Essex Partnership University
NHS Foundation Trust

CPA PROCEDURE

PROCEDURE REFERENCE NUMBER:	CLPG30
VERSION NUMBER:	1.2
KEY CHANGES FROM PREVIOUS VERSION	Further Covid-19 6 month extension applied
AUTHOR:	[redacted], Associate Director, Community MH Services
CONSULTATION GROUPS:	AD's, Service Managers and Community Teams Community Quality and Safety Group Members Workforce Development Policy Group (North)
IMPLEMENTATION DATE:	1 July 2017
AMENDMENT DATE(S):	Dec 18 (Author)
LAST REVIEW DATE:	N/A
NEXT REVIEW DATE:	~~May 2020~~ ~~November 2020~~ May 2021
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	26 May 2017
RATIFICATION BY QUALITY COMMITTEE:	15 June 2017
COPYRIGHT	

PROCEDURE SUMMARY
This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust (EPUT). The main components of the CPA Framework outlined in this procedure are: ▪ Assessing ▪ Risk assessing and planning ▪ Care planning (including crisis and contingency planning) ▪ Co-ordinating care ▪ Reviewing ▪ Transitions

governing the operation/delivery of CPA & Non-CPA within the Trust.
The Trust monitors the implementation of and compliance with this procedure in the following ways:
Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Trust Safeguarding Group and the Mental Health and Safeguarding Committee.

Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

The Director responsible for monitoring and reviewing this procedure is Executive Chief Operating Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA PROCEDURE

CONTENTS

THIS IS AN INTERACTIVE CONTENTS LIST – CLICK ON THE SECTION HEADINGS TO GO TO THE SECTIONS

1.0 INTRODUCTION

2.0 COMPONENTS OF CPA

3.0 ASSESSMENT

4.0 RISK ASSESSING AND PLANNING

5.0 CARE PLANNING

6.0 CO-ORDINATING CARE

7.0 REVIEWS

8.0 TRANSITIONS

APPENDICES

APPENDIX 1 – CPA INFORMATION LEAFLET

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA PROCEDURE

1.0 INTRODUCTION

1.1 This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust.

1.2 A **CPA INFORMATION LEAFLET** (See Appendix 1) should be given to all patients at the start of their journey.

2.0 COMPONENTS OF CPA

2.1 The main components of the CPA framework are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Co-ordinating care
- Reviewing
- Transitions

3.0 ASSESSING

3.1 What is an Assessment?

The assessment is the starting point for all patient care. Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act 2014) and this must always include an assessment of risk.

3.2 Who can undertake an Assessment?

All assessments are undertaken by a qualified clinician, including nurses, occupational therapists, social workers, psychologists and medical staff. On occasions, it may be appropriate to organise a joint assessment, for example where there are complexities and/or high risks.

3.3 Confidentiality

All those assessed (and those with parental responsibility for those young people seen in our service) must be informed at their initial assessment that information that is collected about them will be stored electronically and may need to be shared with other Trust staff, in particular the rest of the multi-

disciplinary team involved in providing care or service to them. They must be advised that all our staff are required to abide by a strict code of conduct on confidentiality.

3.4 Purpose of an assessment

The purpose of an assessment is to:

- Provide an initial assessment of needs and how they may be met (including identifying any S117 health or social care needs).
- Evaluate the individual's strengths.
- Identify their goals, aspirations and choices.
- Assess the level of risk and safety.
- Ascertain carer's involvement.
- Identify any safeguarding issues.
- Identify the need for specialist assessment, i.e. personality disorder, substance misuse, and where appropriate, refer to relevant service, agency or profession.
- Determine whether intervention from services is appropriate.
- Identify the person's need for CPA, Non-CPA or other care process that can support them.
- Establish an information base.

3.5 **The full assessment should take into account the following**:

Psychiatric & Psychological Functioning	**Personal Circumstances**
▪ Reason for referral	▪ Patients views on strengths & aims
▪ Presentation	▪ Personal circumstances
▪ Impact on daily life	▪ Family including Genogram
▪ Recent life event	▪ Caring responsibilities
▪ Precipitating factors	▪ Childcare issues
▪ Psychiatric history	▪ Relationship status
▪ Forensic history	▪ Religious & spiritual needs
▪ Pre-morbid personality	▪ Gender, sexuality, sexual orientation
▪ Significant life events	▪ Advance decision
▪ Team/Specific Assessment	▪ Statement of wishes
▪ Experience of violence & abuse	▪ Lasting Power of Attorney
▪ Family history	▪ Veteran (Armed Forces Covenant)
▪ Risks to individual or others	▪ Personalised budget
▪ Learning Disability	▪ Consent to seek or share information with other agencies
Social Functioning	**Physical Health Needs**
▪ Support network	▪ Physical health needs
▪ Housing status & needs	▪ Medical history
▪ Financial status & needs	▪ Allergies
▪ Carer & family involvement	▪ Accidents
▪ Involvement with other agencies	▪ Hospitalisation
▪ Advocacy needs	▪ Weight/Height/BMI
▪ Employment	▪ Smoking status
▪ Training & education	▪ Current Medications
▪ Leisure	▪ Disabilities
▪ Social function & social needs	
▪ Communication & cultural needs	

