the responsibility of monitoring and reviewing the care provided to an individual, and one way of informing this process is by measuring outcomes. Measures of function and measures of need are two complementary approaches that can be used.

40.2 For people on CPA, HoNOS (Health of the Nation Outcome Scales) ratings will be completed at significant points of change within the care pathway and at any event, at least once a year. In addition, however, there is a growing number of instruments available to help measure outcomes.

40.3 The Health of the Nation Outcome Scales (HoNOS) are a brief standardised assessment measure which provide a means of measuring progress. The scales are designed for use by all mental health workers and are simple enough to be used routinely.

40.4 In April 2011, the Care Packages and Pathways (Clustering) process commenced. It is the responsibility of all Care Co-ordinators to ensure they complete an initial cluster for all of their caseload by 31 December 2011 and to ensure that on-going clustering occurs according to each cluster’s particular review requirement.

40.5 The agreed RiO Core Assessment will be used routinely as part of the review process provide measures of the extent to which needs are being met.
40.4 All practitioners must ensure rigorous evaluation of goals and outcomes of the individual’s care plan. Individual practitioners will need the skills and be given the support to identify ineffective quality systems and approaches.

41 Criminal Justice and Assessment of Offenders

41.1 The Care Programme Approach (CPA) is one of the key elements of current mental health care policies, and should extend to the prison context. Prisoners who were on CPA before entry into prison should be able to have their programmes of treatment set out for them and continued as far as possible within the prison setting. Care co-ordinators based in the community should endeavour to retain contact with patients who have been sent to prison, and liaise with prison based staff working with the patient, in order to provide continuity of care, particularly on release. Furthermore, inmates whose clinical profile would precipitate CPA in the community should commence on CPA in prison. It will be important to ensure that there are mechanisms in place to help identify prisoners who are, or should be, on CPA.’

41.2 CPA has applied to offenders in England for a number of years, and Secondary Mental Health Teams working in prisons have often used it very successfully to ensure a safe and effective re-engagement with mental health services in local areas. There are, however, some critical points in the pathway.

41.3 Where (new) CPA is appropriate in prison or hospital (criteria will apply), the same safeguards should be continued for an appropriate period when the service user is released or discharged. Automatically removing the support of CPA at this point could compromise the safety and treatment of the individual at a vulnerable point in their care pathway.

41.4 Establishing whether a service user is a parent at the initial assessment stage is critical, and should be routine. Parents who play an active role in the care giving role and who are temporarily separated from their children (e.g. when in prison) should also be included (in CPA).

41.5 Full details of the Criminal Justice and Assessment of Offenders Procedure can be found in Section 53

42 Discharge/Transfer/Leave (including Clinical Handover of Care)

42.1 Any type of discharge, transfer or leave includes potential risks of disengagement, loss of contact, disruption of services, discontinuity, or harm to the individual or others. It is therefore essential that:

- The process is co-ordinated by one named individual;
- There are clear plans, made in advance and agreed with all concerned;
- Information is shared with all relevant people;
- There is some follow-up afterwards to ensure that the process worked and the person is safe; and
- In the case of Transfer, all proper Infection Control measures have been addressed.

42.2 See Section 54 for procedural guidance
Confidentiality and Privacy

43.1 Mental health care is based on good communication that flows readily to the people who need it, with Care Co-ordinators at the centre of the process. Confidentiality is therefore important in respecting the rights and sensibilities of service users and carers.

43.2 To ensure that individuals receive the seamless’, high quality support or service relevant to their needs a co-ordinated, multi-agency approach may be appropriate. It may then be necessary for those involved to share personal identifiable information between the organisations and this requires both mutual trust and confidence in the way that each manages that information.

**Where a clear and significant risk of the patient causing harm to others cannot be abated by any other means, confidence may be broken.**

43.3 The following principles are intended to help decisions about what to pass on, to whom and how much:

- Both the individual and those trying to help them can be put at risk by a failure to communicate with others who are also involved.
- Care Co-ordinators and other people are entitled to information they need to provide care safely - no more and no less.
- Other people involved in someone’s care also have a duty of confidentiality, and it may be appropriate to check their policy.
- Each organisation must inform service users that information is being collected and recorded about them, the reasons or purposes for doing so (including any statistical or analytical purposes), the persons or organisations with whom it may be shared and the reasons for such sharing. Each participant organisation must inform service users what the implications may be if they choose to agree or restrict the disclosure of information.
- Always attempt to obtain the consent of service users and carers to the disclosure of information, however, issues around confidentiality should not be used as a reason for not listening to carers, nor for not discussing fully with service users the need for carers to receive information so that they can continue to support them.
- Where consent has been withdrawn, passing information on can be difficult but necessary.

43.4 If consent is withdrawn it is good practice to discuss the reasons for this, and the implications of not passing information on. The information may have to be passed on in any case:

- in the interests of the person’s care
- in the public interest or in the interest of public protection
- if the information is required by statute or court order

43.5 The risk to any therapeutic relationships should be balanced against the potential benefits for the person or others if the information is passed on.

43.6 When in doubt consult colleagues, managers and (in particularly sensitive situations) legal opinion.

43.7 If a prisoner is judged to present, by virtue of a mental illness a potential risk to
others or to themselves but does not consent to communication of information about their condition, prison health care staff should (on public interest grounds) release relevant information to appropriate agencies including voluntary organisations) who are or may be involved in ongoing care.

43.8 The capacity of the individual to make a decision about information sharing must be taken into account, and the safeguards present in the Mental Capacity Act used where appropriate.

43.9 The Data Protection Act 1998 influences many of these issues, in particular concerning Social Work Records, health records, and joint health and social care records. NHS trusts and social services departments will need to have appropriate procedures in place where joint records are held. to inform the data subject that the data are held jointly, that access can be provided through either organisation, and to inform each other that access has been given. See the Data Protection Act 1998 and related guidance for further information.

43.10 Guidance in Confidentiality NHS Code of Practice gives guidelines on Informing Patients Effectively (No Surprises) including:
- Check that patients have seen the available information leaflet;
- Make clear to patients when information is recorded or health records are accessed;
- Make clear to patients when information is or may be disclosed to others;
- Respect the right of patients to have access to their health records; and
- Communicate effectively with patients to help them understand.

43.11 Robust CPA standards require that protocols are agreed for the sharing of information with the police, probation service, local prison (if appropriate), court liaison and independent/voluntary sector agencies involved in care provision.

44 Caseload management and clinical supervision

44.1 Good caseload management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that care co-ordinators are maintaining caseloads of suitable sizes with individuals who have active needs, and that support and clinical supervision is provided.

44.2 The Care Co-ordinator should expect to have:
- A policy and procedure which is clear as to the form that caseload management takes;
- Regular and planned caseload management/clinical supervision sessions;
- A local policy on the procedure for dealing with caseloads which are too large;
- All staff including managers should have training on the caseload management/clinical supervision system in use;
- Audit of caseloads; and
- The possibility of inter-disciplinary clinical supervision.
- To have the opportunity to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on care or on the delivery of services.
44.3 Workload management should take into account commitments, other than caseload, such as: ASW duty; management responsibilities; training etc.

44.4 Newly qualified staff should be allocated less complex cases and be closely supervised. The more formal the risk assessment, the higher the degree of personal competency required. All staff should receive supervision — regardless of their skills, competency or experience.

44.5 A commitment to good quality supervision which includes professional development is essential to support multi agency working.

45 Care Co-ordinators Capabilities, Competencies and training

45.1 The role of the Care Co-ordinator is the key to the successful operation of Care Coordination. The Care Co-ordinator is charged with the responsibility to keep in close touch with the Service User and monitor care.

45.2 The Principles under which a Care Co-ordinator operates are defined below. It is expected that they will:
   - work in partnership with people who have complex mental health and social care needs, and those supporting them;
   - strive to empower people using services to have choices and make decisions to determine their wellbeing and recovery;
   - integrate and co-ordinate a person’s journey through all parts of the health and social care system;
   - enable each person to have a personalised care plan based on his/her needs’ preferences and choices;
   - ensure that the person receives the least restrictive care in the setting most appropriate for that person;
   - support the person to attain wellbeing and recovery;
   - ensure that the needs of carers/families are addressed.
   - broker partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems.

46 Care Co-ordinator capabilities and competencies

46.1 The 10 Essential Shared Capabilities framework suggests the essential capabilities that should be included as core in pre and post qualification training for all professional and non-professionally affiliated staff:
   - Working in partnership
   - Respecting diversity
   - Practicing ethically
   - Challenging inequality
   - Promoting recovery
   - Identifying people’s needs and strengths
   - Providing service user centred care
   - Making a difference
   - Promoting safety and positive risk taking
   - Personal development and learning
46.2 Care Co-ordinators have a professional responsibility to ensure their knowledge base and skills are adequate to meet the needs of the role. Organisations have a responsibility to ensure their employees are equipped to practice in any role they are undertaking. As the Care Programme Approach is about multi-disciplinary and multi-agency working, any training given on the role of the Care Co-ordinator should be facilitated in the same way. Training should be updated regularly and at a period not exceeding 3 years.

46.3 The development of care co-ordinator competencies, principles of practice and core functions should inform supervision and appraisal, and support caseload management processes.

46.4 Further information on Competencies and Capabilities can be found in Section 56

47 Audit of CPA

47.1 The aim of the Care Programme Approach Audit Programme is to develop and maintain a culture in which both quantitative and qualitative aspects of recording of care are routinely examined.

47.2 Quantitative audits consider whether the file is up to date, contains all the relevant documentation and that the documentation has been properly completed.

47.3 Qualitative auditing considers the quality of the recording on file, and whether it reflects good practice.

47.4 Although these can be conducted independently both are necessary. The record may be up to date and contain all the relevant documentation, but the quality of the recording may be poor or inappropriate, similarly, the record may be of a high standard, but out of date.

47.5 The Audit Programme involves the participation of all Community and In Patient Care Co-ordinators including those in adult mental health services, child and adolescent services, older peoples’ mental health services and learning disability and specialist services. It is intended to encourage continuous improvement of outcomes for users and ensure the spread of good practice.

47.6 The Audit Programme has been registered on the Trust’s annual audit plan and the Audit Committee, Operational Management and Service Governance Committee will be updated every 6 months on emerging trends and key themes.

47.7 The Audit process will be undertaken every 3 months (from January 2012).

47.8 The Audit tool is to be used by Team Managers in their monthly caseload management meetings to ensure that standards are being applied by Care Co-ordinators. This will provide regular and substantive evidence of performance monitoring, action and improvement.

47.9 To supplement the caseload management work, Care Groups will still undertake a number of Peer Reviews, in neighbouring teams, within their own Care Group.

47.10 Each Team Manager will nominate two senior practitioners to carry out Audit
reviews in neighbouring teams within the same Care Group. Managers and Team Leaders will assure themselves that people identified are competent to carry out the audit process on their behalf. It is anticipated that Service User Support Workers would initially provide a Service User perspective.

47.11 The CPA Audit consists of checking the list of evidence and making a judgement as to whether the evidence meets the standards set out in the audit tool. The Audit Team will report back their initial findings to the manager of the team visited on the day of the visit.

47.12 The audit tool consists of a list of criteria, a column for the Peer Auditor to indicate the criteria has been fully, partially or not met and a column to say why they have rated the criteria this way. The audit tool can only be completed in electronic format.

48 Assessment Procedure

An individual service user’s care plan must be based on a thorough assessment of their health and social care needs. This assessment will involve the user and care, where appropriate, as central participants in the process.

48.1 Purpose of assessment

Assessment is a core activity of all workers in mental health services. Its purposes are to:

- Provide an initial assessment of mental health needs and where they may be met;
- Evaluate the individual’s strengths;
- Identify the service users goals, aspirations and choices; Identify areas of need;
- Assess the level of risk;
- Identify the need for specialist assessment, i.e. personality disorder, substance misuse, etc, and where appropriate refer to a relevant service, agency or profession;
- Determine whether intervention from mental health services is appropriate; Identify the person’s need for CPA; and
- Establish an information base.

48.2 Needs and Unmet Needs

Exploration of unmet need should also include needs of specific equality or minority groups e.g.: single-sex services for women or some ethnic minority groups; language and translation services; specialist support for disabled people.

An important aspect of a fully global assessment is the accurate identification of needs that currently cannot be met. Generally these will be needs that go beyond current service provision. However, there are some grey areas concerning unmet needs, for example a service that is currently available but has no capacity to accommodate any more service users can be designated as an unmet need.

Need assessment must focus on the persons needs, rather than the services available. It is a continuous process, based on the identification of strengths and vulnerabilities. It is also necessary to identify unmet needs, as needs must be
assessed whether resources are available or not. The assessment process should conclude with a summary of any needs/unmet needs identified, including the identification for the request for a specialist assessment as part of the care plan. The care plan would be developed from the identification of need/unmet need.

48.3 The assessment process

The Assessment Process must be:

- **Systematic** and carried out with the individual concerned, enabling them to identify their own needs;
- Undertaken with due **regard to confidentiality**; **Thorough** and comprehensive;
- **A unified** health and social care assessment, joint (between health and social care) to prevent duplication for the service user and carer and **commonly agreed** (for risk assessment);
- **A single assessment** to facilitate access to both health and social care, based on a **single point of access**;
- Aiming to meet the **service users needs and choices**, not just focusing on what professional and services can offer;
- **Explained** to the service user in an appropriate format; and
- Carried out in the most **appropriate setting**.

The quality of initial assessments is enhanced when **multi-disciplinary** and undertaken in partnership between health and social care staff and information is gathered from all those involved including the service user and carer

The process should include

- **Service user and carer involvement** (where appropriate), including writing their own accounts of their illness in the notes;
- Prompt assessment **for young people** with the first signs of a psychotic illness;
- Identification of **advance statements** and advance decisions (see the Mental Capacity Act);
- The **capacity** of the service user must be assumed; and
- If possible attempts should be made to identify whether or not the service user has a **lasting power of attorney or a deputy** appointed by the court of protection.
- A **service user’s own caring responsibilities** should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for.

48.4 What an assessment should include:

Mental health professionals should consider service user’s needs holistically and aim to improve their quality of life and their health.

Clearly in some emergency situations it will be neither possible nor appropriate to carry out a comprehensive assessment of need, but the list below includes issues that should be covered in a full assessment of needs:

- **Psychiatric functioning**;
- **Psychological functioning** (permitted tools: Beck’s hopelessness Scale; Suicide Inventory);
Any needs arising from co-morbidity and co-existing problems such as substance misuse, learning disabilities, or personality disorders;

Current and past substance should be asked about, including type and method of administration, quantity and frequency, and including legal and illicit drug use;

Physical health needs; including dietary requirements taking into account the impact of mental ill health on physical health and vice versa. A basic physical assessment should be carried out, preferably through primary care;

Social functioning, social needs and social circumstances;

Personal circumstances (including family or other carers) family and welfare circumstances including activities of daily living and self care;

Child care issues, child protection; ‘the child’s needs must take priority’ and caring responsibilities. Be aware that children and families services may have relevant information that should be included in the assessment/risk assessment, and the needs of the parent, child and family should be assessed routinely at all stages of the care process;

Experience of violence and abuse;

Housing status and needs; particularly issues of homelessness, temporary or insecure accommodation;

Financial status;

Leisure, occupational status, ‘vocational aspirations’ and employment needs, training and education;

Risk to the individual or others (including previous violence and criminal record) and degree of danger they pose;

Need for positive risk-taking;

Need for medication management;

Level of support (practical and emotional) and intervention required;

An identified Care Cluster which outlines the level of support required

Ability to self-manage their mental health problems

Informal support network;

Likelihood of maintaining appropriate contact with services;

Service user’s strengths and aims

Carer’s involvement;

Religious and spiritual needs;

Communication, cultural, gender and access needs;

Advocacy and legal advice;

Exploration of violence and abuse (following appropriate training); and

Service users’ own caring responsibilities should be explored.

Other issues to consider include:

Communication must be effective both with the person and between different workers and agencies;

Validity - be sure that the right areas of need are being assessed;

Potential conflict between the person’s and their carers needs;

Confidentiality and privacy issues;

The quality of the referral information may vary; and

Advocacy for the person being assessed.

In England an initial assessment will be undertaken to identify those whose needs are best met by a secondary mental health service, which must include all the issues relevant to the criteria for CPA.
49 Risk Assessment Procedure

49.1 Introduction

*The best quality of care can be provided only if there are established links between the need assessments of service users and risk assessment.’*

Risk assessment is an essential and on-going element of good mental health practice and critical and integral component of all assessment, planning and review processes.

‘Risk Assessment is an essential and ongoing part of the CPA process.’ Risk assessment is about weighting up both the possible beneficial and harmful outcomes and stating their likelihood.’

Modern risk assessment and management should be based on the principle that the assessment of risk is structured, evidence based and as consistent as possible across a range of settings and across service providers. This consistency is essential for good communication between practitioners and agencies and will contribute to improved care. In England, any locally agreed policies and procedures in relating to the management of risk should be informed by ‘Best Practice in Managing Risk’.

Risk assessment tools however can only contribute one element to a broader overview of the risks presented by a particular individual; they should only be used as part of a general clinical risk assessment conducted with the service user. The findings of tool-based assessments must always be combined with information on many other aspects of the person’s life and current situation.

**They are an aid to clinical decision-making, not a substitute for it.**

Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgement.

49.2 Fundamentals

- Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.
- Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.
- Risk management must be built on a recognition of the service user’s strengths and should emphasise recovery.
- Risk management requires an organisational strategy as well as efforts by the individual practitioner.

49.3 Basic ideas in risk management

- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm. Knowledge and understanding of mental health legislation is an important component of risk management.

The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

49.4 Best Practice in Managing Risk

Risk management should be based on assessment using the structured clinical judgement approach. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

Risk should be clearly documented and reviewed regularly as part of (or directly linked to) the CPA review process. Risk is assessed by all workers, but formal risk assessment should only be carried out by someone with the appropriate training and experience (as agreed locally).

Risk Assessment and management should aim to cover at least the following areas:

- **Self-harm**, including accidental harm at home/outside the home, risks associated with alcohol, drug or substance misuse including any ‘likely interaction between medication and substances, degree of dependence/withdrawal problems’, deliberate self-harm;
- **Suicide**, including previous attempts, threats, opportunity, means;
- **Violence to others**, including access to potential victims, specific threats made. history of violence to family, staff, to other service users, the general public, specific other people, degree of physical harm caused, history of sexual assault, risk to child (non-accidental);
- **Other types of risk to other people**, including risk to child (accidental), arson, risk to staff other than violence, destruction of property;
- **Self neglect** including inability to care for self, lack of carer support; and
- **Exploitation by others/vulnerability to abuse** such as financial, sexual, physical.

Where appropriate, criminal justice agencies (particularly the Offender Manager Service using the OASys (The Offender Assessment System) and the Multi-Agency Public Protection Arrangements (MAPPPA) can provide essential support to risk assessment in relation to some offenders and should be consulted as part of a holistic assessment.

Risk assessment for people with a learning disability needs to be multi-agency, including speech and language therapists where necessary, so that a balance between risk management and the individual having a fulfilling life is achieved.

49.5 Primary Care Mental Health Services assessment of Risk

From 1 April 2011, Primary Care Mental Health Services form part of the range of services offered by Bradford District Care Trust.
Whilst the principles of CPA will not usually apply to service users accessing this service, there may be circumstances where referral into secondary mental care will occur and an understanding of the requirements for assessing risk in both services is required. Primary Care Mental Health Services use the Threat Assessment Grid (TAG) to assess the risk of service users harming themselves or others.

