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5 June 2018

Freedom of Information Request – Ref: FOI 058-1819

Thank you for your recent Freedom of Information request about staff contact details. Please find the Trust's response below.

- The name of the person responsible for overseeing the Care Programme Approach, or the equivalent, within the Trust and their contact details. **Matthew Edwards, mattthew.edwards9@nhs.net**
- The name of the person responsible for overseeing Clinical Risk, or the equivalent, within the Trust and their contact details. **Matthew Edwards, mattthew.edwards9@nhs.net**
- Copies of your Trust's policy / protocol for the management of the Care Programme Approach/Clinical Risk or equivalent standards. **Please see attached.**

Should you have any queries in relation to our response in this letter, please do not hesitate to contact me. If you are unhappy with the response you have received in relation to your request and wish to ask us to review our response, you should write to:-

Anna Hilditch
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If you are not content with the outcome of any review, you may apply directly to the Information Commissioner's Office (ICO) for further advice/guidance. Generally, the ICO will not consider your case unless you have exhausted your enquiries with the Trust which should include considering the use of the Trust's formal complaints procedure. The ICO can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely,

Lisa Evans

LISA EVANS
Information Governance Officer
^{2}gether NHS Foundation Trust

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Trust Wide Policy on

Assessing and Managing Clinical Risk and Safety
In Health & Social Care Practice

Version:	V14 20.02.2018
Consultation:	Locality Directors Clinical Directors Risk Policy Review Group
Ratified by:	Marie Crofts - Director of Quality
Date ratified:	20.02.2018
Name of originator/author:	Matthew Edwards, Assistant Director of Quality Assurance and Transformation, Ruth Wethey, Clinical Systems Manager, Jessica Blakeman, Assistant Clinical Systems Manager Rob Newman – Quality Assurance Manager
Date issued:	26.02.2018
Review date:	February 2020
Scope:	Staff engaged in clinical work in the Trust

Version History

Version	Date	Reason for Change
7.4	September 2011	*Amendments to cover DASH service*
8	May 13	Format change
9	October 2013	Full review
10	March 2015	Amendments to cover service development of Mental Health Intermediate care Services Gloucestershire – Agreed at Governance Committee
11	October 2015	Amendments to Crisis and Contingency planning guidance
12	June 2016	Amendments to risk assessment and screening templates for PMHS/ICT Herefordshire and Gloucestershire
13	June 2017	Amendments to reflect current risk template within RiO
14	February 2018	Amendments to reflect organisational learning

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Part 1 Policy Background

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1. Introduction

Risk assessment is an integral part of the assessment, support and treatment of each service user when in contact with the Trust. This is not something that happens only once, or only at set times in a service user's journey towards recovery, but is an on-going fluid process.

1.1 It is not possible to eliminate all risk, but through the use of risk assessment it is possible for the service user and their care team to understand and try to manage any identified risks.

1.2 Risk assessment should be structured, evidenced based and consistent across all the care settings within the Trust.

1.3 Best practise involves making decisions based on knowledge of the research evidence, knowledge of the individual service user, their social context, knowledge of the services users own experience and clinical judgment' .

1.4 Risk assessment and management is often developed with and or in conjunction with other agencies or providers. Where a service user is supported by care providers external to the Trust, or a service user's care is primarily managed and delivered by another service, the Trust still retains a responsibility to consider risk. Where a risk management plan is required, but the responsibility for delivering key elements lie outside of the Trust, this should still be documented and monitored.

2. Purpose

2.1 This policy has been written to provide a clear framework for risk assessment and risk management within the Trust. It outlines how these principles will be applied within the Trust, and will act as a benchmark for monitoring practice against standards.

3. Duty

3.1 The person responsible for Risk Assessment and Management at a board level is the **Director of Quality**. The day-to-day responsibility will be held by the **Assistant Director of Quality, Assurance and Transformation**. They will be responsible for developing and maintaining the policy, offering advice and guidance to staff, ensuring that training is developed and delivered, and monitoring compliance across the Trust against this policy.