3.6 Outcome Scale

Outcome measures, as required by the service, must be completed at the point of assessment and at review.

3.7 Assessment Outcome

All assessments should conclude with the assessment outcome and a summary of what happens following the assessment. This could include advice, information and guidance given or the formulation and plan for what happens next. All assessments must be dated and include the name and designation of the assessor.

3.8 Discharge back to the GP following Assessment

If following the assessment, the person is deemed not to require any further intervention from our secondary mental health service; they should be discharged back to their GP with a copy of the assessment outcome and personalised advice, information and guidance on re-direction or signposting to other services if required.

4.0 RISK ASSESSING AND PLANNING

4.1 Assessing Risk

The assessment and management of risk provides the services the structure to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others. Risk is dynamic and is constantly changing in response to circumstances, in particular treatment and management decisions are likely to influence the risks.

4.2 Risk Assessment Tool

The risk assessment must be carried out using the Trust's approved Risk Assessment tool.

4.3 Gathering Risk Information

Risk assessments must take into account all the available information from the patient, and other sources, such as the GP, carers, family members, forensic, other professionals and agencies that have knowledge of the individual. It is essential to seek information on the patient's past behaviour and any previous potential triggers for dangerous behaviour, and to consider the information in the context of the patient's present circumstances, as well as considering what previous strategies have worked.

4.4 **Risk Categories & Indicators**

Suicide	**Self-harm**
▪ Previous attempts	▪ Current/recent episodes of self-harm
▪ Threats	▪ Deliberate self-harm
▪ Opportunity	▪ History of self-harm
▪ Means	▪ Accidental harm
▪ Internet (access to information & suicide promoting groups)	▪ Alcohol/drug/substance misuse issues
▪ Expressed intent	▪ Food issues
▪ Plans	▪ Cutting
▪ Chronic suffering of persistent pain	▪ Binge drinking
▪ Recent diagnosis of life changing/threatening illness	▪ Degree of dependence/withdrawal problems
▪ Recent discharge from hospital	▪ Change in method
▪ Recent discharge from the services	▪ Increase in severity/Frequency
▪ Family history of successful or attempted suicide	▪ Deliberate promiscuous sexual behaviour
▪ Red Flag Alerts from Connecting with People / STORM Training	▪ Deliberate avoidance of prescribed meds or treatment
▪ Rational decision	
▪ Sleep disturbances	
Aggression & Violence	**Vulnerability & Neglect**
▪ Violence to others	▪ Inability to care for self
▪ Domestic violence	▪ Lack of carer support
▪ Access to potential victims	▪ Falls
▪ Specific threats made	▪ Cognitive impairment/confusion
▪ History of sexual assault	▪ Capacity issues
▪ Paranoid delusion	▪ Fire risk
▪ Verbal aggression	▪ Social isolation
▪ Escalation of threats	▪ Social media
▪ Response associated to withdrawal symptoms	▪ Recent discharge from hospital
▪ Aggressive behaviours whilst under the influence	▪ Impaired eyesight and/or hearing
▪ Predatory towards vulnerable individuals	▪ Physical ill health
▪ History of violence to family/staff/ other people & degree of harm caused	▪ Recent discharge from prison or the services
	▪ Lack of health education
	▪ Poverty or lack of resources
	▪ Recent bereavement