Primary Care Mental Health Services Risk Assessment Policy and guidance to staff can be read in Section 51

49.6 Positive Risk Management

This involves improving the service user’s quality of life and plans for recovery whilst remaining aware of the safety needs of the service user, their carer and the public. It is considered that over-defensive practice is bad practice and that positive risk management should be part of a carefully constructed plan and therefore must be a desirable competence for all mental health practitioners.

Positive risk management includes:
- Working with the service user to identify what is likely to work;
- Paying attention to the views of carers;
- Weighing up potential benefits and harms of choosing one action over another; Being willing to make a decision that involves an element of risk because the potential positive benefits out weigh the risk;
- Ensuring that the service user, carer and others who might be effected are fully informed of the decision, the reasons for it and the associated plans;
- Using available resources and support to achieve a balance between a focus on achieving the desired outcome and minimising the potential harmful outcome;
- A good relationship between service user and all those involved in providing their care;
- Recognising the service user’s strengths alongside possible problems that they might encounter; and
- Previous risk-taking behaviour.

The service user should be involved in his/her own risk assessment and their views included in the written record of risk assessment.

49.7 Risk Management Training

Care Co-ordinators are identified as those people with a professional qualification in Nursing, Social work or Allied Health Profession, who are banded at Agenda for Change Band 5 or above (or equivalent).

Lead Professionals are drawn for the pool of staff who seem to the person best placed to support the Service user.

Both Care Co-ordinators and Lead Professionals will be trained in the use of Risk Assessment Tools through a series of training days available from the CPA Team. This will equip those trained to competently assess risk.

The CPA Team will maintain a database of staff who have been trained and this information will feed into the Electronic Staff Record (ESR).
The Use of RiO Risk Assessment Tool

Guidance for staff on completing RiO

RiO is a comprehensive risk assessment and risk management tool that is designed to be used by mental health services. It provides:

A convenient way of summarising and collating key information that is also easily accessible.

A structured method of reminding professionals of areas that should be covered when screening for risk.

A means of recording that basic screening for risk has been carried out.
A means of recording risk management plans.

A format that is used and understood by all agencies involved in mental health service provision.

The Care Trust now operates ONE version of RiO, which can be used across all Teams including In Patient areas, Intensive Home Treatment Teams, Community Mental Health and other Specialist Teams across: Adult Service Users, Forensic Services, Substance Misuse Services, Older People, CAMHS and Learning Disability Services. In addition, Low Secure Services use HCR-20, which can also be accessed on RiO.

Use of the RiO Risk Tool

Everyone in contact with the mental health services should have their risk assessed. Service Users on (new) CPA should usually be subject to a full risk assessment in which the client’s history and current risks are recorded. Service Users on Standard Care should have risk issues considered and the results noted on the RiO form. Where there are no or very low risks, the form is designed so that this can be recorded without the whole form being completed.

RiO is an integral part of CPA and the form is part of the documentation. It should not duplicate the information in the Care Plan or the Contingency Plan. The latest RiO Risk Profile should be kept with the care plan, at the front of medical or social work files, where it is easily accessible.

RiO risk assessment and management plan may be accessed when needed 24 hours a day.

When to use RiO Risk Profile

Risk should be considered in all the following situations and the RiO Risk Profile should be completed or amended if this is necessary:

As soon as is practical after initial assessment of new clients (but no later than four weeks after the initial contact).
• At every CPA review.
• Following admission to hospital or residential provision.
• Prior to discharge from hospital.
• Prior to discharge from Mental Health Services
• Prior to the granting of section 17 leave
• Prior to the Clinical Transfer of Service Users to other areas or agencies.
• Following any major incident or change of circumstances.
• When serious concerns are raised by carers, family members or other agencies.

The RiO form is designed to be part of a risk management process and, as such, may be as useful for some emergency assessments, particularly when the user is not known to the assessor. The use of RiO as part of Mental Health Act Assessments, or during the assessments of patients in A&E who have attempted suicide, should be the decision of the practitioner involved. The checklist may be a useful part of the assessment process in these cases.

Intensive Home Treatment Teams are expected to use the RiO Risk Profile in all referred cases as the basis for building their knowledge of risk issues and planning to manage those risks effectively.

The risk profile needs to be updated regularly to be useful.

50.4 Completion of the RiO form

The assessment of risk and the completion of the risk profile will usually be the responsibility of the care co-ordinator, who should be supported by the multi-disciplinary team. The greater the identified risk, the more involvement the MDT should have in decision making and planning about a clients care.

50.5 The use of RiO in Hospital

When the person to be assessed is an inpatient, the named nurse will also take an active role in the completion of the risk profile. If the Service User is not known to the mental health services, nursing staff will complete the form soon after admission and then work with the multi-disciplinary team to plan for discharge from hospital. If the Service User has a Care Co-ordinator, they should review the risk profile with the named nurse as soon as practical following admission, and again prior to discharge.

Care Co-ordination plans and risk profile should be made available to the nursing staff as soon as possible following admission, preferably on the day of admission.

Multi-disciplinary review meetings in hospital should be reviewing CPA for inpatients and this should always include a review of risk and the RiO Risk Profile. It is particularly important that risk is assessed or reviewed at admission and prior to discharge and the granting of leave.

It is very important to take positive risks on behalf of Service Users who may benefit from leave or early discharge and decisions about whether to discharge or grant leave need to be made with the full knowledge of current and historical risks that is available.
The views of the Service User, the Carer and involved professionals should also be considered. The level of support that should be provided by the community services should also be considered.

Does the Service User need a visit within seven days, as prescribed by CPA for Service Users who have a history of risky behaviour?

Does a contingency plan need to be written for Service Users who may deteriorate on leave?

What information or support should be given to the Service User's Carer, family or support workers prior to discharge or leave?

50.6 Confidentiality and the sharing of information

The RiO Risk Profile is designed to facilitate the passing of relevant information between appropriate agencies and individuals, in order to reduce risk. Respect for client confidentiality and privacy remains, however, an important principle behind the use of RiO.

RiO provides a comprehensive risk assessment and risk management tool including:

- A convenient way of summarising and collating key information that is also easily accessible.
- A structured method of reminding professionals of areas that should be covered when screening for risk.
- A means of recording that basic screening for risk has been carried out.
- A means of recording risk management plans.
- A format that is used and understood by all agencies involved in learning disability service provision.

The risk management component informs actions taken by care teams in relation to two key areas:

The contingency plan aims to prevent a crisis developing by detailing the arrangements to be used when, at short notice, either the Care Co-ordinator is not available or part of the care plan cannot be provided.

The crisis / relapse plan, sets out the actions to be taken, based on previous experience, if the service user's mental health is rapidly deteriorating or their challenging behaviour increases significantly in frequency / severity.

The RiO Risk Profile documentation will be incorporated into the learning disability MHAP forms. As a minimum, profiles should be revisited at all MHAP reviews. The RiO Risk Profile training programme will provide more detailed guidance regarding the use of the system (available via the Intranet).

The profile will also help inform decision-making processes regarding risk taking where potential benefits of activities must be weighed against potential hazards.
A balance needs to be sought between the rights of Service Users and Carers and the need to reduce risk. The following principles are a guide to achieving this balance:

The Service User should usually be involved in every stage of the process that leads to the writing of the risk profile and risk management plan.

The Service User should usually be given a copy of the risk profile, along with the rest of the CPA documentation.

The Service User should usually be made aware of whom the risk profile is likely to be sent to and should give their permission.

The Carer should also be involved in the drawing up of the risk profile, as long the Service User has no objection. Carers should particularly be consulted or informed about aspects of the management plan that are concerned with their safety.

The risk profile should only usually be distributed to agencies directly involved in the delivery of the Care Plan, where the user has given permission.

Where there is conflict between the Service User, the Carer or other agencies, or there are particular risk issues that require information to be shared, the following principles should be followed:

- Information should always be shared if this is necessary to maintain the safety of the Service User, Carer, members of the public or other agencies.
- If the Service User has requested that their Carer or other person should not see information about them this should usually be respected, but information essential to their safety should be shared.

It is possible to override the Service Users wishes, or to decide not to involve the Service User, if there are major risk issues apparent in the risk profile. Any decision to override the Service Users wishes should be recorded and backed up by the multi-disciplinary team.

50.7 How to complete the RiO Risk Profile form

The Risk Profile is designed to guide the practitioner through the process of assessing risk and deciding what action is necessary to reduce risk. It does not dictate the way the assessment is carried out. Other assessment tools may also be used alongside RiO to help provide a more comprehensive assessment. The Risk Profile is not designed to predict risk, but to provide a framework of information and planning in which risk is less likely to occur. The form is part of the CPA documentation.

50.8 The RiO Risk Profile Headings

RiO groups risk issues under the following main headings:
- Harm to self;
- Harm from others;
- Harm to others;
- Accidents;
- Other Risk behaviour; and
- Factors affecting risk

Those assessing risk are asked to consider if there are risk factors which are current (occurring within the last 6 months) or whether the risk factor has ever occurred (no time limit).

Each factor in both columns (last 6 months or ever) must be ticked either Yes or No.

Any issue highlighted with a Yes response MUST be explained within the descriptive section, which sits below each risk section.

50.9 The Evaluation:

The Evaluation is a summary of the practitioners overall judgement of the level of risk identified.

The question ‘any evidence of a history of risk’ should only be answered ‘no’ if there is no information on history in the checklist. The issue to be considered when deciding if there is a history of risk behaviour is “If such behaviour should recur now, would it be considered a risk?”

‘Current risk status’ should reflect the practitioner’s current judgement as to the level of risk; it is not a prediction of future behaviour.

This information is on the front sheet so that it is immediately clear to practitioners what the level of risk and planning is for each individual.

If there is no risk history it is unlikely that the risk management plan will be completed. This will be a clinical decision based on the Service Users individual circumstances.

50.10 The descriptive account:

Any issues identified as current (last 6 months) or historical (ever) risks in the checklist should be explained here. A short explanation is all that is needed. Other, more detailed, documents or assessments may be referred to or attached.

Any unsubstantiated information or rumours should be used with caution and highlighted as such.

Information used to make the assessment should be recorded. As wide a range of sources as possible should be used to ensure an accurate assessment.

50.11 The relapse and risk management (contingency) plan:

Target signs & behaviour suggestive of risk/relapse’ should identify how and when an increase in risk may be identified, on the basis of past knowledge.

Persons potentially at risk should be identified along with why they are at risk. Action to protect them should be in the risk management plan.
‘Further action to be taken if the Service User fails to meet commitments’ should specify exactly what the commitments are and why they are important.

The Risk Management Plan should identify who is responsible for each aspect of the plan and the timescales involved. It should specify action known to reduce or contain risk and a fallback plan if this fails. It should identify what is known to reduce risk and how this can be maintained. There is no need to repeat information already contained in the contingency plan.

If a decision is taken not to send the form to any agency or individual, the reasons for this should be recorded.

It is important that previous strategies, views of Carers, Advance Decisions agreed with Service Users and the Service Users own coping strategies are considered in this section.

A Risk Assessment should not be regarded as complete until the relapse plan has been fully outlined.

All services using the RiO Risk Profile (as outlined in 50.1) are required to complete a relapse plan for all service users accessing that service.

50.12 Principles for the assessment of risk

The process should assess the risk of violence, aggression, suicide and self-harm, neglect, exploitation, physical health and living conditions. It should also consider the effects of poverty, discrimination, homelessness and isolation.

Risk assessment should consider the relevant risk factors that may increase levels of risk. These should be compared with the known risk history and current situation. This process should lead to a decision about the level of risk present and the formulation of a risk management plan.

The assessor should consider how recent and severe any risk has been. Is there any pattern to risk behaviour or triggers that are known? How frequent was the risk behaviour in the past. In addition the assessor should be aware of any current plans or intent related to risk behaviour.

The risks to Carers should be considered throughout the process.

Risk assessment should not increase discrimination and should be carried out sensitively with respect to peoples’ race, sexuality culture, religion etc.

Positive risk taking on behalf of Service Users is an important part of the process.

All Care Co-ordinators are trained to review Risk Assessments with the following factors in mind:

The Current Risk Assessment can be edited and updated provided the changes being made are not introducing any new risk element and is not being changed in
response to a Risk Incident. It is permitted to edit the current Risk Assessment for up to 1 year from creation.

A New Risk Assessment must created when: a significant change occurs; new risk factors are being considered; or the current Risk Assessment has been active for 12 months.

A blank RiO Risk Profile now follows:
### Safeguarding Children

Have you considered if the service users are likely to have or resume contact with their own child or have children in their network of family siblings and friends, even when the children are not living with the service user.

Please give further details if necessary.

<table>
<thead>
<tr>
<th>Are there any Actual or potential risks to the children, including delusional beliefs involving them. Please draw on as many sources of information as possible, including compliance with treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes please give further details.</td>
</tr>
</tbody>
</table>
Does this service user:
1. Express delusional beliefs involving a child.
2. Have a suicide plan involving a child.
3. Have mental health needs that co-exist with drug and alcohol issues and/or domestic abuse

☐ Yes  ☐ No

If chosen Yes for any of the above, please make a referral to Children Social Care, add a Safeguarding Children Alert and give further details below.

All fields to be completed:
On RiO there is now a drop down list to select from. There are three selections from the down arrow. YES - NO - NOT KNOWN.
Choose Yes for risk factors which apply. Any selected Yes must also be fully explained in the free text box below;
Select No if Risk Factor does not apply;
Select Not Known if the risk has either not been assessed at this time, there is no available Information, or the client is not providing any information. Explain rationale for choosing any Not Known selections in the free text box below.

### Harm To Self

<table>
<thead>
<tr>
<th></th>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act with suicidal intent</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Self-injury or harm</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Self-neglect</td>
<td>Select</td>
<td>Select</td>
</tr>
</tbody>
</table>

Harm to Self: *Please specify your reasons for selecting the – Harm to Self – risk category(ies)*
### Harm from Others

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of neglect</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of sexual exploitation</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of emotional / psychological abuse including bullying</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of unlawful restrictions (e.g. locks on doors, physical restraints etc.)</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of physical harm</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of financial abuse</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk caused by medication / services / treatment</td>
<td>Select</td>
<td>Select</td>
</tr>
</tbody>
</table>

**Harm from Others - Please specify your reasons for selecting the — risk category(ies).**

### Harm To Others

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Assault (including touching/exposure)</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Violence / aggression / abuse to family</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Violence / aggression / abuse to other clients</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Arson</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Hostage taking</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Weapons</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk to children</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Violence / aggression / abuse to staff</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Violence / aggression / abuse to general public</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Exploitation of others (eg financial, emotional)</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Stalking</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk to vulnerable adults</td>
<td>Select</td>
<td>Select</td>
</tr>
</tbody>
</table>

**Harm from Others: Please specify your reasons for selecting the — risk category(ies).**
### Accidents

<table>
<thead>
<tr>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td></td>
</tr>
<tr>
<td>Accidental harm outside the home (eg wandering)</td>
<td></td>
</tr>
<tr>
<td>Unsafe use of medication</td>
<td></td>
</tr>
<tr>
<td>Other accidental harm at home</td>
<td></td>
</tr>
<tr>
<td>Driving / Road safety</td>
<td></td>
</tr>
</tbody>
</table>

*Accidents - Please specify your reasons for selecting the — risk category(ies).*

### Other Risk Behaviours

<table>
<thead>
<tr>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents involving the police</td>
<td></td>
</tr>
<tr>
<td>Correspondence</td>
<td></td>
</tr>
<tr>
<td>Phone Calls</td>
<td></td>
</tr>
<tr>
<td>Restricted client</td>
<td></td>
</tr>
<tr>
<td>MAPPA</td>
<td></td>
</tr>
<tr>
<td>Schedule 1</td>
<td></td>
</tr>
<tr>
<td>Absconing/Escape</td>
<td></td>
</tr>
<tr>
<td>Visitors</td>
<td></td>
</tr>
<tr>
<td>Sex Offenders Act 2003</td>
<td></td>
</tr>
<tr>
<td>TILT high risk</td>
<td></td>
</tr>
<tr>
<td>Probation Service involvement</td>
<td></td>
</tr>
<tr>
<td>Damage to property</td>
<td></td>
</tr>
<tr>
<td>Theft</td>
<td></td>
</tr>
</tbody>
</table>
Other Risk Behaviours - Please specify your reasons for selecting the — risk category (ies).

<table>
<thead>
<tr>
<th>Factors Affecting Risk</th>
<th>In last 6 months</th>
<th>Ever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance misuse (eg Alcohol/Drug Abuse)</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Risk of losing essential services</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Major life event</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Current mental state</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Client would be unable to summon help</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Refusal of services</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Discontinuation of medication</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Housing status</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Client is unaware of risk</td>
<td>Select</td>
<td>Select</td>
</tr>
<tr>
<td>Clients care network is unaware of risk</td>
<td>Select</td>
<td>Select</td>
</tr>
</tbody>
</table>
OVERALL RISK SUMMARY (n.b. risk-related interventions should be included in Care Plan)
51 Clinical Risk Assessment and Management Procedures for Primary Care Mental Health Service

51.1 Introduction

The aim of this document is to ensure that Primary Care Mental Health service (PCMH) practitioners take an evidence based approach to assessing and managing the risk of service users harming themselves or others.

It provides a framework and clear information on good practice to enable PCMH practitioners to make informed risk assessment and risk management decisions.

51.2 Scope

All primary care mental health service clients must undergo risk assessment in accordance with this policy.

All employees working within primary care mental health services must work in accordance with this procedure. Failure to do so may result in disciplinary action.

Contractors and sub-contractors employed to deliver primary care mental health services are also expected to comply with this policy. Failure to do so may be considered a breach of contract.

51.3 Key related documents

- Vulnerable people guidance (PACE)
- Safeguarding children policy
- Safeguarding adults’ policy
- Records management policy
- Managing violence and aggression - Policy, Procedure and Guidelines

51.4 Background

The National Service Framework for Mental Health 1999 (NSF) Standard 2 states: “Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it

BDCT considers that a key element of this assessment is exploration and evaluation of the potential for self harm and for harm to be caused to others.

This procedure has been formulated using principles from The Department of Health’s document “Best Practice in Managing Risk” 2007

51.5 Principles and values

The following principles are adapted from “Justifying Risk Decisions” (Criminal Behaviour and Mental Health 18; 139-144 2008) by Dr David Carson and “Rethinking
By definition, it is inevitable that harm will sometimes occur from risk taking, even with the highest quality decisions.

When judging a risk decision both the assessment of the risk and the management of its implementation should be considered.

Risk assessment is an assessment of a current situation, not itself a predictor of a particular event. Although accurate prediction is never possible in individual patients or service users, some negative outcomes can be reduced in frequency by sensible contingency planning.

Mental health and social care professionals in PCMH services must ensure that they have the necessary competencies to make risk decisions, including using approved relevant structured risk assessment tools.

51.6. Roles and responsibilities

Heads of Service; where appropriate, are required to implement this procedure within their business unit, in particular to:

- Training
- Support managers as necessary
- Risk assessment
- Application of control measures
- Monitoring
- Incident reporting
- Lessons learned

Service Lead for Primary Care Mental Health; will work with team managers to introduce and monitor implementation of the procedure and make informed decisions on training, staff development and changes where evidence supports this.

The Risk Management Department; is required to ensure that systems are in place for reporting and recording incidents, both internally and externally ie RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences, Regulations 1995), PARS (Physical Assault Reporting System), and encourage the reporting of all incidents of violence and aggression.