3.2 **The Governance Committee** will be sign off this policy. They will also receive copies of any reports and audits relating to standards and practises in this policy, as a minimum this must include an annual report.

3.3 **All staff** who have contact with service users are responsible for using the policy correctly to ensure patient safety.

4. Context

4.1 This policy has been written to ensure that the Trust maintains a robust and effective process of assessing and managing risk. A number of key publications have been drawn on to help develop this document which have focused on developing safe and supportive clinical services to reduce specific risks around suicide, homicide and sudden deaths these include:

- *The National confidential enquiry into suicide and homicide by people with mental illness "Avoidable Deaths" (2013)*
- *Best Practice in Managing Risk (2007)*
- *Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study (2013)*
- *Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature (2012)*
- *National Patient Safety Agency (2004)*

5. Scope

5.1 The standards and procedures outlined in this policy apply to the following areas:-

- *Service Users referred for assessment in a specialist primary care setting such as the Primary Mental Health Service and IAPT.*
- *Service Users receiving assessment and care via Liaison Services*
- *All Service Users receiving specialist secondary care within the Trust.*

5.2 This policy should be read alongside the Trust's policies and procedures on:-

- *Child and Adult safeguarding*
- *The Mental Capacity Act*
- *The Mental Health Act*
- *Assessment, Care Coordination and Care Planning*
- *The Data Protection Act Record Keeping*

6. Definitions

6.1 A detailed definition of <u>risk</u> and the key terms of High, Medium and Low are provided in part 2.

6.2 A full list of abbreviations and terms are provided in Appendix 1.

7. Ownership & Consultation

7.1 Responsibility for the development, maintenance, review and ratification of this document lies within the **Director of Quality and Medical Director**; however this has been delegated for this policy, to the Head of Quality Development and Assurance.

8. Ratification Details

8.1 This policy will be ratified by the Governance Committee.

9. Release Details

9.1 Care Practice Policies are not routinely placed on the Trust public website. Upon request most are available to members of the public if requested.

9.2 This policy is on the Trust intranet under Care Practice Policies, general.

9.3 An article appears in News in Brief which notifies of significant reviews and updates of Care Practice Polices, which will include the updates on this Policy.

10. Review Arrangements

10.1 This policy will be reviewed at least every 2 years to ensure that it continues to meet the needs of the Trust, by the Head of Quality Development and Assurance, under the authority of the Director of Quality, though a review can be completed sooner if any of the following are identified -

- *a. There is a significant change in national guidance or policy*
- *b. There is a significant change in best practice*
- *c. Or local practice issues are identified that are not adequately covered by this policy and that need addressing.*

11. Procedure for Monitoring Compliance

11.1 A programme for regular auditing and monitoring will be carried out, as agreed by the Governance Committee this will include the following -

- *a. all teams audited against core standards and practises outlined in this policy at least twice a year as part of the Assessment and Care Management Policy.*
- *b. focused audits exploring specific standards and aspects of this policy as applied in practice. These include:*
    - *Audit of duties of staff groups in relation to the policy*
    - *Audit of compliance and concordance with training plan maintained by the Trust*
    - *The tools and procedures followed*
    - *Documentation regarding discussion and provision of information to patient*
    - *Audit of the quality of content of Risk Assessments; Risk progress notes and Risk Incidents*

11.2 The Governance Committee will receive copies of any reports and audits relating to standards and practises in this policy.

12. Recording of Risk

12.1 **Tools.** This policy describes the recording of Risk within 2gethers' Health and Social Care notes. The majority of Service Users records will be recorded using the Trust's Electronic Patient Record systems e.g. RiO, IAPTus. Staff are required to record Risk Assessments, Risk Incidents, Risk Progress Notes, Risk Management Plans, Crisis & Contingency Plans in all electronic patient record systems according to the latest training guidance and system updates.

13. Training

13.1 Training in this subject area is mandatory for identified groups of staff. The staff groups to which the training is applicable have been listed in the Trust's Training Needs Analysis document which is managed and published by the Trust's Training Department. The document is located within the Trust's Training Plan and can be found on the training intranet site.