Safeguarding	Hazards
▪ Exploitation from others	▪ Environment
▪ Vulnerability to abuse	▪ Neighbourhood
▪ Bullying and harassment	▪ Unsafe buildings
▪ Domestic abuse	▪ Hoarding
▪ Risk of being radicalized	▪ Hazardous surroundings
▪ Financial abuse	▪ Unsafe buildings
▪ Institutional abuse	▪ Aggressive pets
▪ Sexual abuse	▪ Inadequate information on patient
▪ Physical abuse	▪ Location
▪ Female Genital Mutilation (FGM)	▪ Bad lighting
▪ Patient is carer of their own relatives	▪ No mobile phone network
▪ Patient is directly or indirectly providing support to a child	▪ Parking difficulties/issues
▪ Being cared for by carers with mental illness/addiction problems	▪ Other members of the household have aggressive/intimidating behaviour
Mental health history	**Personal**
▪ Previous admissions to hospital	▪ Age
▪ Previous risk taking behaviour	▪ Gender
▪ Detention under the Mental Health Act	▪ Social situation (for example Redundancy, Divorce)
	▪ Key life events
	▪ Relapse indicators
	▪ Triggers
	▪ Anniversary date of death of loved one (or pet)
	▪ Non-compliance with medication
	▪ Failure to attend appointments
	▪ Incidents involving the Criminal Justice system
	▪ Reluctance to engage with services
	▪ Substance misuse

4.5 Documenting Risks

All risks identified in the risk assessment and at every review must be clearly documented and evidenced in the patient's clinical record.

4.6 Planning & Sharing of Risks

All risks must be shared with all professionals involved with the patient. It is essential to record all considerations and risk plans and ensure that the relevant professionals are kept informed. All members of the multi-disciplinary team have a responsibility to consider risk and how these risks will be planned and managed. The outcome of the risk assessment must form the basis of a clear crisis and contingency plan.

4.7 Reviewing Risk

The assessment of risk is an essential and continuous ongoing part of the CPA process and must be considered on an individual basis. It is an essential mandatory requirement whenever a review takes place, or an individual's circumstances change (e.g. through admission to an inpatient unit or on transfer back to the community) to consider all the risk implications and how these will be planned and managed.

5.0 CARE PLANNING

5.1 Person-Centred Care

Person centred care planning is about listening to the patient and finding out what he/she wants and needs. It is about helping patients to think and plan what they want from their life now and in the future, and to enable friends, family & professionals to work together with the person to achieve these goals.

5.2 Jargon-free

In developing care plans in partnership with the patient and their family and/or carers, it is important that they must be created using language and terminology that the patient and their family or carer is able to understand.

5.3 Wellbeing and Recovery

The care plan is a record of the agreed care and treatment for the patient and should focus on their well-being and recovery.

5.4 Specialist Care Plans

When a range of services are identified in the overarching personalised care plan, each service, in partnership with the service user, must agree their specialist care plan which outlines the specific care a person, team or service will deliver. All those involved with specialist care plans must ensure that progress is communicated to the care coordinator/lead professional.

5.5 **What should be considered in the Care Plan?**

Consideration needs to be given to everything outlined in the table below.

Need	**Actions/Goals/Outcomes**
▪ Diverse needs and preferences	▪ Interventions
▪ Translation/interpretation requirements	▪ Contributions of all agencies involved (include their contact details)
▪ Specific needs arising from co-existing physical disability, sensory impairment, learning disability/autism	▪ Agreement of each professional or service to undertake their aspect of the care delivery
▪ Physical healthcare	▪ SMART goals
▪ Parenting or caring needs	▪ Patients actions necessary to achieve the agreed goals
▪ Specific needs arising from drug, alcohol or substance misuse	▪ Agree desired outcomes with patient and carer
▪ Consideration of self-directed support (SDS)/personalised budgets	▪ Arrangements for measuring and reviewing outcomes
▪ S117 Aftercare needs	▪ An estimated timescale by which the outcomes and goals will be achieved or reviewed
▪ Social, cultural or spiritual needs	▪ Date of next planned review
▪ Any unmet needs and service deficits	
▪ Easy read format care plans	
Risk, Contingency & Crisis	**Patient/Carers & Staff Involvement**
▪ Triggers & Relapse indicators	▪ Patients/carers responsibility to achieve the agreed goals
▪ Key events	▪ Patients comments
▪ Contingency plans	▪ Carers comments
▪ Advance decision & Statement of wishes	▪ Copy given to the patient
▪ Crisis contact details	▪ Copy given to the carer (where appropriate)
▪ Outline of who the patient best responds to in a crisis	▪ A note if the patient disagrees with the care plan and the reasons for the disagreement
▪ Crisis plans	▪ Dated and timed
▪ Contact Numbers to ring in a crisis	▪ A note if the patient does not wish to receive a copy
▪ Identified risks and safety issues	
▪ Things to take into account when a crisis happens (children, elderly relatives, animals etc.)	