The PCMH practitioner is ultimately responsible for ensuring that care for PCMH service users is based on robust risk assessment and that the plan of care is proportionate to assessed risks.

All PCMH practitioners are required to ensure they act responsibly in ensuring risks are identified, recorded, managed and result in the formation of an appropriate care and support plan which is shared with the client and appropriate others.
51.7 Duties and Responsibilities

- Work in accordance with this procedure
- Take account of clinical risk assessment and management issues in all contacts with service users.
- Work collaboratively with service users to achieve an acceptable risk management plan
- Make sure that information on which clinical risk management decisions are made is as up to date and accurate as possible
- Ensure that an initial risk assessment is undertaken as part of the first assessment for all service users and that further risk assessment is undertaken at each subsequent therapy session
- Communicate and clearly record all risk assessment, outcomes and management plans in the service users’ case notes (electronic and/or paper records).
- Keep up-to-date with developments in clinical risk assessment and management pertinent to primary care mental health

The Trust accepts that the assessment and management of risk in its PCMH service in relation to clinical issues is not an exact science and it is difficult to predict risk accurately.

51.8 Risk assessment

All service users referred into the primary care mental health service will have a risk assessment as part of their initial assessment, first therapy and at all subsequent therapy sessions. This risk assessment will be an integral part of the overall assessment process.

Risk assessment is the process of assessing whether or not, and in what circumstances a person may harm themselves or others (or be harmed, if they are vulnerable themselves).

Harm may be intentional or unintentional. This clinical risk assessment involves chance, uncertainty and unpredictability. It is about assessing:
- how likely it is that the event will occur
- how soon it is expected to occur
- how severe the outcome will be if it does occur (DH 2007).

Risk assessment is a dynamic process that changes over time, and it should be noted that risk cannot be eliminated and adverse incidents will occur even with best risk assessment and management practice. The objective of any assessment of clinical risk is to prevent hazardous outcome from occurring, or at the very least, minimize its impact on the individual or others. Within the clinical risk assessment/management process it is essential that clients are fully involved at all times.
Defining Risk Factors

- Static factors - are unchangeable, e.g. history of child abuse or suicide attempts.
- Dynamic factors - are those that change over time e.g. misuse of alcohol, social deprivation, etc. These factors, because they are changeable are more amenable to management.
- Stable or chronic risk factors - are risks which are quite stable and change only slowly
- Acute factors or triggers - change rapidly and their influence on the level of risk may be short lived. (Summarised from DH 2007)

Types of Risk

These factors may include:
- Intentional self harm
- Unintentional self harm
- Risk from others
- Risk to others
- Psychological
- Social

More detailed information on specific factors within the above domains is detailed on the Threshold Assessment Grid (TAG) checklist for guidance in Section xx

Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgment.

Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

The views of other professionals, ie the referrer and relevant others should be taken into account when assessing risk

Research indicates that the reliability and validity of clinical risk assessments are improved if practitioners use a structured form of risk assessment. BACHS requires its employees to use their clinical knowledge and skills in combination with a formal assessment tool to undertake risk assessments, interpret the available information and devise a risk management plan.

The formal assessment tool to be used by PCMH staff is the Threshold Assessment Grid (TAG). The TAG was developed by a Department of Health working group between the years 1994 -1996. Its psychometric properties were tested between 1999 and 2000, in a multi site study involving 605 service users from 10 adult, elderly and day care mental health services throughout London. It has been evaluated in practice in a multi site cluster randomised control trial in London and Manchester. The tool is currently being used in Manchester, Plymouth, Bath and North East Somerset and Avon and Wiltshire mental health providers

The tool itself is attached as Section 51.15 and guidance on completion of the tool is presented in Section 51.16 of this document.
51.9 When should the TAG Clinical Risk Assessment tool be completed?

- At initial Assessment
- At first therapy session
- At every clinical contact thereafter

51.10 Management

Where scores indicate risk, then a risk management plan should be made with the service user and documented clearly within clinical records and communicated back to the referrer (as appropriate) and/or GP.

When working with a risk management plan it is a positive step to identify this with the referrer and where necessary include them (the referrer) in the plan.

Any identified others be it potential victims or persons at risk should, where it is reasonable and appropriate be notified and involved in any future risk assessment and management plan.

The agreed process for clinical risk assessment and clinical risk management should be associated with an implementation plan which needs to be reviewed at each client contact.

Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.

Risk management must be built on recognition of the service user's strengths and should emphasise recovery.

Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

Knowledge and understanding of mental health legislation is an important component of risk management.

The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

Risk management must always be based on awareness of the capacity for the service user’s risk level to change over time, and recognition that each service user requires a consistent and individualised approach.

Within the care plan evidence needs to be visible that a thorough check has been made to identify the risks and that any precautions taken or advised on are reasonable and acceptable to the service user. The risk management plan and possible solutions/outcomes must be realistic and practicable and effective.
Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.

A risk management plan is only as good as the time and effort put into communicating its findings to others.

The service user’s perspective on the identified risks must be sought and considered whenever practicable.

All risks identified should be managed in order to reduce/ minimise the likelihood or effect of negative outcomes and maximise potential positive outcomes.

Any risk management plan should be clearly identifiable within the care plan and in instances where a member of staff is absent the manager of the team must be made aware that there is a risk management plan in operation.

Identified risk must be managed within the professional knowledge and skill framework of the practitioner working with the service user, if the identified risk exceeds the boundaries of clinical skill and competence, then the worker MUST seek immediate advice in the first instance via their line manager or more senior member of staff within the team, who has a recognised level of experience and expertise in assessing and managing clinical risk. It is also advisable for staff to seek clinical supervision in line with the Trust’s supervision policy.

Whatever the level of identified risk, there should be a management plan which must include a contingency and crisis plan within the service user’s clinical record. It is good practice to supply the service user with a copy of this.

Where the level of risk is of a significant concern to the service user, their family, carers, children, staff, members of the public then appropriate action needs to be taken, this may involve the service user being referred on to specialist mental health services/Secondary Care Mental Health Services. It may be necessary in some circumstances to involve the police. A collaborative approach should be taken with the service user and all outcomes documented clearly within the clinical record of the service user. The referrer/GP should be made aware and kept informed.

51.11 Record keeping

All PCMH risk assessments must be recorded, as per PCMH Addendum to the records management policy and shared as appropriate

51.12 Training and competence

Positive risk management as part of a carefully constructed plan of care is a required competence for all mental health practitioners.

All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. Attendance to BACHS Equity and Diversity is a mandatory requirement.
All staff involved in risk management should receive relevant training, which should be updated at least every three years

### 51.13 Training

A training plan will be developed and implemented to ensure that PCMH clinical staff and other practitioners are familiar with the process of clinical risk assessment and the associated tools, and can implement an effective clinical risk management plan when risk is identified:

- Provide clinical risk assessment as part of new starter induction programmes.
- Provide practical guidance for clinicians in the assessment of clinical risk and clinical risk management.
- To detail procedure on clinical risk assessment and clinical risk management.
- To utilise tools to assist in clinical risk assessment which have been agreed by the PCMH service.

All staff involved in risk management must engage in regular training that meets their learning needs.

PCMH practitioners involved in risk management should engage in relevant Learning opportunities about risk and this should be updated every three years. The depth, complexity and focus of the training should be determined by the practitioners learning needs. Such training may include ongoing reflective practice, in depth team discussions about risk management, reading best practice guidance and literature, supervision focusing on risk management, internal and external courses. Training should include at least some problem based learning with peers or experienced practitioners.

Needs for future training in risk management should be assessed annually as part of annual appraisals. Training will be formally reviewed every three years with a brief record of recent training, analysis of training needs and a brief plan of how to achieve these.

### 51.14. Monitoring

Following implementation an audit will be carried out every 3 months which will identify the implementation and appropriateness of the tool within the PCMH service. A review of the procedure will be undertaken after 2 years
## THRESHOLD ASSESSMENT GRID (TAG)

**SCORE SHEET**

TAG ASSESSES THE SEVERITY OF A PERSON’S MENTAL HEALTH PROBLEMS

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g. 'None', 'Very Severe') add the number of ticks and record in the box at the bottom of the column. ‘Very Severe’ is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklist provides some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive. Further information on the TAG is available from www.topltd.ae/uk/printing.

### Domain 1: Intentional self-harm
- **NONE**: No concerns about risk of deliberate self-harm or suicide attempt
- **MILD**: Minor concerns about risk of deliberate self-harm or suicide attempt
- **MODERATE**: Definite indicators of risk of deliberate self-harm or suicide attempt
- **SEVERE**: High risk to physical safety as a result of deliberate self-harm or suicide attempt
- **VERY SEVERE**: Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt

### Domain 2: Unintentional self-harm
- **NONE**: No concerns about unintentional risk to physical safety
- **MILD**: Minor concerns about unintentional risk to physical safety
- **MODERATE**: Definite indicators of unintentional risk to physical safety
- **SEVERE**: High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment

### Domain 3: Risk from others
- **NONE**: No concerns about risk of abuse or exploitation from other individuals or society
- **MILD**: Minor concerns about risk of abuse or exploitation from other individuals or society
- **MODERATE**: Definite risk of abuse or exploitation from other individuals or society
- **SEVERE**: Positive evidence of abuse or exploitation from other individuals or society

### Domain 4: Risk to others
- **NONE**: No concerns about risk to physical safety of others
- **MILD**: Antisocial behaviour
- **MODERATE**: Risk to property and/or minor risk to physical safety of others
- **SEVERE**: High risk to physical safety of others as a result of dangerous behaviour
- **VERY SEVERE**: Immediate risk to physical safety of others as a result of dangerous behaviour

### Domain 5: Survival
- **NONE**: No concerns about basic amenities, resources or living skills
- **MILD**: Minor concerns about basic amenities, resources or living skills
- **MODERATE**: Marked lack of basic amenities, resources or living skills
- **SEVERE**: Serious lack of basic amenities, resources or living skills
- **VERY SEVERE**: Life-threatening lack of basic amenities, resources or living skills

### Domain 6: Psychological
- **NONE**: No disabling or distressing problems with thinking, feeling or behaviour
- **MILD**: Minor disabling or distressing problems with thinking, feeling or behaviour
- **MODERATE**: Disabling or distressing problems with thinking, feeling or behaviour
- **SEVERE**: Very disabling or distressing problems with thinking, feeling or behaviour

### Domain 7: Social
- **NONE**: No disabling problems with activities or in relationships with other people
- **MILD**: Minor disabling problems with activities or in relationships with other people
- **MODERATE**: Disabling problems with activities or in relationships with other people
- **SEVERE**: Very disabling problems with activities or in relationships with other people

<table>
<thead>
<tr>
<th>Domain</th>
<th>NONE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>VERY SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>NONE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>VERY SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of ticks</th>
<th>TAG row 1</th>
<th>TAG row 2</th>
<th>TAG row 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TAG score**

- 0 points for each None rating
- 1 point for each Mild rating
- 2 points for each Moderate
- 3 points for each Severe
- 4 points for each Very Severe
THRESHOLD ASSESSMENT GRID (TAG)
CHECKLISTS FOR GUIDANCE

Also consider any other aspects which are relevant. The tick-boxes are provided for optional use to identify concerns, but the TAG rating is made on the score sheet.

1. Intentional Self-Harm
   - Individual factors:
     - expressing suicidal intent
     - clear plan
     - available means
     - preparation
     - hopelessness
     - no support, e.g., partner, friends, professionals
     - poor coping resources
     - lack of blocks to self-harm
   - Consider risk factors:
     - past history of deliberate self-harm
     - alcohol/drug abuse
       - (i) diagnosis (e.g., depression, schizophrenia, personality disorder)
       - (ii) AND (i) = increased risk
     - physical illness/disability
     - recent GP contact
     - recent psychiatric hospitalisation
     - recent loss
     - no friends/family
     - living alone
     - unemployed
     - elderly people
     - male (especially young males)

2. Unintentional Self-Harm
   - Consider self-neglect:
     - lack of self-care
     - not eating or drinking appropriately
   - Consider unsafe behaviour:
     - not seeking help for problems posing risk
     - refusing appropriate help e.g., not taking medication
     - not changing environment
     - lack of awareness of own safety in home e.g. fire risk
     - risky sexual behaviour
     - substance misuse
     - wandering
   - Consider the inability to maintain a safe environment:
     - unable to manage accommodation
     - not paying rent
     - running up debts

3. Risk From Others
   - Consider different types of abuse or exploitation:
     - physical
     - sexual
     - emotional
     - financial
     - neglect
   - Consider risk from:
     - staff
     - relatives
     - friends
     - neighbours
     - strangers
     - treatments
   - Consider risk from society:
     - history of abusive/exploitative relationships
     - harassment from public
     - use of intimate partner
     - inadequate home security
     - fear of retaliation for reporting abuse

4. Risk To Others
   - Consider risk factors:
     - current threats, especially to a named person
     - history of violence to
       - people
       - property
     - care's concern
     - access to weapons
     - no blocks to violence e.g., fear of consequences
     - history of assault
     - mental illness
     - alcohol/drug abuse
     - stress
     - voicing/selling person to harm someone
     - parasuicide
     - risky sexual behaviour
     - anti-social behaviour e.g., manic driving
     - lack of information about
       - situation
       - person
     - no trusting relationship with professionals

5. Survival
   - Consider whether the person has problems with:
     - a home
     - heating for the home
     - essential amenities (e.g., washing facilities, toilet, cooker, bed)
     - the ability to look after their home
     - the ability to keep adequately clean and tidy
     - enough food & fluids
     - clothing
     - enough money to live on
     - mobility
     - the ability to use public transport
     - the ability to cope with physical health problems

6. Psychological
   - Consider:
     - overactive, aggressive, disruptive or irritable behaviour
     - problems with hallucinations & delusions
     - cognitive problems with memory, orientation & understanding
     - mood problems e.g., depressed, manic, anxious
     - problems with reading or writing
     - a lack of coping strategies
     - attitude to problems
     - help seeking behaviour
     - spiritual problems
     - feelings of alienation

7. Social
   - Consider problems in relationships with others:
     - lack of ability to make or maintain friendships
     - lack of support relationships
     - lack of intimate relationship
     - social problems
     - communication problems
     - unable to handle daily hassles
   - Consider problems in activities:
     - leisure
     - unpaid work
     - paid work
     - education
     - travel
     - lack of personally meaningful life

Further information on the Threshold Assessment Grid is available from www.iop.kcl.ac.uk/prism/tag
51.16 TAG Guidance

**THRESHOLD ASSESSMENT GRID (TAG)**

**FURTHER GUIDANCE**

**PURPOSE OF TAG**

TAG is a brief assessment of the severity of an individual's mental health problems. Instructions for completing it are contained on the score sheet, and this page provides further guidance. TAG is very easy to complete, requiring seven ticks on the Score Sheet. It is rated by staff for people who have (or are believed to have) mental health problems. Information on diagnosis should be recorded separately, if required.

TAG can be used in different ways, including:

- by GPs and other agencies (e.g. social services) who think someone has mental health problems and want to refer to a specialist mental health team - by appending a TAG to their referral letter, specialist mental health services will be helped to prioritise those most in need of help.
- to give a means of agreeing between agencies at what point in the care system people should receive help - this might be done by locally agreeing thresholds for referral.
- as a routine outcome measure for patients on the caseload of a mental health team
- to give commissioners a means of specifying the way in which community mental health teams are to focus on the severely mentally ill

**COMPLETING TAG**

TAG has seven domains covering the areas of Safety (two domains), Risk (two domains), and Needs and Disabilities (three domains). In each domain on the Score Sheet, you should tick one box, to indicate the rating of severity for that domain (ranging from 'None' to 'Very Severe'). A checklist is provided for each domain, to indicate some of the important aspects to consider. The checklists are based on evidence and current practice, but must be used in conjunction with clinical judgement. If an aspect which is relevant to the person is not on the checklist, it should still inform the ratings made.

The rating chosen should be the one that best applies to the person being assessed. The time frame is not specified, since problems (e.g. violence) may only occasionally occur, but still be ongoing causes of concern. As a general guide, however, consider problems in the last month, but also include current concerns which originate from before this period.

**Example - Domain 1. Intentional Self-Harm**

Looking across the row, if 'High risk to physical safety as a result of deliberate self-harm or suicide attempt' is the statement that best applies to the person, then tick this box. This rating is classified as 'Severe' (shown at the top of the grid).

When all seven domains have been ticked (once in each domain), the assessment is complete. If desired, the number of ticks for each column can be recorded in the first row at the bottom. (The total should then add up to seven). Example: if there are three ticks in the 'Severe' column, write '3' in the box at the bottom of the 'Severe' column. Also, if desired, the TAG score can be calculated, by recording the total weighted score for each domain (e.g. 2 points for each Moderate rating) in the second row at the bottom, and then adding those scores together. The maximum TAG score is 24.

**HOW TO USE A TAG ASSESSMENT**

The two rows at the bottom of the Score Sheet indicate the severity of mental health problems. 445 TAG referrals to mental health services across London were analysed to provide guidance on referral thresholds. If the goal is to ensure that all referrals are suitable, then a threshold of at least 1 severe or very severe domain will ensure that 93% of referrals are suitable, but 74% of referrals not meeting this criterion will in fact be suitable - a high false negative rate. If the concern is to ensure that all suitable referrals are offered assessment, then using a threshold TAG score of 3 or more will ensure that 91% of suitable referrals are identified. However, 20% of unsuitable referrals will also meet this criterion - a high false positive rate. The best cut-off is found using either a TAG score of 5 or more, or at least 2 moderate domains.

**Example**: A team may agree with its referrers that a TAG will be completed for all referrals, and that the team will assess anyone referred with a Very Severe rating within 24 hours, with 2 or more Severe ratings within 72 hours, and anyone else with at least 2 Moderate rating within 2 weeks. For patients with less than 2 Moderate ratings, the referral letter will state that the patient's mental health problems are of a severity to warrant specialist mental health service.

Further information on the Threshold Assessment Grid is available from www.iop.kcl.ac.uk/prism/tag
Threshold Assessment Grid (TAG) Completion and Scoring

No training is required to complete the TAG.

Scanning the evidence-based checklists, reading the further guidance, and practice in completing the TAG will all improve the reliability of the scores.

How is the TAG completed?

TAG is completed by ticking 7 boxes, one for each domain. The scores range from NONE (no problem in that particular domain) to either SEVERE or VERY SEVERE. For each domain, tick the statement that best applies to the patient. There should be a total of 7 ticks on the grid (remember to tick NONE if there is no problem). Only the single TAG score sheet needs to be written on to complete the TAG.

The TAG has two supplemental pages. The evidence-based checklists can be used as an aide memoire, to identify some of the important aspects to consider in rating each domain. Alternatively, the boxes for the individual items in the evidence-based checklists can be ticked, to provide extra information to add to that contained on the TAG score sheet.

How is the TAG scored?

TAG can be scored by summing the scores for each domain:

a) TAG total score

| None | = 0 |
| Mild | = 1 |
| Moderate | = 2 |
| Severe | = 3 |
| Very Severe | = 4 |

Summing the 7 domain scores in this way gives the Total Score.

Example:

a) For an assessment comprising three NONE, two MILD, and two SEVERE domains, the Total Score would be 8 (1+1+3+3).

b) TAG domain score

Alternatively, TAG can be scored using the number of ticks in each column, i.e. the number of NONE, MILD, MODERATE, SEVERE or VERY SEVERE. These are the Domain Scores.