Part 2 Background

Covered in this section –
Over-arching Principles
Defining Risk
Positive Risk Management

1. Over-Arching Principles

1.1 Everyone referred to the Trust must be assessed for risk excluding self-referrals to IAPT group psychological / educational courses. Where a service user does not appear to have any significant risk, it should still be recorded that risk has been considered; this is to ensure that it is evident that an assessment has taken place and has not been forgotten.

1.2 It is not possible to eliminate all risk; the purpose of risk assessment it is to enable the care team and the service user to understand and try to minimise the risks. Wherever possible this should be done using positive risk management.

1.3 Risk assessment and management is more than the consideration of solely violence or suicide but covers a range of areas, such as: -

- *harm to self; harm from others; harm to others; accidents; other risk behaviours / events*

These may have been caused deliberately or unintentionally. They can be planned or spontaneous; a risk through inaction or neglect; caused by a lack of awareness, understanding, or environmental risks.

1.4 In line with national guidance, the Trust uses structured clinical (or professional) judgement, in assessing risk. This approach involves the practitioner making a judgement about risk on the basis of combining:

- *an assessment of clearly defined factors derived from research*
- *staff clinical experience and knowledge of the service user –*
- *the service user's own view of their experience when documenting this information within a risk assessment it is essential to define whether the information is based upon **clinical opinion** or upon **factual occurrence(s) that can be evidenced as such.***
- *family/carer experience if available*

Risk assessments are an aid and should be used with clinical judgment. Once an assessment has been completed, wherever possible positive risk taking strategies should be adopted.

1.5. All risk incidents should be recorded in a clear, accurate and timely fashion within the Health and Social Care notes.

1.6 Risk assessment and risk management should be carried out in collaboration with the service user and any other relevant individuals unless there is a clear documented reason why they are not involved. It is a 'live' dynamic process, changing and being updated throughout the service user's journey. Discussion with the service user and others involved is key to ensure an accurate assessment of the situation including any contextual factors which are crucial to the understanding of the service users past or present behaviour . Where this is disagreement about factors or context this should be noted in the service users record

1.7 Risk assessments should not be completed in isolation, but should form part of the overall initial assessment, and then the day to day support treatment and management of the service user.

1.8 All risk assessment and management plans, regardless of specialism, should fit into a common recognisable framework, whilst supporting differences in the needs of the service user being assessed and the different parts of the service.

1.9 All risk assessment and management plans within the Trust should use the same common definitions of risk.

1.10 The level and the intensity of assessment will vary according to clinical need and the type of service the service user is being assessed by.

2. Defining Risk

2.1 For the purposes of this policy, risk assessment is the process of recognising, understanding, and responding to potential events or behaviours that may be harmful or have a negative outcome.

2.2 Risk assessment needs to take into account a wide range of information about the service user, including:- history of violence, losses, environment, self-harm, employment, caring roles, self-neglect, housing issues, reliance on carers and others, development, family and support networks, relationships and relationship difficulties, health and wellbeing, health conditions, chronic conditions and pain[5]; and their more general social contacts.

2.3 When completing a risk assessment there are a number of different factors that can affect the probability of a risk occurring these are:-

Unchangeable factors *(Sometimes known as static factors) These are social or cultural factors such as upbringing, cultural group or events that have happened in the past and are unchangeable, for example a history of child abuse or suicide attempts.*

Changeable factors *(Sometimes known as dynamic factors) are those that change over time, e.g. mental state, misuse of alcohol. They can be aspects of the individual's health and wellbeing or aspects of their environment and social network, such as the attitudes of their carers or social deprivation.*

Acute /Trigger Factors. *Change rapidly and may be short lived, allow assessment of immediate risk*

Protective Factors *are factors in a person's life that promote mental health and wellbeing, reducing risk*.