5.6 **Copy of the Care Plan given to Patient**

A copy of the care plan must be offered to the patient, and made available to all those involved in the care plan. It is essential that practitioners maximise the extent to which the patient knows and understands their care plan and agrees with it. Any disagreements should be recorded.

5.7 **Care Plan for Patients on Non-CPA**

For those patients who are placed on Non-CPA, their care plan will often be in letter format (for example a copy of the letter from the consultant/clinician sent to their GP is copied directly to them).

5.8 **Copy of the Care Plan sent to GP**

The care plan must always be shared with the patient's GP.

6.0 CO-ORDINATING CARE

6.1 Co-ordinating care is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care by the appropriate agency or provider.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.
- The term Lead Professional is used for those working with individuals on Non-CPA.

6.2 **Who can co-ordinate?**

The role of the CPA care co-ordinator or Lead Professional will be allocated to the practitioner who, after consideration of the initial assessment, is best qualified to oversee and to support the care needs of the individual. Care co-ordinators will be qualified professionals who are employed by or seconded to EPUT.

6.3 The responsibilities of the care co-ordinator remain in place whatever the setting, especially during the period of inpatient treatment or when the patient is receiving intensive support from specialist services, such as community teams or residing in a residential home.

6.4 **Absence/Leave arrangements**

When a care coordinator/lead professional is on leave, arrangements must be made as to who will cover their absence.

6.5 **Co-ordinating Care – Main Responsibilities**

The main duties and responsibilities for the care co-ordinator are outlined in the table overleaf and have been divided into the following categories:

- Assessing
- Planning
- Co-ordinating
- Reviewing

Assessing	Planning
▪ Carry out a thorough assessment of the person's physical, social, emotional and psychological needs	▪ Agree goals with the patient
▪ Assess any immediate risk to the person or others	▪ Identify and agree actions and interventions
▪ Assess the impact on others in the household (particularly children)	▪ Develop risk management plans to support the individual's independence and daily living
▪ Ensure the identified carer has been informed of their rights to a Carer's Needs Assessment, and where relevant undergo this assessment	▪ Work with the person, their families and carers to identify measures to be taken to prevent a crisis developing and develop a **personal** crisis and contingency plan
	▪ Encourage the person to write an Advance Decision/Statement of Wish
Co-ordinating/Implementing	**Reviewing**
▪ Ensure regular contact is maintained to monitor the person's progress (whether at home/in hospital or prison) taking into account their needs & risks	▪ Review the effectiveness of the therapeutic interventions and recovery/ living well strategies with all involved
▪ Ensure the patient understands the care co-ordinator role and knows how to make contact and who to contact in their absence	▪ Review where there is deterioration in the patient's mental health or where problems may arise in the delivery of the care plan or if significant new risk factors are identified in the course of delivering the care plan
▪ Ensuring all those involved understand and are implementing their identified responsibilities	▪ Discuss the options for transfer of care or discharge
▪ Work with the patient & their families/ carers during times of crisis, ensuring crisis situations are responded to timely, effectively and safely	▪ Agree transfer/discharge plan and the arrangements including the support needs upon transfer/ discharge
▪ Arrange advocacy for those unable to represent their own interests	▪ Care plans are revised and updated after a review and re-issued to those involved
▪ Support patients on their caseload to have an annual health check	▪ Review of S117 needs at every review
▪ Work in collaboration with carers and ensure information, advice or signposting to services is given	

6.6 **Recording**

It is essential that information collected is recorded in line with legal and operational requirements.

7.0 REVIEWING

7.1 Review is the way we find out if the care plan is working, look at progress the patient has made and the ways in which their needs may have changed.

7.2 **Who attends the review?**

The level of complexity of each case will determine who needs to be present at the review. It may not be practical to have all those individuals involved in the care plan attend the review meeting, and it is essential that the patient's feelings and views are taken into account, as large meetings can be intimidating. In some cases, the review may consist of just the patient and the care co-ordinator. However, the care co-ordinator should ensure the views of others are represented.

7.3 **Where the review takes place?**

The patient's wishes about the location and timing of the review and the number of people attending should be respected wherever possible.

7.4 **How often does a review take place?**

All patients on CPA must have their care reviewed no less than once every six month, in response to any change and prior to any transition (e.g. discharge from hospital).