Example

The Domain Scores for the previous example would be three NONE, two MILD, and two SEVERE.

The score to use depends on what the TAG is being used for.
51.17 References

DH document ‘Best Practice in Managing Risk” (June 2007)

“Justifying Risk Decisions” (Criminal Behaviour and Mental Health 18; 139-144 2008) by Dr David Carson

“Rethinking Risk to Others in Mental Health Services” Final report of a scoping group (Royal College of Psychiatrists June 2008)

52 Care Planning Procedure

52.1 The Process of Care Planning

Care should be planned in a way that is appropriate to the individual's needs and wishes. Care plans are more relevant if they involve the person in agreeing and writing the care plan as much as possible and have a flexible approach to their involvement, reflecting the service user’s strengths as well as their needs.

The written care plan should be drawn up by the named Care Co-ordinator/Lead Professional, with the involvement of the service user, and where appropriate their carer and family members. A copy should be offered to the service user, his/her and others involved.

When the mental health care of a young person needs to transfer to services for working age adults, a joint review must be undertaken to ensure effective hand-over of care takes place. This should be carried out within agreed transitional processes locally and incorporated into a care plan under CPA.

Where an individual now in prison was previously cared for under the CPA, the care plan should (with the prisoner’s consent) be formulated with the full involvement of their mental health Care Co-ordinator before release. The process should be supported by probation, police, and housing colleagues who will need to be involved in ongoing risk assessment, risk management, and review of care arrangements.

Ensure that adequate administrative arrangements are in place. Try to understand the feelings of the person using the services - large meetings can be intimidating.

Be clear about who needs to be involved, and who the person would like to be involved.

Be flexible in where meetings are held - and be clear about for whose benefit they are being held.

Be clear about who is chairing the meeting and their role/authority.

Follow up all verbal arrangements in writing, setting the date and time for review.

Be aware that a plan is unlikely to succeed unless the person can fully relate it to their own wants, needs, and goals.

With regard to the criminal justice system the planning of care should involve the
relevant authorities i.e. in-reach.

The care plan should follow the service user in all settings this includes the criminal justice system.

52.2 Content of the care plan

The care plans for all service users will:

- Identify the **interventions including complementary therapies** and **anticipated outcomes**;
- Record all the **actions** necessary to achieve the **agreed goals**;
- Include the reasons in the event of a **disagreement**;
- Give an **estimated timescale** by which the outcomes or goals will be achieved or reviewed;
- Detail the **contributions** of the agencies involved; Have the **date of the next planned review**;
- Include **crisis and contingency** arrangements: which may contain an advance directive that describes preferred treatment choice in the event of the individual experiencing an acute episode of illness;
- Include details of the Service User’s post-discharge medication regime (where required);
- Be delivered and show that the **agreement** of each professional or service to undertake such aspects of care delivery has been agreed; and
- Be based on the needs of the individual.

52.3 Crisis and Contingency Plans

Crisis plans should set out the action to be taken if the service user becomes very ill or their mental health is rapidly deteriorating. Crisis plans will include:

- Who the service user is most responsive to;
- How to contact that person;
- Previous strategies which have been successful in engaging the service user; and
- Early warning and relapse indicators.

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

The contingency plan should include the information necessary to continue implementing the care plan in the interim, for example, telephone numbers of service providers and the name and contact details of substitutes who have agreed to provide interim support. A deputy or deputising service should be identified for the Care Co-ordinator.

Crisis plans should include any identified potential risks to the child, in and out of crisis and over time, and the steps being taken to safeguard the child.

52.4 For people on CPA, the care plan should also include:
The arrangements for the management of risk to the service user and to others, carers, and the wider public, including the circumstances in which defined contingency action should be taken;

- Explicit plans for responding to non-compliance and missed contact;
- The crisis plan should include: who the service user is most responsive to; how to contact that person; and previous strategies that have been successful in engaging the service user. This information should be easily accessible out of normal office hours;

- Explicit contingency arrangements to prevent crisis developing when, at short notice, either the Care Co-ordinator is not available, or part of the care plan cannot be provided. The contingency plan should include the information necessary to continue implementing the care plan in the interim, for example, telephone numbers of service providers and names and contact details of those who have agreed to provide interim support;

- Arrangements for physical health care: how and what will be provided - usually by the GP but also by social services when help with meals and personal care may be offered;

- Action needed to secure accommodation, appropriate to the service user’s needs;

- Arrangements for mental health care including medication and other care or intervention as relevant, and for service users with complex medication needs, pharmacists should be involved in care planning;

- Action needed for employment, education or training or another occupation; and should promote access to employment information advice and support, options for skill development and link with local employment agencies;

- Arrangements to provide domestic support;

- Arrangements needed for an adequate income; Action to provide for cultural and faith needs.

- Arrangements to promote independence and sustain social contact, including therapeutic leisure activity;

- The need for psychological therapy.

Where the adult is a parent, consideration of how the needs of the parent and their child are addressed separately and together. If there are other agencies working with the family then the care plan needs to articulate how the different services will impact on each other and how communication with the family and each other will take place; and

- Special needs relating to ethnicity, gender and disability.

For service users with severe mental illness who are at high risk of suicide, the care plan should include:

- More intensive provision for the first three months after discharge from patient care; and

- Specific follow-up in the first 48 hours (by Named Nurse) to first week (by Care Co-ordinator) after discharge.

52.5 Wellness Recovery Action Planning (WRAP)

WRAP is a structured system for monitoring uncomfortable or distressing symptoms or experiences through planned responses, reducing, modifying or eliminating those
symptoms or experiences, It also includes plans for responses from others when symptoms or experiences have made it impossible to continue to make decisions, take care of yourself and keep yourself safe.

WRAP plans are not incompatible with care plans under CPA. They are written and owned by the person themselves, and cover what they need to feel well, including personal support mechanisms and techniques.

Where the Care Co-ordinator is happy that this covers the relevant issues, the WRAP plan can be the care plan under CPA, but it may also be included (with the person’s permission) as part of the overall care plan.

52.6 Single Assessment Process for older adults

There should be a single care plan for older adults, where possible co-ordinated by a single health or social care worker.

52.7 Person Centred Planning and Health Action Planning for people with learning disabilities

‘Person centred planning is about being in charge of what happens in my life and getting people I want and trust to help me make things happen’

Person centred planning is about:
- Listening to and learning about what people want from their lives
- Helping people to think about what they want now and in the future
- Family, friends, professionals and services working together with person to make this happen

A Health Action Plan is a personal plan about what a person with learning disabilities can do to be healthy. It lists any help people might need to do those things.

Where a service user with learning disabilities is accessing specialist mental health services, a Care Co-ordinator will be appointed from the care team, who will with the Health Action Plan Co-ordinator to ensure a single co-ordinated care plan is produced.

As there is a high population of people with learning disabilities in prisons there also a need to ensure that assessments for these individuals are linked with the Person Centred Health Action Plan (HAP).
52.8 CPA Planning timescales are shown in the attached flowcharts

Flow Chart - Community

Where action is taken &/or by whom → Event → Timescales

Person involved in the Service Users care

Staff from any of the agencies involved in their care

Person in the community recognised as meeting inclusion criteria for CPA

Process explained to Service User & Carer

Within 14 working days of first contact with services following recognition that inclusion criteria are met

CPA meeting set up, held & information collection activated

Care Co-ordinator identified

Immediately at the meeting

Care Plan agreed & persons responsible for implementation identified

Information exchanged with Service User & Carer

Within 5 working days following the meeting

Care Plan Review process planned

Written record of meeting sent out

Within 5 working days following the meeting

Information collected for clinical record and central recording

Process continues until discharge agreed at a review
Event:

- Person admitted to inpatient service

Timescales:

- Before initial CPA meeting
- Within 14 working days of admission, following recognition that inclusion criteria are met

Where action is taken &/or by whom:

- Named/ Primary Nurse
  - Process explained to Service User & Carer
  - CPA meeting set up, held & information collection activated
  - Community-based Care Co-ordinator identified and level agreed
  - Care Plan agreed & persons responsible for implementation identified
  - Information exchanged with Service User & Carer
  - Care Plan Review process planned
  - Written record of meeting sent out
  - Information collected for clinical record and central recording

- Care Co-ordinator
  - Visits Service User within 48 hours of discharge from hospital. Medication monitored.

- Named Nurse from In Patient nursing team
  - Immediate handover to Community Team, following this visit
53 Review Procedure

53.1 Reviews and Care Packages and Pathways of Care (Clustering)

The format of reviews depends on the amount of support being offered to the person and their needs. The service user and carer should be involved where possible, to the extent that they are able.

As part of their role the Care Co-ordinator will therefore need to ensure that as part of the CPA Review process, all service users for whom they are Care Coordinators, have an up to date HONOS and identified Cluster, with on-going clustering occurring according to cluster review requirements shown in the following table:

<table>
<thead>
<tr>
<th>Cluster no.</th>
<th>Cluster label</th>
<th>Cluster review interval (maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Variance</td>
<td>Not applicable</td>
</tr>
<tr>
<td>1</td>
<td>Common mental health problems (low severity)</td>
<td>12 weeks</td>
</tr>
<tr>
<td>2</td>
<td>Common mental health problems</td>
<td>15 weeks</td>
</tr>
<tr>
<td>3</td>
<td>Non-psychotic (moderate severity)</td>
<td>6 months</td>
</tr>
<tr>
<td>4</td>
<td>Non-psychotic (severe)</td>
<td>6 months</td>
</tr>
<tr>
<td>5</td>
<td>Non-psychotic (very severe)</td>
<td>6 months</td>
</tr>
<tr>
<td>6</td>
<td>Non-psychotic disorders of overvalued Ideas</td>
<td>6 months</td>
</tr>
<tr>
<td>7</td>
<td>Enduring non-psychotic disorders (high disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>8</td>
<td>Non-psychotic chaotic and challenging disorders</td>
<td>Annual</td>
</tr>
<tr>
<td>9</td>
<td>Blank cluster</td>
<td>Not applicable</td>
</tr>
<tr>
<td>10</td>
<td>First episode in psychosis</td>
<td>Annual</td>
</tr>
<tr>
<td>11</td>
<td>Ongoing recurrent psychosis (low symptoms)</td>
<td>Annual</td>
</tr>
<tr>
<td>12</td>
<td>Ongoing or recurrent psychosis (high disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>13</td>
<td>Ongoing or recurrent psychosis (high symptom and disability)</td>
<td>Annual</td>
</tr>
<tr>
<td>14</td>
<td>Psychotic crisis</td>
<td>4 weeks</td>
</tr>
<tr>
<td>15</td>
<td>Severe psychotic depression</td>
<td>4 weeks</td>
</tr>
<tr>
<td>16</td>
<td>Dual diagnosis (substance abuse and mental illness)</td>
<td>6 months</td>
</tr>
<tr>
<td>17</td>
<td>Psychosis and affective disorder difficult to engage</td>
<td>6 months</td>
</tr>
<tr>
<td>18</td>
<td>Cognitive impairment (low need)</td>
<td>6 months</td>
</tr>
<tr>
<td>19</td>
<td>Cognitive impairment or dementia (moderate need)</td>
<td>6 months</td>
</tr>
<tr>
<td>20</td>
<td>Cognitive impairment or dementia (high need)</td>
<td>6 months</td>
</tr>
<tr>
<td>21</td>
<td>Cognitive impairment or dementia (high physical or engagement)</td>
<td>6 months</td>
</tr>
</tbody>
</table>

A Review Date Calculator is available on the Care Programme Approach pages on the Intranet. The Calculator can be accessed by clicking on this link: [Calculator](#)

53.2 Review Requirements

Regardless of the number of people involved the following features should always be present:

- The review must be **planned** in advance, with sufficient notice given, and an agenda, chair and minute-taker agreed if required;
- The review must be **recorded** appropriately. For people on Standard Care, who only have contact with one professional, the clinical or practice notes may constitute the record of the review, although a copy must still be offered to the service user;
- Ensuring that the proposed **venue is accessible** (for public transport as well as for people with disabilities);
- If someone is **unable to attend** a review ask them to send a report; Reviews and multi-disciplinary team meetings must take account of health and social care perspectives;
- Give an opportunity to jointly consider/change the current **care plan and risk management plan**;
- Everyone’s opinions should be taken into account, and **divergent views** recorded;
- Changes in the care plan, crisis and contingency plan, and risk assessment and management plan should be **agreed and recorded**;
- A record of progressive **HONOS** scores and assigned **Cluster**;
- Any **needs which cannot be met** should be recorded;
- The need for continued support from **CPA**; and
- **At each review meeting the date of the next review** must be set and recorded.

One formal meeting, with the user, should be used to determine all care planning aspects including Mental Health Act status and discharge planning where required. There is no requirement to hold separate meetings, whether the service user is in a hospital or community setting

For **young people**, the review and other meetings should be young-person friendly (including the language used, timing of meetings, location of venues, who is in attendance, the possible need for interpreters).

It is particularly important not to duplicate meetings where other care processes apply, such as SAP or Looked After Child reviews, and agencies need to work together to ensure minimum duplication.

**Involving children** and young people or ascertaining their views beforehand (with parental consent) will provide an important and unique perspective on what has been happening with their parent, how it is has been for them and what they think has worked well.

### 53.3 When CPA is No Longer Needed

Services should consider at every formal review whether the support provided by CPA continues to be needed. As a service user’s needs change, or the need for co-ordination support is minimised, moving towards self-directed support will be the natural progression and the need for intensive care co-ordination support and CPA will end. It is critical that there should be a process for changing arrangements when the need for CPA or secondary mental health services ends. The additional support of CPA should not be withdrawn without:

- An appropriate review and handover (e.g. to the lead professional or GP);
- Exchange of appropriate information with all concerned, including with carers;
- Plans for review, support and follow-up, as appropriate; and
- A clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that person’s mental wellbeing.
53.4 When to review

For those needing the support of CPA on-going review, formal multi-disciplinary, multi-agency review must take place at least once a year, but is likely to be needed more regularly. Reviewing CPA, also necessitates a review of the Service User’s Care Plan and their Risk Assessment and Crisis/Contingency Plan.

Review and evaluation of the service user’s care plan should be ongoing. Given that each Service User will have been assigned to a Care Cluster, the review of a person’s care should be aligned with the requirements of that particular cluster (see Section 53.1 for details of review frequency).

A change in circumstance: be that a change in clinical presentation, a change of risk factors or a review of the appropriate care cluster should all be seen as a valid reason to call a review.

Reviews may need to be held more frequently for children and young people compared to adults. The regularity of reviews will depend on the needs of the individual, but should take account of the agreed care plan requirements. The care team should agree which issues will an emergency review (e.g. non-compliance with treatment plan)

It is particularly important to hold a review:

- Before discharge from hospital, prison or other residential setting; and
- Within the first month after discharge from hospital
- When there is a noteworthy change in presentation or change of risk factor(s)
- When a care cluster is due for review or the care cluster changes

Any member of the care team or the service user or carer must be able to ask for a review at any time. All requests for a review of the care plan must be considered by the care team. If the team decide that a review is not necessary, the reasons for this must be recorded. The annual audit of the CPA should check that reviews of the care plan have been carried out.

A review is a process, not always a specific meeting, and the date of the review may be determined in one of four ways:

- Simple reviews, for service users seeing only one member of staff, usually happen in a clinic or home setting as part of a service, and the date of the review is the date of the contact.
- Where a multi-disciplinary review comprising a meeting of all concerned is held (perhaps with smaller meetings beforehand), the review date is the date of the final meeting.
- In rare cases, the review might comprise a series of conversations, perhaps some by telephone, co-ordinated by the Care Co-ordinator. In these cases, the decisions finally agreed will be recorded in the care plan, the date of which is then the review date.
- Finally, some reviews may be carried out for the purpose of closing cases where the service user is no longer in contact. The review date will be the date when the responsible clinician closes the case.
53.5 Chairing CPA meetings:

The CPA meeting should be chaired by the Care Co-ordinator in the way described below. If the Multi Disciplinary Team feels that the case is particularly complex or there are other relevant issues, then they can arrange for an independent chair to run the meeting. The people currently available for this role in are: CPA Lead and Modern Matrons

In all other circumstances the Care Co-ordinator should be in control of the meeting and should try to ensure that it doesn’t over-run. If the case is very complex, a double session should be booked. The chair should check that the right people are present (especially the Service User, Carers and Care Co-ordinator) and the correct information is available (this should have been organised before the meeting). If there are major omissions, it may need to be reorganised at a later date. The chair should explain the process to Service Users and Carers who are attending and give them a copy of the CPA information leaflet.

The decision of the meeting will be recorded by the care co-ordinator on the previous CPA document or, when there are many changes to the care plan, the CPA decisions form designed for this purpose (attached). Some Care Co-ordinators prefer to identify the issues with the Service User before the meeting and have a draft care plan prepared. This is fine as long as the meeting is able to discuss and change this draft when appropriate and the service user is fully involved.

It is often helpful, especially in complex cases, for a ward administrator to attend to record these details. In this case, it is very important that the meeting is run in a way that supports this person in making an accurate recording of decisions made. They should not have to take control of the meeting to get the information they need or be left to interpret general discussions to formulate the care plan. Once the meeting is over, the document recording the care plan decisions should be recorded onto the database and the CPA Care Plan will be produced.

The multi-disciplinary team should also consider the following issues:

- Does the plan identify the Named Nurse who will arrange for the user to be **visited within 48 hours of discharge from hospital**? This should be arranged for all Service Users, particularly those who have a previous risk of suicide or a history of serious mental health problems.
- Is this person **entitled to Aftercare under section 117 of the MHA 1983**? If so they must be placed on (new) CPA /section 117 and it should be recorded on the care plan that this is also a section 117 meeting.
- Are there any **physical health issues** that need to be resolved? Does the GP need to carry out a physical health check?
- Would the user benefit from completing an **Advanced Decision** as part of any crisis plan. This is available on the Intranet or from the CPA office and should be offered to all Service Users.
- Would the carer benefit from a **Carers Assessment**? (Usually done by the Care Co-ordinator, but the nurse can give out the form to carers if they identify that there is a need).
- Does an **Outpatient Appointment** need to be organised prior to discharge? (This can be done on the database before they leave the ward).
When should the date of the next review be set? The length of time until the next review will usually be dependant on needs or risk and the view of the MDT.

The user should be given the opportunity to say how they feel about the issues in the care plan, as should the carer and both should be given a Leaflet on CPA. Users may need to be supported before the meeting to identify exactly what they want to be included in the care plan.

Patients who leave the ward early (i.e. take own discharge) or are removed for violence or drug taking should also be subject to a discharge procedure. In these cases nurses should review risk and care needs as soon as possible after discharge. If risks or needs are high, then a referral should be made to on call locality duty workers or the Crisis Resolution Team and details should be passed to the Locality CMHT for allocation to a care co-ordinator.

In situations where patients are likely to be discharged in this manner (e.g. when there is a history of self discharge) then this should be planned for within the crisis/contingency plan.

It is very important that patients leave with a clear contingency plan as to what will happen in a crisis. This may be the same as the RiO Risk Management Plan, but should be copied onto the care plan. This should not usually just be a collection of phone numbers, but a plan to avoid future crisis and hospital admissions.

54 Discharge/Transfer/Leave (including Clinical Handover of Care)

54.1 The period around discharge is a time of elevated risk, particularly of self-harm, and it is important that proper safeguards are in place. It highlights the importance of thorough review and assessment prior to discharge, effective follow up after discharge, and liaison between services.