2.4 It is useful to consider common risk factors for assessing violence and suicide based on actuarial and other data. These are subject to frequent change and the Trust will publish updated versions as and when required. This policy contains common risk factors listed in appendices 4-7 for the following areas: -

- *Violence in adults;*
- *Suicide and self-harm for adults;*
- *Neglect for older adults;*
- *Suicide and self-harm for young people*

2.5 Overall risk is defined by the sum of recorded risk factors. These actuarial factors for Risk change over time in accordance with current evidence based research. Clinicians need to be aware that this will happen and this policy allows for changes to actuarials to be made.

2.6 When reviewing historical or current incidents, it is important that these are described accurately and that the origin of where this information is derived from is included (where known). If information regarding an incident is unclear – this should be discussed with the service user When describing any form of assault or violent outburst, the Trust's approved method is the Assaulting Rating Scale (ARS)[2] . This defines incidents using a scale from 1-7 which are described below. Whilst this describes the physical effects, it does not take into account the psychological effect of an incident which should also be considered.

ARS Level	**Description**
1	*Threat of assault but no physical contact*
2	*Physical contact but no physical injury*
3	*Mild Soreness / surface abrasions/ scratches/ small bruises*
4	*Major Soreness/ cuts / large bruises*
5	*Severe lacerations/ fractures/ head injury*
6	*Loss of limb/ permanent physical disability*
7	*Death*

2.7 Risks are uncertain, but through risk assessment one aims to:–

- Clarify what the areas of concern are: -

  e.g. harm to self; harm from others; harm to others; accidents; or other risk behaviours / events such as absconding.

- Consider whether these concerns are: -

  planned or spontaneous; a risk through inaction or neglect; caused by a lack of awareness or a lack of understanding; or environmental

- Determine what the level of risk is by considering -
  - *What the probability of them occurring is*
  - *Whether this is a short, medium or long term risk*
  - *If there are any protective or mitigating factors, including cooperation / and adherence to treatment plans*
  - *If they did occur what the probable consequences might be*
- Develop strategies and plans to manage and reduce the likelihood or consequence of harm

2.8 In determining whether the service user has a High, Medium or Low level of risk short and long term risk factors should be considered. Recent studies have highlighted the 'low risk paradox', whereby Service Users who commit homicide or die by suicide often have a history of high risk factors, yet at the time of discharge from the services, are considered as low risk (NCISH, 2013). The distinction needs to be clear between long standing risk and high imminent risk.

2.9 The following matrix is designed to support clinicians in making a judgement about the level of risk.

Risk Matrix

^{2}gether NHS Foundation Trust - Risk Matrix			**Probability**			
			Unlikely	**Possible**	**Likely**	**Almost certain**
			there are many protective factors & or high adherence to treatment	there are good protective factors & or good adherence to treatment	limited protective factors to mitigate or reduce the risk with partial compliance to treatment	There are few, if any, protective factors, and low adherence/ cooperation with treatment
Consequence	**Negligible**	• physical injury to self / others that requires no treatment including first aid-*(ARS 1)* • minimal psychological impact requiring no support • low vulnerability requiring no intervention	**Low**	**Low**	**Low**	**Low**
	Minor	• slight physical injury to self / others that may require first aid *(ARS 2-3)* • emotional distress requiring minimal intervention • increased vulnerability but managed by low level intervention	**Low**	**Low**	**Medium**	**Medium**
	Moderate	• physical injury to self / others requiring medical treatment; (ARS 4) • psychological distress / formal intervention • vulnerability requiring increased intervention	**Low**	**Medium**	**Medium**	**High**
	Major	• significant physical harm to self / others (*ARS 5 or higher)* • significant psychological distress needing specialist intervention • Vulnerability requiring high levels of intervention	**Medium**	**Medium**	**High**	**High**

Are there any Child/Adult Safeguarding concerns? Seek advice? Make a referral?