7.5 **The review process**

The review process is outlined in the table on the next page and has been divided into the following categories:

- Purpose of a review
- Preparation for a review
- During the review
- Outcome of the review

7.6 The table below outlines the review process

Purpose of Review	Preparation for Review
▪ Any person involved in the care plan, including the patient or carer, can ask for a review to be held at any time (if refused, this must be recorded in the patient's notes)	▪ Reviews should be prepared for in advance
▪ Ensure the patient's personal details are up-to-date and correct	▪ Respect the patient's wishes for the location and timing of the review and who attends the review
▪ Review the consent to share agreement	▪ Invite all those involved in the patient's care plan
▪ Discussion of any progress the person has made	▪ Where appropriate carers should be involved in the review
▪ Whether they continue to or now need the support of CPA, S117 aftercare, and/or a Community Treatment Order (CTO)	▪ Care co-ordinator/lead professional must ensure they obtain the views of those involved in the care plan who are unable to attend the review
▪ The extent to which the care plan (including crisis and contingency plan) needs amending	
▪ Reassessment of risk factors	
During the Review	**Outcome of Review**
▪ Record all present and apologies received	▪ Change the amount of support required
▪ Determine views of the patient, carer and professionals	▪ Move from or to CPA
▪ Decide upon the best plan of care and setting approximate timescales based on the above discussions	▪ Discharge from the service back to the GP or transfer to another system of care
▪ Consider whether someone continues to have S117 aftercare needs, or if they continue to require a CTO under the MHA & the impact of any user led document (such as an Advance Decision) has on the care plan	▪ Update the care plan, risk plan, crisis and contingency plan and draw up the modified care plan

▪ Any changes must be agreed by all parties and disagreements recorded	▪ Ensure everyone receives a copy of the updated care plan even if they were unable to attend the review

7.7 **Date of the Next Review**

At every review the date of the next review must be planned and appropriately recorded.

7.8 **Professionals Meetings**

It may be necessary on occasions to hold a multi-disciplinary professionals meeting to discuss and decide on the support and treatment of patients who may present with complex needs, high risks and probable non-concordance with their care plan, and where there maybe differences of opinion within the multi-disciplinary group.

8.0 TRANSITIONS

8.1 Individuals can experience any number of transitions during their contact with our service, such as discharge from the services, transfer between services, or transfer of care to another provider.

8.2 **Examples of transitions:**

- Admission to hospital
- Discharge to community from hospital
- Move to a residential home/nursing home
- Imprisonment or release from jail
- Change of geographical area
- Change of care co-ordinator
- Move from the child & adolescent service to the adult service
- Move from the adult service to the older adult service

8.3 **At the time of transfer it is essential that:**

- The process is co-ordinated by the care co-ordinator/lead professional
- The patient and all relevant members of the multi-disciplinary team are involved in the planning of any transition
- Handovers of care are clearly documented with transfers of responsibility agreed in a timely manner
- There are clear plans which have been agreed with all concerned
- Information is shared with all the relevant people

Inpatient transitions – communication

8.4 If it becomes necessary for the patient to have a period of inpatient care, the care co-ordinator will maintain contact with the patient throughout.

8.5 During the period of inpatient care, the care co-ordinator and the inpatient team will maintain open communication to facilitate full assessments of needs and appropriate plans of care.

8.6 The care co-ordinator will retain his/her responsibility for actively overseeing the patient's CPA care plan in close liaison with the inpatient team throughout the period of the inpatient stay.

8.7 **Care Planning for leaving inpatient care**
It is the responsibility of the care co-ordinator in conjunction with the inpatient team and others involved in the care package, to oversee all arrangements for transfer out of the inpatient setting into the community. At the time of leaving inpatient care, the patient must have a current and coherent care plan that includes any changes in need or circumstances and risk factors that were not considered or included in the previous care plan.

8.8 **Follow up arrangements when leaving inpatient care**

The care plan must include details of follow-up arrangements and these should be in line with the 7 day follow up policy.

8.9 **Change of care co-ordinator**
If a change of care co-ordinator/lead professional is necessary, either within the existing team or to another team within the Trust or outside the Trust, the current co-ordinator must arrange to hold a formal CPA review with the patient, any carers if applicable and the new co-ordinator. The care co-ordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team/service.

8.10 **Transfer to residential homes/nursing homes/prisons**
When a patient is removed from their normal place of residence (e.g. they go into a prison, residential home, nursing home or children being placed into out-of-area foster care), it remains the responsibility of the care co-ordinator to review the quality and appropriateness of their care in accordance with Trust Policy. The care co-ordinator must always ensure that they remain in contact with the patient and ensure that reviews are still carried out in accordance with Trust policy.

8.11 **Change of geographical area**
The national Care Co-ordination Association (CCA) has outlined the procedure for the transfer of patients between Trusts and Local Authority Areas.

END