This Procedure outlines expectations in relation to Clinical Transfer between teams/services within the Trust, as well as Discharge from services altogether.

Service Users can expect to receive as a minimum the following information ahead of, or at the latest at the point of transfer, leave or discharge:

- A copy of their relevant Care Plan;
- A copy of their Section 17 Leave form (where this applies)
- A copy of their contingency plan containing contact details and what to do in an emergency;
- A copy of the discharge summary (In patients only)
- A copy of any other information relating to their on-going treatment, including post-discharge medication regime.

54.2 This Procedure is to be used when Transfer or Discharge is planned for Service Users from the following areas:

- Adult Mental Health
- Older Peoples Mental Health
- Low Secure Services
• Learning Disabilities Services
• Any other Specialist Admission requiring on-going support from a community mental health or learning disability service

54.3 Transfer and Discharge procedures related to patients accessing other Community Services (such as District Nursing or Health Visiting) is covered under separate guidance. See Community Services Transfer and Discharge Policy and Procedure.

Health Care Professionals (Care Co-ordinators/ Lead Professionals) retain the responsibility for transferring any key documentation between teams or services within the Trust. Where the person is to be discharged, this will include ensuring that the minimum information exchange requirements outlined above (Care Plan, Contingency information, discharge summary etc) are provided to all key individuals including the persons GP, as well as returning the case file to medical records at the point of discharge. Items returned to medical records should include: the case file; Discharge Summary; any associated history sheets; Medicine Form; any Advance Decision to Refuse Treatment or Advance Statement of wishes, any other information as deemed important for continuity of care.

Whilst it should be the responsibility of the host service to provide this information prior to transfer in to BDCT services, Care Co-ordinators should make every effort to ensure that they have a copy at their disposal prior to accepting the transfer. This is to ensure the Care Co-ordinator is fully aware of any care or risk related issues affecting the service user.

In-patients going on leave should have close community follow-up.

CPA documentation should include more intensive provisions for the first three months after discharge from in-patient care, and specific reference to the first post-discharge week.

54.4 Introduction

This procedure provides guidance to staff of BDCT on Clinical Transfer and Discharge between BDCT Mental Health and Learning Disability services and outlines the agreements for access to acute hospital care services provided by:
1) Bradford Foundation NHS Trust
2) Airedale NHS Trust

It is written to enable staff to ensure that patients with a primary diagnosis relating to their mental health or learning disability can also receive high quality physical health care of a preventative and/or treatment orientation in a way that provides equity of access as compared with the general population.

The Procedure is component part of the Trust’s Care Programme Approach Policy and should be read in conjunction with that Policy.

Staff should note the equivalent procedure for access and admission to services at BDCT by patients of the Acute Trusts mentioned above.

This procedure covers BDCT in-patients at the following sites:
Lynfield Mount Hospital;
Airedale Centre for Mental Health;
Airedale General Hospital;
Daisy Hill House;
Highfield and Moorlands View.

and the transfer arrangements to acute beds at:
Bradford Royal Infirmary;
Airedale General Hospital; and
St Luke’s Hospital.
(See scope of policy below)

54.5 Issues of note relevant to this procedure:

People with a medium and long term mental health condition and those with learning disabilities are known to have significantly higher rates of physical ill-health than the general population.

People experiencing acute episodes of care may present with neglect of their physical care and or may have harmed themselves increasing their need for high quality physical care.

Clinical Transfer or Discharge outside normal daytime hours is discouraged, given the lack of support services available. Wherever possible all Transfers and discharges will occur when co-ordinated resources are available to support the Service User and Carer(s)/Family. Exceptions to this will be for medical emergencies or pre-arranged transfer or discharge which has a specified time to take place (e.g. discharge to a Nursing or Residential home on a Saturday or Sunday).

No patient can have two NHS beds at the same time, unless they are subject to the Mental Health Act and one of those beds is a leave bed.

This procedure should be read in conjunction with the Care Programme Approach Policy.

54.6 Principles

General Principles:

The NHS has a general duty to provide healthcare to the entire population. NHS Trusts and Primary Care Trusts, have a responsibility to ensure all people, regardless of ethnicity, values, economic position, etc have equal and fair access to healthcare resources.

In general – people with mental health conditions and/or learning disabilities should be treated as members of the public with the access and equity rights that follow.

When they are community clients they are the responsibility of the General Practitioner.

The Trust and its staff should work with General Practitioners to ensure the physical care need of the person are understood, assessed as regularly as is necessary,
(evidence suggests routine physical care assessment should be more frequent for people with long term mental health conditions), and referral and treatments organised to ensure equity of access and provision.

Discharge/CPA planning should take place at the earliest stage possible during an episode of care. If admission as an inpatient is possible discharge planning should begin either prior to admission or as soon as possible after admission.

A review of care will be facilitated by the Care Co-ordinator to support discharge planning. This review will include:
1. The assessment/Review of health and social care needs.
2. The assessment/Review of Risk and Risk management plans
3. Identification of outcomes to support discharge planning
4. Care planning to support timely discharge
5. To agree arrangements for follow-up post discharge by In Patient Staff, followed by handover to Community Resources
6. To formulate the care plan on discharge

Confidentiality must be preserved throughout the service; however, it is acknowledged that in some relatively rare situations, associated risks to others must be taken into account in decision making concerning confidentiality issues. One example is where a child is at risk as a result of a parent's mental health problems and a balance must be achieved between the needs of the parent and the child.

Each service user on an in-patient ward will have a named nurse/professional who under the lead direction of the Care Co-ordinator will have responsibilities for his or her in-patient care and for assisting in co-ordinating the individual service user's discharge arrangements. This will be done in consultation with the multi-disciplinary team.

Service users and their carers should be fully involved where possible and appropriate in arranging discharge and aftercare arrangements, with choices given wherever possible.

Information should be provided to service users and where appropriate their friends, relatives and carers at all stages of organising discharge planning.

Prior to discharge a care plan supporting discharge and relapse prevention will be in place and agreed. This will be communicated to all involved agencies. This is the responsibility of the Care Co-ordinator who may delegate actions to other involved persons.

The care plan supporting discharge will clearly identify the Named Nurse responsible for 48-hour follow-up and a time and date will be recorded.

The Care Plan will also provide details of post-discharge medication provided and the Named Nurse will monitor and record compliance within progress notes in RiO.

The Care Plan will outline arrangements for transfer to a community-based Care Co-ordinator following the initial 48-hour visit by the Named Nurse.
The care plan on discharge will allow for more intensive provision of care in the first three months after discharge and will identify how community living is supported.

Any discharge planning must take into consideration the requirements of Safeguarding issues regarding the protection of children and adults.

All service users are entitled to request an independent advocate at any stage in their care (advocacy is the process of representing the needs and wishes of another person).

All those involved in the care of the individual will have access to the care plan. In circumstances this may involve the service user giving permission if not implied consent.

Adequate information should be provided to the responsible individual when service users are discharged or transferred to residential settings including information relating to health care. The information includes everything the other service, individual, team or agency will need to ensure the needs of the person who uses services are met safely, even when the transfer of information is required urgently. As a minimum this includes:

- Their name
- Gender
- Date of birth
- Address
- Unique identification number where one exists
- Emergency contact details
- Any person(s) acting on behalf of the person who uses services, with contact details if available
- Records of care, treatment and support provided up to the point of transfer
- Assessed needs
- Known preferences and any relevant diverse needs
- Previous medical history that is relevant to the person’s current needs including general practitioner’s contact details
- Any infection that needs to be managed
- Any medicine they need to take
- Any allergies they have
- Key contact in the service the person is leaving
- Reason for transferring to the new service
- Any advance decision
- Any assessed risk of suicide and homicide and harm to self and others
- The information is transferred in time to make sure that there is no delay to the assessment of needs by the service, team, individual or agency
- There are no interruptions to the continuity of care, treatment and support for the person who uses services

Discrimination must not take place on grounds of age, social class, ethnic origin, religion, language, sex, marital status, responsibility for dependants, physical or sensory impairment, learning disabilities, mental health, sexual orientation, body size, HIV status, diagnosis, financial circumstances or behaviour (unless in breach of written rules or procedures).
Wherever possible a service user should be able to choose the sex of the professionals involved in their care.

Service users with communication difficulties for example, people whose first language is not English, should have access to interpreters.

Particular care should be paid to discharge arrangements where the service user is being discharged outside of the local authority area in which they previously lived, to ensure adequate involvement and communication and agreement of the care plan with the new care team.

Any unplanned discharge, i.e. a person taking their own discharge, will require a CPA review to be facilitated by the care co-ordinator within 2 working days of discharge.

Where a service user is discharged from all aspects of Mental Health care delivered by the Trust, a comprehensive summary of the service users care and treatment is provided to their GP for future reference. The responsibility for this is with the discharging clinician.

However, when a person is admitted as an in-patient to the Trust, formal responsibility shifts to the Responsible Clinician (RC) to coordinate support to the care needs of the person. Thus the Trust and its staff, working to the direction of the RC, need to work with Acute Hospital Trusts to access quality physical health care meeting the same equity and access standards as for a community resident.

54.7 Principles guiding the good practice of transfer of a patient between Trusts

All patients will be fully informed and involved in the planning of their transfer of care.

With the consent of the patient, relatives and carers will be informed and involved in the planning of their transfer of care. In assessing the views of relatives and carers the current law in relation to the issue of consent will apply.

During a transfer patients should be treated and cared for in such a way as to maintain:
- Patient safety
- Necessary treatment and care
- Contact with appropriate staff
- Dignity
- Respect of individual needs

The transfer of patients occurs within the day-to-day clinical operational environment and there is a need to ensure that the safe care and treatment of patients takes precedence over the pressure on available beds.

54.8 Scope of this Procedure

The guidelines captured within this procedure are aimed at ensuring in-patients of this Trust are dealt with by Acute Trusts in an equitable fashion. To do this the staff of this Trust, (BDCT) may at times, (described below) need to provide support and
assistance to the person and to the Acute Trust to make sure that care can be delivered effectively.

This procedure describes the agreed approach for in-patients of BDCT to be referred to:
- a) Emergency access services: (Non-elective in-patient care)
- b) Planned admission to ward based care, (Elective – Day-care or overnight in-patient care)

The Procedure is essential to ensure:

- the effective transfer of patients between units to ensure the provision of safe and high quality patient treatment and care in the most appropriate environment
- to provide a mechanism to manage transfers for elective and emergency care effectively and efficiently.

Note: The term transfer is used to denote a (usually) temporary arrangement for the care of an In-patient at a different NHS Trust for a period of time relative to the care required. Acute medical bed or team refers to any acute hospital bed or team managed by an Acute NHS Trust, including surgical, older peoples, trauma, paediatric etc.

54.9 Duties

- **The Service Governance Committee** has the responsibility to *ratify* the Care Programme Approach Policy, to which this Procedure is associated;
- **The Professional Council** holds the responsibility to *approve* this Procedure
- **The Chief Operating Office/Director of Nursing** is responsible for ensuring this Procedure is adhered to (delegated to the Care Programme Approach Lead)
- **The Care Programme Approach Lead** is responsible for ensuring this Procedure is up to date, properly disseminated and its use audited via the audit processes.

**Responsibility of Line Manager.** It is the responsibility of the Line manager to ensure that:
- Relevant training is identified for staff through the appraisal process.
- Staffs attend training and subsequent refreshers.
- New employees receive information on the Care Programme Approach Policy and its associated Procedures such as this one

**Role of Consultant/Responsible Clinician**

The ultimate responsibility for the discharge of a service user lies with the consultant/responsible clinician in liaison with the multi-disciplinary team.

Discuss with the service user, and multi-disciplinary team prior to admission, if possible, the likely outcome of the episode of care, length of stay and support likely to be needed on discharge.
Ensure appropriate medical assessment of all service users before discharge; prescribe 'take home' medication, as per the Trusts Medicines Code. ‘A supply of 14 days will be supplied unless a shorter course is required’.

Ensure all service users have a care co-ordinator prior to discharge and an associated aftercare plan.

Discuss concerns raised by service users, relatives and other professionals with regard to discharge arrangements.

Make it clear on a service user’s discharge care plan what clinical interventions will be required on discharge, such as follow-up medical care or referral to other clinical services.

Provide the service user with certificates needed to enable him to draw benefits.

Check discharge summary on day of discharge, prepared by named nurse, particularly the diagnosis and medication and authorise with a signature.

Ensure that, in the event a service user discharging himself against medical advice, the general practitioner and care co-ordinator are informed within 24 hours (by telephone) and ensure that a review meeting is organised.

Dispatch formal letter to general practitioner within 2 weeks service user’s discharge.

- **Role of Clinical Team Manager/Ward Manager/Unit Manager**

  It is the responsibility of the manager to ensure adherence to this policy.

- **Role of Nurse in Charge of the in-patient facility at the time of discharge**

  The nurse in charge of the relevant ward/unit is usually the last professional who will have contact with the service user prior to discharge and as such has specific responsibilities.

  Ensure that the service user has necessary medication (enough to last until his next appointment with either GP or consultant as appropriate) and understands the verbal and written instructions given to him.

  Where the service user’s ongoing medication is to be provided by the general practitioner, the nurse in charge should advise the service user to make an appointment, giving necessary assistance and advice as required.

  Ensure that any property, including valuables, are returned to the service user and a receipt obtained.

- **Role of Named Nurse/Professional**

  Named nurses/professionals are responsible for being involved in co-ordinating service users’ discharge arrangements as well as their in-patient care.
If at any stage during discharge planning it is likely the service user will require social care on discharge, ensure that a social worker is involved, and where possible any other involved agency representative e.g. Department of Work and Pensions.

Ensure that discharge and aftercare arrangements are discussed with the service user's carer, care co-ordinator and other relevant professionals or voluntary agencies. In consultation with the care co-ordinator, ensure there is a written aftercare plan, agreed with all the agencies involved, which includes specific attention to the first weeks post discharge and allows for more intensive support in the first 3 months after discharge.

Ensure that the date and time of discharge is discussed with the service user, carer (where applicable) and care co-ordinator, and that arrangements for escort and reception at destination are available.

Arrange any out-patient appointment, and/or day service appointment, with transport where appropriate.

Re-establish clinical services (as appropriate) to which the service user may have had access prior to admission, e.g. podiatry, clinical psychology.

Carry out the initial 48-hour post-discharge home visit, to assess progress, monitor medication compliance and prepare handover to the community-based Care Co-ordinator.

Ensure that the service user has a copy of his Care Plan and understands its content, including how to contact the care co-ordinator and who to contact in an emergency (including out of hours).

Complete the discharge checklist and place in service user's records.

Arrange for a practitioner to make contact with the service user within seven days of discharge from hospital.

- **Role of Care Co-ordinator**

Many service users have care co-ordinators involved before their admission. The care coordinator will maintain their involvement during a service user's episode of care and will be involved in the service user's discharge.

Ensure that a written CPA Care Plan or clinical care plan has been agreed prior to discharge and all services understand their role and are committed to their input into this plan and that the service user understands the plan. The plan will include specific attention to the first week post discharge and allow for more intensive provision of care in the first 3 months after discharge.

Ensure that the general practitioner is aware of and has a copy of the proposed care plan and the name and contact details of the care co-ordinator.

Ensure appropriate review arrangements for the care plan have been made.
Attend all the Care Programme Approach meetings prior to the service user’s discharge.

Accept handover of the Service User’s care from the In Patient Named Nurse who has carried out the 48-hour post-discharge home visit.

Ensure consideration is given to delaying the discharge where it is unclear whether the proposed care plan can be implemented by the nominated agencies.

Act as a consistent point of contact for the service user, his or her carers and other professionals.

- **Role of Allied Health Professionals**

  All appropriate clinical services should have been involved in the discharge care plan via the Care Programme Approach.

  All discharge arrangements will be discussed and agreed with the service user and other relevant agencies before the end of that episode of care and in conjunction with the consultant/responsible clinician and multi-disciplinary team.

  All service users using allied health professionals services while an in-patient will be given a review appointment including a contact name and telephone number.

  Where relevant, all service users will be discharged from allied health professionals’ care with the prescribed aids and individualised home programme/intervention.

  Allied health professionals services should liaise with the local authority Services for provision of disability equipment and adaptations if appropriate.

  Clinical services available prior to admission should be reorganized as appropriate, e.g., clinical psychology.

- **Role of Social Services**

  Depending on the requirements of the service users, social workers work as part of the community mental health teams, as part of hospital social work teams or as part of generic community social work teams.

  The role and function of the social worker in connection with the discharge of service users from hospital includes counselling service users and relatives in readiness for discharge and assessing the appropriateness of social support services being provided, including housing.

  The range of services for which the social services department is responsible includes domiciliary help and care, residential care services including nursing home provision and the provision of disability equipment and home adaptations.

- **Role of Community Teams**

  Community Teams refers to all teams which provide management and support to individuals receiving services under the Trust in a community setting. This will include
Community Mental Health Teams, Community Teams Learning Disability Teams and other teams providing services for the Trust

Multi-disciplinary/agency community teams deal with the needs of people suffering from severe and/or enduring mental illness/Learning Disabilities within a community setting. A large proportion of service user users being discharged from hospital will have had contact with a community team prior to their admission. In all probability the service user's care co-ordinator/ Care Manager is a member of a community team and will involve other members of the team as appropriate.

Where a service user has not had prior contact with a community team, a referral will have been made while the service user is in hospital. Ideally a member of the community team will have visited the service user prior to his or her discharge and will have been involved in developing the service user’s care plan. Where this is not possible (due to the admission being of short duration), arrangements should have been made to carry out a post-discharge assessment of the service user in his or her home environment as soon as possible after discharge. The service user should be fully notified of these arrangements.

- **Responsibility of the employee.** It is the responsibility of the employees to ensure that they:
  - Follow the Care Programme Approach Policy and its associated procedures.
  - Attend training and subsequent refreshers.
  - Put their training into practice

- **All Managers and Team Leaders**, both in-patient and in the community, are responsible for ensuring that their teams are aware of the policy and are implementing it fully and correctly.

- **All clinical, social care staff and administrative staff** are responsible for using the policy correctly to ensure Service Users, their families and carers receive the highest quality of service.

**54.10 Purpose**

To describe:

- How patients should be transferred between units taking into consideration the patient’s experience; the carer’s perspective; the safety of patients and staff and making the best use of available services

- How transfer of patients requiring emergency or elective admission should occur in a timely and efficient manner without detriment to the clinical condition of the patient.

- How the safe transfer is assured by an agreement between the medical and psychiatric team’s that a patient has his/her needs met and care provided in the most suitable hospital environment.

To provide assurance to the Medical Team, (and Acute Trust) that:
- Good communication exists between all parties involved in the process to ensure the optimum use of and access to beds to provide most appropriate patient care and treatment and to enable return of patients back to BDCT in a safe and timely fashion.

- The BDCT mental health team will ensure that the patients specialist mental health needs can be met during their care and treatment with the acute medical team.

- The BDCT mental health team will provide advice and liaison to the medical team to ensure that any mental health needs are provided for and reviewed and amended during their care and treatment with the acute medical team.

- The acute medical team will be provided with a recent assessment of need, CPA Care Plan and risk assessment and confirmation of the current and required level of observation.

Clarify that:

- The referring unit remains responsible for the provision of care until the patient arrives on the accepting ward or unit and the patient is accepted by the receiving unit.

54.11 The safe transfer of a patient from a psychiatric bed to an acute medical bed

Circumstances under which transfer to a local acute general hospital may occur

If it is determined by the mental health clinical team either independently or after consultation with the acute medical team that an urgent/emergency assessment of the patient's physical health is required.

If emergency department management is required.

If it is determined after consultation with the acute medical team that an non-urgent elective assessment and/or treatment of the patient's physical health is required which it has not been possible to arrange via normal out-patient processes.

If the patient is required to stay in the Acute Trust for a defined procedure scheduled in continuance of a planned general health care treatment programme, (e.g. continuance of care organised via a general practitioner or out-patient diagnostic and treatment process).

54.12 Guidance regarding the care and transfer of patients

The request for an acute medical bed is based on the assumption that the referring RC is correct in their diagnosis and that care is required from the Acute Trust, thereby mirroring the arrangement following referral by a GP in the community and ensuring equity of access for people with mental health problems. Request for admission to a bed within Bradford Hospitals NHS Trust and Airedale NHS Trust differ, as outlined below: If emergency department management is required this is provided at the appropriate Accident and Emergency departments, with advance notice by telephone whenever possible.
Bradford Hospitals:
Requests for a bed will be made through the appropriate speciality:
Elderly Medical Unit, via Admitting SHO 364355
Medical Assessment Unit, via admitting SHO 364357
Surgical Assessment Unit, Ward 20 via Surgical SHO 364413
Orthopaedic admission via the SHO on-call through BRI switchboard 01274 542200
Gynaecology admission via the SHO on-call through BRI switchboard 01274 542200
Paediatric assessment room 382311

Airedale:
All requests to be made via the bed manager bleep number 3150 or via switchboard, other than Older Peoples Medicine which should be made directly to the Consultant on-call, bleep number 3291, 10.00 – 20.00 hours or via switchboard.

54.13 Assessment of mental health need

If it is determined that the patient requires care within a local Acute Trust the mental health clinical team will ensure that a comprehensive assessment of the individuals needs at that time has been completed.

This assessment should be completed before the patient has left the mental health unit or as soon as possible afterwards in an emergency

The assessment should include the identification of any specialist mental health care needs of the patient during the period of their transfer to and care within the general hospital service and ensure that there is a risk management plan in place to appropriately address the risks associated with their specialist mental health e.g. risk of self harm or risk to others.

The assessment should include details of any known infections, whether those infection-risks have been screened and whether infection control methods have been applied (identifying specific treatments given).

The mental health teams should where possible seek to develop this risk management plan in conjunction with the physical care team to ensure that it is both realistic and achievable within the physical care setting.

A copy of the comprehensive assessment documentation, risk assessment, risk management plan and other care plans should accompany the patient to the general hospital.

In the event that the full documentation has not been completed at the point of transfer of the service user i.e. in the event of an urgent/emergency transfer then a comprehensive verbal assessment will be given by the mental health clinical team to the receiving acute medical team. In these circumstances copies of all necessary documentation will follow as soon as possible.

If it is anticipated or known that the patient will require admission to an acute ward a transfer summary form should also be completed.
54.14 **Infection control**

Prior to planning suspected or confirmed infectious patients discharge or inter-
healthcare transfer or re-admission the infection control nurse must be notified to 
equip that the risks of cross infection are assessed and minimised. A ‘confirmed 
risk’ patient is one who has been confirmed as being colonised or infected with 
Meticillin-resistant staphylococcus aureus (MRSA), Extended Spectrum Beta 
Lactamase (ESBL), Pulmonary Tuberculosis (TB) and enteric infections (diarrhoea 
and/or vomiting) including Clostridium difficile, (see relevant policies for further 
information).

A ‘suspected risk’ patient includes one who is awaiting laboratory test results to 
identify infections/organisms. When transferring patients/clients in either of the 
above risk groups between wards and departments or to another healthcare setting 
it is essential to inform the infection control team at the receiving ward/unit of any 
infectious conditions, before the transfer is carried out and before arranging an 
appointment or ordering transport.

A transfer form must also be completed for all transfers whether the patient 
presents an infection risk or not, (DH 2008). In general the transfer of an infectious 
patient should be avoided unless for essential medical or psychological intervention. 
In emergency situations include the infection risk status in any verbal 
communication to the ambulance personnel and the receiving A&E department to 
ensure that isolation facilities are identified. A documented transfer form should 
follow at the earliest opportunity.

General Practitioners should be informed in the Discharge Letter if an infectious 
patient is to be discharged home. If patients require continuing care and 
management of their infection e.g. MRSA in the community, then the District 
Nurses, Community Infection Control nurse and Community Psychiatric nurse 
should also be advised of their discharge. If treatment courses need to be continued 
following discharge a referral should be made to the district nurse to ensure that the 
course is completed.

Patients with diarrhoea should not be transferred (excluding transfer for emergency 
care or admission on clinical grounds) to a General Hospital.

A terminal clean of the vacated isolation area must be carried out prior to 
occupation by another patient, refer to the Decontamination, Cleaning and 
Disinfection Policy for further guidance.

When patients are transferred between wards/units or admitted from another 
healthcare facility, the transfer documentation must be checked for suspected or 
confirmed infection risks. The patient’s current condition should be assessed on 
admission to ensure appropriate isolation/placement for infection risk minimisation. 
For further guidance the nurse in charge **must** inform the Infection Control Nurse.

54.15 **Arranging transfer**

The mental health team have responsibility for ensuring that appropriate transfer 
arrangements are in place to enable the patient to be safely transferred to the local 
acute hospital for assessment and/or treatment.
When it is appropriate for the transfer to be planned, arrangements should be made for this to take place between 0900 hours and 1700 hours Monday to Friday. This should facilitate the maximum availability of staff in both organisations.

In an emergency situation, transfer will be made by emergency ambulance services, (999 blue light) and the operational managers will coordinate with other wards where necessary to facilitate adequate staff resource to accompany and where appropriate stay with the patient, (see below)

When transfers are planned the arrangements should be clearly documented within the patients' healthcare records.

Once it is confirmed that an admission to an acute hospital ward is required and that the transfer has been completed, the patient will be discharged from the mental health inpatient unit. The only exception to this position is if the service user is detained under a section of the Mental Health Act in which case a leave bed will be held for them and transfer will be coordinated under Section 17 (Authorised leave) of the MH Act.

The patient will always be accompanied by a member of nursing staff with the appropriate skills and training necessary to undertake the role. If the risk assessment indicates, then more than one staff member may be required to accompany the patient. Whenever possible the named nurse should undertake these duties, if that is not possible then the nurse will be known to the service user and be familiar with their care.

The role of the escort is to ensure that the patient’s healthcare needs are appropriately met during their transfer to the acute hospital site and for communicating any necessary information required by the receiving acute medical or A&E care team on arrival. The escort will normally take responsibility for transferring the healthcare records of the patient and any required medication.

54.16 **On-going care from BDCT (including issues of Observation)**

Where the patient’s mental state is such that a high level of care and observation is required (as documented by the care records, risk assessment and observation record sheets), the mental health nursing team will make available sufficient staff to assist in the transfer and provide care and observation for the patient in the acute hospital until the patient no longer requires that level of input and the medical team have made their own arrangements.

The observation level required to ensure that the patient’s mental health care needs are appropriately met within the acute hospital should be identified as part of the risk assessment by the referring mental health clinical team. This risk assessment should be shared with and agreed by the acute medical care team. The BDCT Observation and Engagement Policy will be used to guide this process.

Details regarding the level of observation required should be included on the transfer documentation.

The mental health clinical team will consult with the acute medical care team regarding the care of the patient and agree how the mental health services will continue to input into the patients care whilst they remain within the acute hospital.
This will include identification of the level of observation necessary and ensure that it remains appropriate to the needs of the patient within an acute hospital ward environment.

By joint agreement and where the observations levels may be assessed as being able to be reduced to a general level, the observation will become the responsibility of the acute medical nursing team unless the care practice is subject to additional guidance, e.g. the Mental Health Act Code of Practice.

The nurse in charge of the acute hospital ward will ensure that they are aware of the level of observation required and this will be clearly documented in the patients’ health care records and staffing planned accordingly.

When the mental health nursing team are required to provide the observation the Mental Health Ward Manager will ensure that arrangements are in place to provide suitably experienced/qualified nursing staff to meet the level of observation identified as necessary. These arrangements should be clearly communicated to the nurse in charge of the acute hospital ward.

The mental state of the patient will be monitored whilst they remain within the acute hospital ward by the mental health clinical team at mutually agreed times, minimal weekly. The role of the mental health clinical team is to ensure that the specialist mental health care needs are appropriately met and to review the level of observation required from the risk assessment in conjunction with the acute medical care team.

This regular assessment will be undertaken by the Responsible Clinician and a member of the mental health nursing team (preferably the named nurse). Where possible this assessment will also include the patient’s care coordinator.

Mental health staff will ensure effective communication with the acute medical team and ensure that the service users’ health care records are effectively maintained.

Nursing staff carrying out observation and/or assessments will record the assessment; ensure that a comprehensive handover is given to the staff member detailed to continue the care of the service user at the end of their shift and report their assessment to the nurse in charge of the acute hospital ward before leaving the unit.

Although the patient may be discharged from our bed, they are not discharged from our care therefore we must maintain contact and support throughout their acute stay and the mental health team must negotiate the patient’s transfer back ensuring their physical care needs are not compromised and that nurses (see appendix 3)

54.17 Medication

When it is known that the patient will be admitted to the acute hospital their prescription card and medication should be sent with them under the care of the staff member. This should include depot medication.

The transfer documentation that accompanies the patient should detail the information necessary to ensure that any medication required to meet their
specialist mental health needs can continue to be administered appropriately within the acute hospital unit.

For patient's who are detained under a section of the Mental Health Act the arrangements for how any specialist medication required by the service user will be administered to them during their acute hospital stay should be included within the care plan that is jointly agreed between the two teams.

This care plan should indicate which staff will undertake responsibility for administering the medication required and when and provide details of review arrangements in place.

54.18 Additional actions if a service user is detained under a section of the Mental Health Act

If the patient is detained under a section of the Mental Health Act they will be placed under section 17 leave and the appropriate documentation (section 17 leave form) completed. A copy of the Section 17 Leave form will accompany the patient

A leave bed on the mental health unit will be held for the service user for the period of their stay within the general hospital ward.

The mental health team will retain responsibility for ensuring that any specialist mental health care needs of the service user can be met effectively in the acute hospital whilst they remain under a section of the Mental Health Act.

The Responsible Clinician must ensure that the patient’s Mental Health Act status is reviewed, minimum weekly.

This regular assessment will be undertaken by the Psychiatric RC and a member of the mental health nursing team (preferably the named nurse). Where possible this assessment will also include the patient’s care coordinator.

Mental health staff will ensure effective communication with the acute medical team and ensure that the service users’ health care records are effectively maintained. Nursing staff carrying out observation and/or assessments will record the assessment; ensure that a comprehensive handover is given to the staff member detailed to continue the care of the service user at the end of their shift and report their assessment to the nurse in charge of the acute hospital ward before leaving the unit.

Although the patient may be discharged from our bed, they are not discharged from our care therefore we must maintain contact and support throughout their acute stay and the mental health team must negotiate the patient’s transfer back ensuring their physical care needs are not compromised and that nurses (see Appendix 3 of this Procedure)

54.19 Follow-Up after discharge from hospital

In 12 points to a Safer Service it was recommended that there should be: Follow-up within 7 days of discharge from hospital for everyone with a severe mental illness or a history of self-harm in the previous 3 months.
The In Patient Care Pathway makes provision for the In Patient Named Nurse to provide initial follow-up with the Service User within 48-hours of Discharge. The CPA Policy and it's procedures supports this process.

And Safety First further recommended that: All discharged in-patients who have severe mental illness or a recent (less than three months) history of deliberate self-harm should be followed up within one week.

Care plans for all discharged in-patients who have a severe mental illness or recent history of deliberate self-harm are to include specific follow-up arrangements for the first week after discharge and more intensive provision for at least the first three months.

54.20 Discharge from CPA

Every formal review should consider whether the support provided by CPA is still needed. It is important that this support is not withdrawn prematurely when a service user is stable because a high level of support is maintaining his/her well-being. A thorough risk assessment with service user and carer involvement should be undertaken before taking the decision.

When there is no longer a need for someone to be supported by CPA, this will not remove their entitlement to services they are eligible for and need, but the additional support of CPA should not be withdrawn without:

- An appropriate review and handover (e.g. to the lead professional or GP);
- Exchange of appropriate information with all concerned, including GP and carer(s);
- Plans for review, support and follow-up, as appropriate.
- A clear statement about the action to take, and who to contact in the event of relapse or change with a potential negative impact on the persons well-being.

Where CPA is appropriate in hospital or prison the same safeguards should apply for a period after release/discharge.

Where a person is to be discharged from services completely, services must ensure:

- They receive a copy of their final care plan outlining the arrangements for discharge and detailing what to do should services be required again in the future;
- That their GP is sent a copy of final correspondence from services outlining the final care arrangements;

54.21 Discharge from Hospital

Patients who are to be discharged from hospital should have a discharge CPA review prior to leaving the ward. These reviews should be co-ordinated in the following way:
CPA discharge or ongoing care meetings should be planned well in advance - at least 2 weeks if possible, to allow adequate notice to people who should attend. For shorter stays in hospital, there should be as much notice as is practically possible. They will be booked through the ward administrator.

It is the responsibility of the named nurse to organise the CPA meetings on the ward, together with the ward administrator. This responsibility can be taken over by the care co-ordinator with prior agreement. The user should be told in advance and encouraged to bring an advocate if they wish to. Any carer should be invited unless there is a specific reason why they should not be there. The care co-ordinator should always attend these meetings and they will usually not go ahead without them. In some instances, it may be appropriate for the Care Co-ordinator to provide written or verbal information about their views for the meeting if they cannot attend.

If the user did not have a care co-ordinator on admission, then a message will have been sent to the appropriate community team as early as possible asking for one to be allocated. This worker should usually be allocated within two weeks of receiving the request. Therefore, the named nurse is the care co-ordinator until a worker is allocated or they are discharged.

A reasonably up to date risk assessment should be available to the meeting, as the purpose of the meeting is to review risk, not write it from scratch. It is the responsibility of the named nurse to ensure that an up to date risk assessment is available to this meeting. If this is not available then it should be written at this meeting. Patients should not leave hospital without an up to date RiO risk assessment that includes a crisis/contingency plan.

54.22 Discharge against Medical Advice

If a service user who is not subject to detention under the Mental Health Act decides he wishes to leave hospital and take his own discharge, the nurse in charge discusses with the service user the reasons for wanting to leave and attempts to dissuade the service user from doing so. The service user is encouraged to wait to see a doctor before he leaves.

If the service user cannot be persuaded to stay they should be asked to sign a declaration that they are leaving hospital against medical advice and should be given a clear explanation of what this means. A copy of the declaration should be fixed in the medical notes. The nurse in charge must give due consideration to detaining the service user under section 5(4) of the 1983 Mental Health Act (Nurse’s holding power) (see Mental Health policy –“Nurse’s Holding power” Similarly, if the duty medical officer has been summoned and cannot persuade the service user to remain, he should consider the use of the Doctor’s Holding Power.

Reassurance should be given that the service user’s decisions will not effect any future treatment or care he may require but if the service user is still determined to leave; his consultant (or Duty Medical Officer if out of hours) should be informed without delay. If a service user refuses to sign the declaration then the nurse in charge must state this on the declaration and in the service user's notes, sign the form and have it witnessed. If the service user refuses to wait for necessary transport or other arrangements to be made before he leaves, the nurse in charge must be satisfied that
every effort to persuade the service user against this course of action was made. The service user's relatives/carers and the General Practitioner must be notified as soon as possible of his departure. Other professionals involved in the service user's care particularly where booked sessions may need cancelling, should be notified by the nurse in charge of the ward/unit as soon as practicable.

Should it be found that the service user has left the hospital without notifying anyone, the missing service user procedure - must be implemented.

Where a service user already has a Care Co-ordinator the co-ordinator should be notified and the Named Nurse/Professional (or other person nominated by the nurse in charge) and the Care Co-ordinator will then be responsible for developing an interim care plan detailing the immediate action to be taken. Where a Care Co-ordinator has not been established, the Named Nurse/Professional will be responsible for ensuring an interim care plan is developed (including immediate action to be taken), in consultation with others involved which will include referral to appropriate aftercare services.

55 Criminal Justice and Assessment of Offenders

55.1 Criminal Justice and CPA

The Care Programme Approach (CPA) is one of the key elements of current mental health care policies, and should extend to the prison context. Prisoners who were on CPA before entry into prison should be able to have their programmes of treatment set out for them and continued as far as possible within the prison setting. Care co-ordinators based in the community should endeavour to retain contact with patients who have been sent to prison, and liaise with prison based staff working with the patient, in order to provide continuity of care, particularly on release. Furthermore, inmates whose clinical profile would precipitate CPA in the community should commence on CPA in prison. It will be important to ensure that there are mechanisms in place to help identify prisoners who are, or should be, on CPA.

CPA has applied to offenders in England for a number of years, and Secondary Mental Health Teams working in prisons have often used it very successfully to ensure a safe and effective re-engagement with mental health services in local areas. There are, however, some critical points in the pathway.

In England, where (new) CPA is appropriate in prison or hospital (criteria will apply), the same safeguards should be continued for an appropriate period when the service user is released or discharged. Automatically removing the support of CPA at this point could compromise the safety and treatment of the individual at a vulnerable point in their care pathway.

Establishing whether a service user is a parent at the initial assessment stage is critical, and should be routine. Parents who play an active role in the care giving role and who are temporarily separated from their children (e.g. when in prison) should also be included (in CPA).

55.2 Movement of Offenders

Movement of offenders between prisons (often at very short notice and to different
areas and regions) and movements between prison, hospital and community can lead to lack of continuity of care due to poor exchange of information. It is therefore vital that relevant information accompanies the offender/Service user during transition through the offender pathway and that both CPA Care Coordinators and Offender Managers have a sound understanding of both the health and criminal justice systems.

The following guidelines mainly come from the Offender Mental Health Pathway DH/NIMHE January 2005. There have been some modifications to the process since 2005, but the general principles remain.

**Community to prison:** Once the prisoner has been through the reception process, a Mental Health Assessment (triage) should be done by the primary mental health nurse.

This is necessary to carry out mental health assessment on prisoners who have been identified as being at particular risk (from the health screening process); to refer to the appropriate mental health team so that a care plan and treatment can be delivered on the prison wing or appropriate prison locality where possible; to provide continuity of care; to initiate the prison wing care planning process for prisoners who need additional care.

Mental health assessment carried out taking into account the Inmate Medical Record, background information, current medication etc

Devise a care plan for prisoners with mild to moderate mental health problems in conjunction with prison wing staff, the primary care team and other agencies as necessary.

Allocate a Care Co-ordinator or key primary mental health worker based on the prison wing.

If the prisoner is presenting with acute mental health symptoms refer to the In-Reach team.

Refer to visiting specialists e.g. psychiatrist for further mental health assessment

ACCT prison care planning process initiated for those at risk of self-harm or suicide

Any relevant information regarding potential risk shared with first night unit staff

**55.3 Prisoners referred to In-Reach (secondary mental health services) who are already on CPA:**

Care co-ordination is retained with the team in the community whilst the service user is on remand. In-Reach will key-work this person and try to ensure contact between outside services and service user are maintained. Where geography is an issue, liaison via telephone, etc. is encouraged. Once the person is sentenced, the role of care co-ordinator may be temporarily transferred to the In-Reach nurse (depending on length of sentence) with a view to it being transferred back to the relevant service in the community once he/she is released.

CPA reviews to be held and initiated by the Care Co-ordinator as required. Where possible, this is to take place in the prison to facilitate service user involvement.
55.4 Prisoners referred to In-Reach (secondary mental health services) who are newly identified as requiring CPA:

Referral to relevant CMHT/agency in anticipation of the person needing to engage with mental health services on release. In-Reach will key-work this service user until a Care Co-ordinator is allocated.

55.5 Prison Transfer to NHS for prisoners placed on CPA either in the community or whilst in prison:

To provide speedy assessment and smooth transfer to specialist or secure NHS facilities for prisoners whose mental health problems or co-morbidity problems are so severe that their mental health requires treatment in hospital.

Pre-referral assessment:
- Collect all relevant background information, Inmate Medical Record (paper-based or computerised), CPA care plans, sentence plans, OASys reports, pre-existing reports that may have bearing on risk (such as probation reports, psychiatric reports, psychology reports);
- Obtain patient consent re: information sharing taking into account that risk factors will override a decision to refuse consent;
- Physical examination; and
- Psychiatric assessment of risk.
- Home Office Mental Health Unit to be contacted and notified of need for diversion of prisoner. Note: No prisoner can be transferred without the consent of the Mental Health Unit who will issue a warrant of transfer prior to the actual transfer itself.
- Referral made to Commissioners of that specific region indicating need for NHS specialist unit, an assessment will be commissioned and clinically-led decisions will be made regarding the appropriateness of hospital placement. In some areas, the individual hospital will liaise directly with the commissioners (as per local arrangements) once a referral has been made and an assessment carried out.
- Admission accepted pending availability of an NHS bed. Advice and support provided by the NHS unit while waiting transfer. Transfer of prisoner to the NHS.
- CPA Co-ordinator and/or member of In-Reach Team will be invited to regular multi-disciplinary team care planning reviews.

55.6 Prison to prison transfers for prisoners on CPA:

Contact receiving prison In-Reach team (or healthcare if they are initially unavailable) and give a verbal summary of the prisoners mental health needs and current care plan.
Fax through CPA care plan and relevant risk factors
- Notify the Care Co-ordinator of the transfer and the new contact details
- Notify the GP

For prisoners at risk of suicide and/or self-harm
- Contact the receiving prison reception staff and give a summary of current care plan.
55.7 **Prison to Community:** Pre-release healthcare planning for prisoners on CPA:

- Multi-disciplinary/agency CPA pre-discharge team meeting arranged.
- CPA Aftercare plan developed and circulated prior to release.
- Copy of the CPA plan given to the prisoner.
- Transfer of care agreed with the Care Co-ordinator.
- Notify the GP and provide a summary of the relevant mental health details, CPI~
  and aftercare plan.
- If a prisoner is under Section 117 of the Mental Health Act, send a copy of the
  aftercare plan to the PCT and Social Services.

55.8 **Aftercare (prison to the community)**

For ex-prisoners on CPA or at particular high risk of self-harm or suicide:

- Initial follow up contact within 7 days of release by relevant team in the
  community identified in pre-discharge meeting.
- Intensive support for first 3 months post release as per aftercare plan.

55.9 **For ex-prisoners on Standard Care:**

- Follow up contact and support as per aftercare plan

55.10 **For ex-prisoners with mild mental health problems:**

- Ex-offender makes GP appointment.

55.11 **For ex-offenders with substance and alcohol misuse problems:**

- Dedicated aftercare service provided by Criminal Justice Drugs team (if in place)
  and/or Community Alcohol Service as per aftercare plan.
- Alternatively CARAT’s (Counselling, Assessment, Referral, Advice and
  Throughcare) provide short term post release support (up to 8 weeks).
- Ex-prisoners identified as having dual diagnosis issues to be supported by Dual
  Diagnosis Service (if in place).

Prison service health care centres and NHS mental health services share responsibility
for ensuring appropriate liaison on the care of mentally ill prisoners. It is particularly
important that effective links are made to ensure sound discharge planning when
inmates are released from prison.

56 **Carers Assessment**

*Carers of service users, including young carers, should be involved in their own
assessment and care planning process, which takes account of the state of their
own mental and physical health needs, and ability to continue to care.*’

56.1 **Who should carry out a Carers Assessment?**

The assessment is the responsibility of the statutory services to arrange, usually
through the Care Co-ordinator. Assessment is not the responsibility of the carer
support worker. Agencies should, wherever possible, work together to ensure that
a carer has one assessment which will enable them to access all services.
Services should ensure co-ordination of service users’ and carers’ assessments, care and support plans and the exchange of information where the agreement has been received to do this.

The worker undertaking the assessment should try to ensure that it is sensitive to:
- Gender, ethnicity, culture, language, religion;
- Assumptions about the ability and willingness to care;
- The needs of young carers. It cannot be assumed that the child can undertake the necessary caring responsibilities. The impact on the parenting role must also be taken into consideration; and
- The role being undertaken and the relationship between the carer and service user.

56.2 The assessment should include:

- Current support provided by the carer or others for the service user;
- Current support for the carer (formal and informal);
- The participation of the carer’s own GP;
- The carer’s views; and
- The carer’s needs including: financial/benefits advice; domestic or personal assistance; respite; emotional support; accommodation; social and recreational; employment; health; advocacy; transport; information.

56.3 Carer’s Support Plan

The information from the assessment will be used to put together a support plan for the carer/s, which may include:

- Information about the mental health needs of the person for whom they are caring, including:
  - information about medication and any side-effects which can be predicted,
  - services available to support them,
  - a way of accessing more general information, such as research into the effectiveness of treatments, alternative therapies, legislation, benefits, rights, and local services. Information packs can be very helpful;
- Agreed actions to meet defined contingencies;
- Where to access services, including crisis and out of hours access information;
- 24-hour, 7 day a week contact numbers;
- What will be provided to meet their own mental and physical health needs, and how it will be provided;
- Action needed to secure advice on income, housing, educational and employment matters;
- Arrangements for short-term breaks;
- Arrangements for social support, including access to carers’ support groups;
- Information about appeals or complaints procedures;
- Training; and
- Social opportunities.

The carer’s assessment should help them to think about the things that they want to
continue to do to help the person they care for. It should also enable them to feel that mental health services will provide the support that they no longer feel able to provide.

56.4 Young Carers

Young carers are children under 18 who provide substantial personal and/or emotional care to another family member. Typically they will be providing care to a lone parent, often their mother, who may be experiencing mental health problems.

Assistance to young carers should not reinforce the role of the child or young person as a carer. Interventions to help support the family as a whole and promote parenting role of adults are more likely to be helpful and ensure that a child’s welfare or development is not impaired.

These 10 messages were written by a group of young carers for people who work in mental health services:

- Introduce yourself. Tell us who you are and what your job is.
- Give us as much information as you can.
- Tell us what is wrong with our parents.
- Tell us what is going to happen next.
- Talk to us and listen to us. Remember it is not hard to speak to us we are not aliens.
- Ask us what we know and what we think. We live with our parents; we know how they have been behaving.
- Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
- Please don’t ignore us. Remember we are part of the family and we live there too.
- Keep on talking to us and keeping us informed. We need to know what is happening.
- Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU’.

The Carers (Recognition and Services) Act 1995, the Carers and Disabled Children Act 2000, and Carers (Equal Opportunities) Act 2004 (which apply to England and Wales), and local policies should be referred to for more information on working with carers.

The Carer Assessment and Support Plan can be access via the CPA pages on the Intranet.

57 Care Co-ordinator capabilities and competencies Guidance

57.1 Essential Capabilities

The 10 Essential Shared Capabilities framework suggests the essential capabilities that should be included as core in pre and post qualification training for all professional and non-professionally affiliated staff:

- Working in partnership
- Respecting diversity
- Practicing ethically
Care Co-ordinators have a professional responsibility to ensure their knowledge base and skills are adequate to meet the needs of the role. Organisations have a responsibility to ensure their employees are equipped to practice in any role they are undertaking. As the Care Programme Approach is about multi-disciplinary and multi-agency working, any training given on the role of the Care Co-ordinator should be facilitated in the same way. Training should be updated regularly and at a period not exceeding 3 years.

The development of care co-ordinator competencies, principles of practice and core functions should inform supervision and appraisal, and support caseload management processes.

Items for consideration basically fall into two groups, knowledge and skills/competencies;

57.2 Knowledge base

- Mental health law and government policy/legislation.
- Local policies and procedures.
- Assessment mechanisms in areas of Health and Social need including Risk Discharge and Care Planning.
- Legislation concerning child protection, local child protection procedures, the working of the ACPC (Area Child Protection Committee), and responsibilities for safeguarding children.
- Roles within the care team.
- Equal opportunities.
- Background to and principles of the CPA.
- The link between the CPA and Care Management.
- Knowledge of community services and the role of other agencies.
- Adult Protection procedures.
- Awareness of race, culture and gender issues.
- Substance misuse and related issues.
- Personality disorders.
- Professional codes of practice.
- Sources of information on mental health and related issues.

57.3 Skills/Competencies

- Competence in delivering mental health care (including an understanding of mental illness).
- Co-ordination/facilitation skills.
- Ability to involve the individual and their carer/s.
- Communication skills; written and verbal.
- Collaboration and negotiation.
- Matching services to needs.
- Recording skills and Administration.
- Group work.
- Needs Assessment.
- Risk assessment and management including risks of suicide and violence which should be updated through training every three years.
- Time management.
- Managing meetings.
- Ability to identify the need for additional specialist assessments.
- Effective communication with families.

All staff in contact with patients at risk of suicide should receive training in the recognition, assessment and management of risk, of both suicide and violence, at intervals of no more than three years. Training numbers are reflected in the Training Needs Analysis (page 36).

Adequate training is made available on the local authority direct payment scheme and its operation within the framework of integrated mental health services. This should be provided for all direct payment scheme and support services staff and a mental health service managers and care co-ordinators.

In England, the ‘Care Co-ordination Core Functions and Competencies’ outlines the functions and competencies, based on the National Occupational Standards, and suggests that the core competencies could include:

57.4 Comprehensive Needs Assessment
- Assess individual’s mental health and related needs.
- Identify potential mental health needs and related issues.
- Identify the physical health needs of individuals with mental health needs.
- Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes.

57.5 Risk Assessment and Management
- Develop risk management plans to support individuals independence and daily living within their home.
- Assess individuals’ needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others.
- Assess the need for Intervention and present assessments of individuals' needs and related risks.

57.6 Crisis planning and management
- Work with families, carers and individuals during times of crisis.
- Respond to crisis situations.
- Assessing and responding to carers needs.
- Work in collaboration with carers in the caring role.
- Assess the needs of carers and families of individuals with mental health needs.
- Develop, implement and review programmes of support for carers and families.
- Empower families, carers and others to support individuals with mental health needs.
57.7 Care Planning and Review
- Co-ordinate, monitor and review service responses to meet individuals’ needs and circumstances.
- Plan and review the effectiveness of therapeutic interventions with individuals with mental health needs.
- Implement, monitor and evaluate therapeutic interventions within an overall care programme.

57.8 Transfer of care or discharge
- Plan and implement transfer of care and discharge with individuals who have a long term condition and their carers.
- Work with others to facilitate the transfer of individuals between agencies or services.

An essential element of all training should be the involvement of service users and carers, particularly those from minority or equality groups.

58 Self-directed Support Procedure

The 5 key messages the reader should note about this section are:
- Self directed support is National Policy
- Self directed support is the new way of delivering social care
- Self directed support is about increasing the choice and control that service users have over their own lives
- Self directed support is about starting with the individual and their specific needs and circumstances instead of fitting service user needs into existing services
- Self directed support is integral to CPA and the responsibility of the individual’s care coordinator although other staff may support them

58.1 Introduction

All Local authorities have a statutory duty under the NHS and Community Care Act (1990) and the National Assistance Act (1948) to assess and provide services to people with social care needs who are eligible for funding under Fair Access to Care Services. In mental health services, these duties are discharged through the Care Programme Approach. Traditionally these services have been offered through block contracted services such as mental health day services, supported accommodation, respite care and residential and nursing home placements. Such services at times can provide limited choice and flexibility to meet service users’ individual needs and preferences.

Social care policy has now changed with a move towards more personalised services and self directed support. New policies such as Putting People First (2007) sets out the vision of transforming social care from a service led system of assessment and provision to one of self directed support. Self directed support puts service users at the centre of the support planning process and allows them greater choice and control over how their social care needs are met and ultimately how they live their lives. Self directed support provides the opportunity for service users to have greater autonomy and self determination through the use of individual budgets.
58.2 Purpose
The purpose of this procedure is:
- To enable staff to carry out their responsibilities to provide self directed support to service users with eligible social care needs as delegated by Bradford Metropolitan District Council (BMDC) within the designated pilot sites
- To highlight other related procedures to be adhered to whilst undertaking self directed support within the designated pilot sites

58.3 Definitions

Sense check – a check for approximate accuracy

Self directed support – is a process which ensures that individuals and their families can use an individual budget in innovative and creative ways to meet their individual eligible social care needs.

Indicative budget- an initial estimate for a yearly budget allocated to a service user to meet their individual social care needs having being assessed through the self directed support questionnaire.

Actual budget- a budget agreed at the Social Care Resource Allocation panel allocated to a service user for a year to meet their individual social care needs having being assessed through the self directed support questionnaire.

Individual budget – an amount of money available to an individual to meet their eligible assessed social care needs

Direct Payments – cash payments paid to an individual which they can tailor to meet their individual social care needs

The following documents are to be used within the self directed support process and can be found on the Trust intranet under the CPA section, Personalisation and self directed support, self directed support staff tool kit

- Self directed support questionnaire – My help care and support needs
- What is self directed support fact sheet
- Self directed support questionnaire electronic version
- My support plan
- Indicative budget letter
- Part managed actual budget letter
- Self managed actual budget letter
- BDCT managed actual budget letter

59 Self directed support process

59.1 Assessment

59.1.1 When a service user is allocated to a care coordinator the agreed procedure for comprehensive assessment should be followed.

59.1.2 The care coordinator should complete a core assessment identifying health and social care needs.
59.1.3 If social care needs are identified the FACS (Fair Access to Care Services) matrix should be completed and applied.

59.1.4 If a service user has eligible social care needs i.e. moderate, substantial or critical then the self directed support process should be followed.

59.1.5 An initial CPA care plan should be completed ensuring that an identified problem of self directed support is selected. This should detail that the service user is undergoing self directed support. The social care outcome (SO code) self directed support must also be selected. Social work staff should select professional support for this problem also.

59.1.6 The service user, carer and allocated care coordinator should complete the self directed support questionnaire, “My help, care and support needs.”

59.1.7 Written information should be given to the service user prior to the assessment to explain self directed support. This should be in the form of the fact sheet, “What is self directed support and what is it for?”

59.1.8 Where disagreement occurs between worker, carer or service user within the assessment this must be recorded within the assessment document.

59.1.9 If disagreement occurs within the scoring the care coordinator must try to resolve this through negotiation with all parties. If this is not possible the care coordinator must make the decision taking into consideration all available information and record the reasoning for this decision within the assessment documentation.

59.1.10 A service user must be supported to complete as much of the assessment process as possible.

59.1.10 Once the self directed support questionnaire has been completed with the service user and carer this information should be transferred to the SDQ electronic version and stored within client records.

59.1.11 On completion of the SDQ electronic version an indicative budget will be generated.

59.2 The Indicative Budget

59.2.1 Once an indicative budget has been generated it needs to be sense checked with the team manager and a case recording made to indicate this has been completed.

59.2.2 On agreement with the team manager the service user must be informed of their indicative budget using the standard indicative budget letter.

59.3 Support Planning

59.3.1 Support planning can be completed with a service user and carer either by the care coordinator or an identified support worker.
59.3.2 A service user can also choose to complete their own support plan either by themselves or with assistance from family, friends, or carer.

59.3.3 To complete a support plan it is important to discuss with the service user how they wish their support needs to be met, what services they would choose or what they wish to purchase, and what plans are in place should things in the support plan go wrong.

59.3.4 The support plan must reflect the needs of the service user identified within the self directed support questionnaire.

59.3.5 The plan must be reasonable, and not be used for food, gambling, or anything illegal and not bring BMDC or BDCT into disrepute.

59.3.6 If a service user is felt to lack capacity in being able to make decisions about a support plan, and how they wish to take their individual budget a mental capacity assessment must be completed. (see section 59)

59.4 The Social Care Resource Allocation Panel

59.4.1 Once completed, the support plan needs to be presented to the Social Care Resource Allocation panel.

59.4.2 This appointment should be booked through the secretary to the Head of Social care and Social Work. Care coordinators must attend in person to discuss the support plan.

59.4.3 The support plan, core assessment, risk assessment, current CPA documentation and current mental capacity assessment will be reviewed at the Social Care Resource Allocation panel. Consideration must be given to positive risk taking and detailed on the Risk assessment.

59.4.4 The panel will make a decision as to whether the support plan has been agreed or further work/changes are required. If it has been agreed the support plan will be signed at the meeting by the chair.

59.4.5 If the support plan is agreed the care coordinator must inform the service user of the actual budget using one of the standard actual budget letters and provide an agreed support plan to the service user.

59.4.6 If the service user is choosing to self manage the budget through a direct payment the self managed actual budget letter must be sent (Appendix 6) If the service user is choosing for BDCT to manage the budget the BDCT managed actual budget letter must be sent. (Appendix 7) If the service user is choosing to partly manage the budget then the part managed budget letter must be sent. (Appendix 8)

59.4.7 If the support plan is not agreed the panel will advise on appropriate action to be taken.
59.4.8 Once these changes are made the support plan must be re-presented to panel. If changes are minor panel may agree the plan on condition of the changes being made.

59.4.9 Service users and carers are welcome to attend the Social Care Resource Allocation Panel in person.

59.5 **CPA Care plan and social care outcomes**

59.5.1 Once the support plan has been completed and agreed it is the responsibility of the care coordinator to ensure that this is documented within a current CPA Care plan and that the risk assessment is updated as necessary.

59.5.2 The self-directed support SO intervention must be amended to have a start date.

59.5.3 It is essential that the body of the CPA care plan reflects the details of the support plan and that all care plans identify appropriate SO codes for each particular need.

59.5.4 SO – self-directed support should only be used once within the identified problem of self-directed support prior to the production of the support plan.

59.6 **Initial Review**

59.6.1 When the support plan goes live an initial review should be undertaken between 2-6 weeks with the service user by the care coordinator.

59.6.2 The initial review is to establish that the plan is meeting the needs of the service user. A case record of this initial review should be made.

59.6.3 If the initial review demonstrates that no changes are required the support plan should be reviewed regularly either just before or during a CPA review.

59.6.4 A formal review process is required after a 12 month period.

59.6.5 If the initial review demonstrates that changes are required to the support plan to ensure the needs of the service user are being met the following guidelines should be followed:

- If a small change is required which is £50 above the existing actual budget or can be made within a one-off £250 additional payment, or is below the actual budget a team manager can authorise these changes but must inform the Social Care Resource allocation panel of the changes.
- If the change requires funds in addition to these amounts the support plan must be re-presented at the Social Care Resource Allocation panel.

59.7 **Twelve month review**

59.7.1 When a support plan has been in place for 12 months the Twelve month review must be completed.
59.7.2 If the plan continues to meet the needs of the service user then it can be agreed by a team manager, the review documentation completed, and a case recording made to demonstrate the review has occurred.

59.7.3 If changes are required the self directed support process must be recompleted.

59.8 Unscheduled Review

59.8.1 An unscheduled review occurs when the support plan no longer meets the needs of the service user and changes outside of the existing budget are required.

59.8.2 An unscheduled review can occur at any time and requires a care coordinator to re complete the self directed support questionnaire, and generate another indicative budget and support plan.

59.8.3 This support plan will need to be presented at the Social Care Resource Allocation panel for authorisation.

59.8.4 Some unscheduled reviews can be avoided if the original support plan contains the allocation of money for contingency planning

59.9 Process Map

59.9.1 The self directed support process map is attached to this document as Appendix 1

60 Mental Capacity

60.1 Service users who lack mental capacity can have access to self directed support and direct payments and care coordinators need to refer and adhere to the BDCT Mental Capacity Policy and procedures on the intranet

60.2 The Mental Capacity Act 2005 supports the values and practice of self directed support by empowering individuals to make their own decisions and choices as far as is possible.

60.3 Care Coordinators must ensure that for all individuals who undergo self directed support and have a proposed support plan presented to the Social Care Resource Allocation Panel mental capacity has been considered. Mental capacity should be recorded either through case recordings or where an individual lacks capacity a mental capacity assessment must be completed.

60.4 An individual who lacks capacity must be involved as fully as is possible in completing the self directed support questionnaire and support plan.

60.5 If an individual is deemed not to have capacity the care coordinator must coordinate a best interest decision in relation to the proposed support plan.

60.6 If through best interest decision it is identified that an individual does not have family, or relative to contribute to the discussion i.e. a suitable person then the care coordinator must ensure the individual has access to an independent mental
capacity advocate to safeguard their rights and views and be referred to the IMCA service, currently at Bradford and Airedale Mental Health Advocacy Group.

61. Safeguarding

61.1 The self directed support process does not require changes to be made to the usual process of safeguarding. However it is recognised that with the management of finances through direct payments and the employment of personal assistants some service users and children could become more vulnerable to abuse.

61.2 Please refer to and follow the relevant policies and procedures on the BDCT intranet: Safeguarding Children Policy and Safeguarding Adults: Local Policy and Procedure.

62. Managing Risk within Personalisation and Self-directed support

62.1 The self directed support process does not require changes to be made to the usual process of risk management and the documentation of risk assessment. However it is recognised that with the additional responsibilities of managing budgets through direct payments, and the use of a wide variety of community resources and personal assistants additional thought should be given to risk management.

62.2 Positive risk taking should be considered when a service user is involved in self directed support. The Rio Risk assessment must include such plans.

62.3 The support plan must include details of what should happen if a support plan goes wrong.

63. Direct Payments

63.1 Individual budgets can be taken as direct payments by service users. When a service user chooses to take their individual budget as a direct payment this must be done through a referral to the direct payment team. The direct payment team referral can be found within the Personalisation and self directed support staff toolkit on the intranet.

63.2 Some service users may be eligible to take their individual budget as a direct payment however it may be advisable to organise for their budget to be managed by BDCT.

For example
- Substance misuse issues
- High risk of financial exploitation
- Being either unwilling or unable to manage the direct payment and do not have a suitable person to undertake this for them

63.3 These circumstances need to be discussed on an individual basis and advice sought from the direct payment team, resource allocation panel, or through usual routes of supervision.

63.4 An individual who lacks capacity can still have access to direct payments by having the direct payment made to a suitable person, i.e. family, carer. This person
must be willing and able to manage the direct payment. If there is no suitable person or the suitable person is unable to or does not wish to manage the direct payment a managed budget should be used.

63.5 There are individual circumstances which may result in a service user being excluded from this option and a managed budget is necessary.

Direct payments may not be made to people who have been placed under certain conditions or requirements by the courts in relation to drug and/or alcohol dependencies.

The specific exclusions can be found in Guidance to direct payments, Dept of health (2009). Advice can be given by the direct payment team.

63.6 Where a direct payment is requested the service user must be advised about possible delays and offered a managed budget. This can be given instead of a direct payment or put in place in the interim.

64. Service users with dual service involvement

64.1 Some service users may have or require the involvement of more than one team to assess their social care needs. E.g. Physical disabilities team. If this is the case only one assessment and support plan should be completed for individual service users.

64.2 The managers of those teams must agree which team has lead responsibility and workers must be allocated to work in partnership to complete one assessment, budget and support plan. The head of social care and social work must be involved to agree with the corresponding senior managers within other teams the level of funding through the social care budget for mental health.

65. Advance Directives and Self-directed Support

65.1 The use of advanced directives may be very useful in considering with a service user what they may wish to do with their individual budget if their needs change or if they are no longer able to manage a self managed budget.

65.2 Please refer to the CPA Policy on the intranet, or the advance directive guidance which can be found under the CPA section of the intranet.

66 References and Glossary

66.1 References:
- Building Bridges DH 1995
- National Service Framework DH 1999
- Carers (recognition and services) Act 1995
- Fair Access to Care Services LAC 2002
- National Service Framework for Older People DH 2001
- Single Assessment Process and CPA LAC 2001
- Changing the Outlook DH 2001
- National Suicide Prevention Strategy DH 2002
Safer Services DH 1999
Working together to safeguard children DH 1999
Confidentiality NHS Code of Practice DH 2003
Mental Health NSF Self Assessment Framework DH 2003
Safety First DH 2001
Refocusing the Care Programme Approach DH 2008
Standards for Better Healthcare DH 2006
Best Practice in Managing Risk DH 2007
Offender Mental Health Pathway DH 2005
Direct Payments for people with mental health problems DH 2005
CPA Core functions and competencies DH 2008
National Service Framework for Children DH 2004
Code of Practice Mental Health Act 1983 DH 2008

66.2 Glossary

Advance Decision is a statutory right to refuse treatment, including life sustaining treatment, that if valid and applicable is binding and cannot be overridden by anybody at a time when the person lacks capacity, having been made when they had capacity.

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

Common Assessment Framework (CAF) The term Common Assessment Framework (CAF) is used to describe assessment systems in adult heath and social care and in children’s services.

Lead officer (CPA) A CPA Lead Officer with access to trust boards must be identified in each mental health trust.

Lead professional The term is used in this document in its ordinary sense, i.e. the professional who has lead responsibility for an individual’s treatment and care. Where it refers to the Lead Professional, i.e. the specific role in Every Child Matters and the Common Assessment Framework for Children, capital letters are used.

MAPPP The Multi Agency Public Protection Panels (made up of representative from relevant public services) manage the Multi Agency Public Protection Arrangements (MAPPA).

Person Centred Care The key principles are:

- It is a continuous process not a product;
- It is a dynamic process of discussion, negotiation, decision making and review that takes place between the individual and the professional — who have an equal partnership;
- The process should be led by the individual with them at the centre, based upon their strengths, goals, aspirations and lifestyle wishes;
- The person should be encouraged to have an active role in their care, be offered options to allow informed choices, and empowered to make their own decisions with adequate information or signposting — all within a framework of managed risk; and
- Self care and self management is an essential element of good care/support and should always be supported.

Recovery is a concept that has been introduced primarily by people who have recovered from mental health experiences and has grown considerably around the developed world. Now many people are talking about and using the word recovery. However, in England, people have differing views of what recovery means, whilst the word is being included in common usage in mental health services, a clear understanding of what this means remains limited. NIMHE has produced a brief statement 79 on the emerging view of mental health recovery to contribute to the development of recovery-oriented services nationwide.

s.117 is a section of the Mental Health Act 1983 which places a duty on health and social care to provide aftercare for people admitted under s.3, 37, 45a, 47 and 48.

Social Inclusion Social inclusion can be defined as people having the same opportunities to participate in, and contribute to, society and community as the rest of the population. This includes improving access to health and social care services but also to community services to enable people to participate. It involves increasing options and empowering people to have confidence in their own abilities and aspirations. Key areas are education, employment, housing, family and relationships, financial security, leisure, arts, cultural and religious opportunities and participation in civic life.

Statement of wishes and preferences, including written statements, are those that are non-binding but which have to be taken into account by those making best interest decisions on a person’s behalf at a time when the person lacks capacity having been made when they had capacity.

Unsettled Accommodation The reference to people in unsettled accommodation includes: rough sleepers and people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the main homelessness duty.

Young Carer Around 3 million children in the UK have a family member with a disability. Not all take on a caring role that is inappropriate to their age. Few parents want their children to be carers but it can happen for many reasons, such as families being isolated, afraid of outside interference or lack of other support.
Dear [Insert Name]

RE: Your help, care and support needs.

At my visit to you on (date) we completed the ‘My help, care and support needs’ assessment and identified areas where you need support.

Based on this assessment we estimate that your individual budget will be approximately £…………….. to meet your needs.

This is an indicative amount and is not the actual budget figure. This indicative budget may be amended depending on how you wish to meet your needs.

We now need to draw up a support plan that sets out how this money will be spent to meet your eligible needs. I can help you with making this support plan if you want me to or you can choose to create the plan yourself or with friends and family. I will contact you this week to find out if you want me to help you with developing this support plan.

If the support plan shows that you need more or less money to meet your needs than we first thought, the individual budget will be adjusted and I will explain this to you. We will let you know the actual amount of money available once your Support Plan has been agreed.

If you need to get in touch with me please use the information at the head of this letter.

Yours sincerely

[Name]
[Title]
Dear [Name]

Re: Your Individual budget

You have recently undergone the assessment, My help, care and support needs and a support plan has been developed and agreed.

The amount of your actual budget is £........

As you have decided to manage the individual budget yourself you must make sure that the money is only spent on meeting your needs as agreed in your support plan, a copy of which is enclosed.

You cannot overspend on the money provided to you, but you can use your own money to top up your spending.

I will be in touch shortly to talk to you about what happens next and how you can manage this budget.

It is important to be aware that your individual budget may not stay the same over time. If your needs change, the allocation may increase or decrease but we will ensure that you continue to receive the appropriate amount of support that you need.

If your needs change or you want to do something different with the money available please contact me.

Yours sincerely

[Name]
[Job Title]
Appendix 4- BDCT managed actual budget letter

[Date]

[Name]
[Address]

Bradford District Care Trust
[Work Address]
Tel:
e-mail:

Dear [Name]

Re: Your Individual Budget

You have recently undergone the assessment, My help care and support needs, and your support plan has now been developed and agreed.

The amount of your actual budget is £… ……

As you have requested that BDCT manage your entire budget, I will be in touch shortly to discuss what will happen now.

I will organise the support plan as you have asked BDCT to manage it.

It is important to be aware that your individual budget may not stay the same over time. If your needs change, the allocation may increase or decrease but we will ensure that you continue to receive the appropriate amount of support that you need.

If your needs change or you want to do something different with the money available please contact me on the number above.

Yours sincerely

[Name]
[Job title]
Appendix 5- part managed actual budget letter

[Date]

[Name]
[Address]

Bradford District
Care Trust

Bradford District Care Trust
[Work Address]
Tel:

e-mail:

Dear [Name]

Re: Your Individual Budget

You have recently undergone an assessment. My help care and support needs, and your support plan has now been developed and agreed.

The amount of your actual budget is £……….

As you have decided to manage some of this budget yourself you must make sure that the money is only spent on meeting your needs as agreed in your support plan, a copy of which is enclosed.

You cannot overspend on the money provided to you, but you can use your own money to top up your spending.

I will be in touch shortly to talk to you about what happens next and how you can manage part of the budget.

I will organise the parts of the support plan you have asked BDCT to manage.

It is important to be aware that your individual budget may not stay the same over time. If your needs change, the allocation may increase or decrease but we will ensure that you continue to receive the appropriate amount of support that you need.

If your needs change or you want to do something different with the money available please contact me on the number above.

Yours sincerely

[name]
[Job title]
## Appendix 6 - Equality Impact Assessment

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Care Co-ordination Policy</td>
</tr>
<tr>
<td>Manager</td>
<td>Clinical Policies &amp; Care Co-Ordination Lead</td>
</tr>
<tr>
<td>Directorate</td>
<td>Director of Operations &amp; Nursing</td>
</tr>
<tr>
<td>Date</td>
<td>25 November 2011</td>
</tr>
<tr>
<td>Review date</td>
<td>31 October 2013</td>
</tr>
<tr>
<td>Purpose of Policy</td>
<td>This policy incorporates Section 117 (of the Mental Health Act 1983) and Care Management procedures within a single comprehensive framework. Whilst CPA is ‘applicable to all service users in contact with the secondary mental health system’, ‘the principles of CPA are relevant to the care and treatment of younger people with mental health problems’ and those service users with a Learning Disability.</td>
</tr>
<tr>
<td>Associated frameworks e.g.</td>
<td>Refocused CPA Guidance 2008</td>
</tr>
<tr>
<td>national targets NSF’s</td>
<td></td>
</tr>
<tr>
<td>Who does it affect</td>
<td>Service Users &amp; Carers</td>
</tr>
<tr>
<td>Target audience</td>
<td>all nursing and social care staff</td>
</tr>
<tr>
<td>Consultation process carried</td>
<td>Director of Operations and Nursing, General Managers, Professional Heads</td>
</tr>
<tr>
<td>out</td>
<td></td>
</tr>
<tr>
<td>QA Approved by</td>
<td>Service Governance Committee; E &amp; D Team</td>
</tr>
<tr>
<td>Impact on</td>
<td>Positive impact expected outcome. System in place to implement policy. There is currently no information identified through the Equality Impact Assessment that would suggest that this policy has the potential to disadvantage any individual or function. Supporting policies and procedures in place to support best practice.</td>
</tr>
<tr>
<td>Discrimination</td>
<td></td>
</tr>
<tr>
<td>Equality of opportunity</td>
<td></td>
</tr>
<tr>
<td>Relations between groups</td>
<td></td>
</tr>
<tr>
<td>Education and learning, or</td>
<td></td>
</tr>
<tr>
<td>skills</td>
<td></td>
</tr>
<tr>
<td>Impact on Lifestyle / affect</td>
<td>There is currently no information identified through the Equality Impact Assessment that would suggest that this policy will have an adverse impact disadvantage any individual or function if implemented and operated in a manner that is laid out within the policy.</td>
</tr>
<tr>
<td>Diet &amp; nutrition</td>
<td></td>
</tr>
<tr>
<td>Exercise &amp; physical activity</td>
<td></td>
</tr>
<tr>
<td>Risk taking behaviour</td>
<td></td>
</tr>
<tr>
<td>Impact on / affect working</td>
<td>Positive impact expected outcome. There is currently no information identified through the Equality Impact Assessment that would suggest that this policy has the potential to disadvantage any individual or function if implemented and operated in a manner that is laid out within the policy statement.</td>
</tr>
<tr>
<td>environment</td>
<td></td>
</tr>
<tr>
<td>Social status</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Impact on / affect physical</td>
<td>Positive impact expected outcome as policies and systems in place for best practice guides. There is currently no information identified through Equality Impact Assessment screening that would suggest that this policy has the potential to disadvantage any individual or function if implemented and operated in a manner that is laid out within the policy statement.</td>
</tr>
<tr>
<td>environment</td>
<td></td>
</tr>
<tr>
<td>Working conditions</td>
<td></td>
</tr>
<tr>
<td>Living conditions</td>
<td></td>
</tr>
<tr>
<td>Health safety &amp; security</td>
<td></td>
</tr>
<tr>
<td>Impact on affect Service</td>
<td>Positive impact expected outcome as policies and systems in place for best practice. There is currently no information identified through the Equality Impact Assessment that would suggest that this policy has the</td>
</tr>
<tr>
<td>Improvement</td>
<td></td>
</tr>
<tr>
<td>Healthcare</td>
<td></td>
</tr>
<tr>
<td>Social Care</td>
<td></td>
</tr>
</tbody>
</table>
potential to disadvantage any individual or function if implemented and operated in a manner that is laid out within the policy statement.

<table>
<thead>
<tr>
<th>Equality protected characteristic</th>
<th>Impact Positive</th>
<th>Impact Negative</th>
<th>Rational for response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td>The policy has been developed to meet the physical health and mental wellbeing of all generations.</td>
</tr>
<tr>
<td>Disability</td>
<td>✓</td>
<td></td>
<td>The policy has been developed to meet the physical health and mental wellbeing of all people regardless of their physical or mental impairment / disability. Policies and systems are in place to ensure reasonable adjustments are being met to meet the needs of all disabled people regardless of their gender.</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>✓</td>
<td></td>
<td>The policy has been developed to meet the physical health and mental wellbeing of both women and men regardless of transition from FtM or MtF transition. There is potential impact for those Trans people who request gender specific clinicians. Due consideration would be given to meeting the needs of individuals when appropriate. However the Trust recognise that this is not always possible but due consideration would be prioritised when possible.</td>
</tr>
</tbody>
</table>
| Race                              | ✓               |                 | The policy has been developed to meet the physical health and mental wellbeing of both women and men regardless of their race, nationality or ethnicity. The policy has no intent to discriminate so the rights of individuals must be considered when  
  - English is not their first language  
  - Cultural norms are expressed. |
| Religion or Belief                 | ✓               |                 | The policy has no intent to discriminate it has been developed to meet the physical health and mental wellbeing of all people. Due consideration must be given to meeting the spiritual, religious and philosophical beliefs of individuals |
| Pregnancy & Maternity             | ✓               |                 | The Equality Impact Assessment screening has found no evidence to suggest this policy would have an adverse impact on pregnancy & maternity |
| Sex                               | ✓               |                 | The policy has been developed to meet the physical health and mental wellbeing needs of both women and men. There is potential to impact on those people who request specific gender clinicians. Consideration should be given to meeting the needs of individuals when appropriate. However it is recognised that this is not always possible but due consideration should be given prioritised where possible. |
The policy has been developed to meet the physical health and mental wellbeing needs of both men and women regardless of their sexual orientation.

**Equality Analysis SIGN - OFF**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have any adverse impacts been identified on any equality groups which are both highly significant and illegal?</td>
<td>No</td>
</tr>
<tr>
<td>Are you satisfied that the conclusions of the EqIA Screening are accurate?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The Trust will publish a summary of the impact analysis carried out to meet the duty and make this available to the public on the Trust Internet site.

<table>
<thead>
<tr>
<th>Completed by Manager</th>
<th>Margaret Hanson</th>
<th>15/08/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q A approved</td>
<td>E &amp; D Team</td>
<td>15/08/2012</td>
</tr>
<tr>
<td>Director approved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 7 Compliance Checklist

Procedural Document Development Checklist
To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Title of document being reviewed:</th>
<th>Yes/No/Unsure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the title clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2. Rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are reasons for development of the document stated?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3. Development Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the method described in brief?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are people involved in the development identified?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Have the requirements of the following been taken into account where applicable:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>● Mental Health Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Mental Capacity Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Care Programme Approach (CPA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Content</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the objective of the document clear?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is the target population clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the intended outcomes described?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>5. Evidence Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are key references cited?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the references cited in full?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>6. Approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the document identify which</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
### Committee Group Approval

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 7. Dissemination and Implementation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the Training Needs Analysis completed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 8. Document Control

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the document identify where it will be held?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 9. Process to Monitor Compliance and Effectiveness

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there a plan to review or audit compliance with the document?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 10. Review Date

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the review date identified?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the frequency of review identified? If so is it acceptable?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 11. Overall Responsibility for the Document

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it clear who will be responsible for coordinating the dissemination, implementation and review of the document?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Individual Approval

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

- **Name**: Simon Binns
- **Date**: 13 August 2012
- **Signature**

### Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

- **Name**: Professional Council
- **Date**: August 2012
- **Signature**