ARS	1	Threat of assault but no physical contact	4	Major Soreness/ cuts / large bruises	7 Death
	2	Physical contact but no physical injury	5	Severe lacerations/ fractures/ head injury	ARS Level taken from - Patient Assault: a comparison of reporting measures, Lanza M Campbell R, 1991 Quality Assurance no 5
	3	Mild Soreness / surface abrasions/ scratches/ small bruises	6	Loss of limb/ permanent physical disability	

Part 3 – Standards for Assessment

Covered in this section –
Standards for Assessment
Risk Assessment Process
Assessment in Specialist Primary Care
Assessment of Risk in Inpatient Care
Specialist Risk Assessment
Non Standard Risk Assessments

1. Standards for Assessment

1.1 All new referrals will have a risk assessment completed during the initial/core assessment. This should be completed and recorded in the Service User's Health & Social Care Notes by a registered practitioner who is specifically required to complete core assessments and risk assessments as part of their job description.

1.2 All new referrals to Mental Health Acute Response Service (MHARS), Mental Health Intermediate Care Teams (ICT) (Primary Mental Health service) and IAPT service (Gloucestershire) and IAPT (Herefordshire) will have a Risk Screen completed. For referrals to Mental Health Acute Response Service (MHARS), IAPT services within the ICT for Gloucestershire and IAPT service Herefordshire risk screening will be undertaken by band 4 practitioners or above (Appendix 11). For all Service Users where overall risk is LOW, no further risk assessment is required at that stage. Where risks are identified as being Medium or High, then a completion of a FULL risk assessment will be undertaken by a practitioner band 5 or above (Appendix 12).

Exception: Online direct psycho-educational course bookings do not receive risk screening or assessment.

1.3 At each of the following key events a Risk Review will be completed and risk documentation updated, if it requires updating:

- *CPA; Cluster /Care review*
- *Transition between Wards /Teams /Care Co-ordinators /Lead Professionals*
- *Admission to and from hospital*
- *At each MDT if the service user is an inpatient*
- *Discharge from services*
- *At any other time, if there is any significant changes or any factors that cause concern*

A Band 4 practitioner /Student Nurse can assist with drafting a risk review; this must be checked and validated by their practice supervisor (as defined in the Assessment and Care Management Policy).

2. Risk Assessment Process

2.1 When completing a Risk Assessment, the practitioner should first review any existing Risk Assessment, Risk progress notes and/or Risk incidents recorded in the Health and Social Care Notes. This provides information about what risks have occurred in the past, when they occurred, and if there are any patterns or known triggers. Where any tick boxes have been checked and there is no commentary to explain the use of the tick box, attempts should be made to obtain information to give rationale/contextual information for its use.

2.2 The Risk Assessment will cover the following areas and include a risk rating of High, Medium or Low identified for each area:

- *Harm to self, including suicide*
- *Harm from others*
- *Harm to others*
- *Accidents*
- *Other risk behaviours*

2.3 The summary of the Risk Assessment should include the rationale for risk level and any actions being taken with information under these headings:

- ***Reason for assessment / review purpose***
- ***People present or involved** in this risk assessment including any other agencies involved and whether the assessment is led by Trust staff (e.g. could include the service users carers, clinicians and other agencies)*
- ***Risk(s) being reviewed** (List the risks identified rather than just the broad headings i.e. deliberate self-harm, self-neglect and suicide rather than just 'Harm to self')*
- ***Who is affected by the risk(s)** (Include what is known e.g. is there a risk to the general public, females or one particular person?)*
- ***Current situation / change since last assessment / review***
- ***Formulation of risks** stating the risk level (Low/Medium) and risk duration (Short/Medium/Long term e.g. if justifying a course of action that increases short term risk for longer term gain) considering the probability and consequences of the risk occurring. Include actuarials and clinical factors and protective factors. The information included should indicate the source and/or origin of information (where known) and whether it is based upon a factual occurrence or is a clinical opinion.*

- ***Risk management and contingency plan** (including any positive risk taking strategies, observation levels)*

These headings allow clinicians to record in as much detail as required by the assessment of risk by using their clinical judgment. (See *Appendices 11 and 12 for IAPTus and Appendix 13 for RiO*).

2.4 Where possible, risk assessment and risk review should be undertaken by more than one person, ideally with Multi-Disciplinary Team (MDT) involvement or CPA/Cluster Care review. Certain situations mean that risk screening is initially completed with service users/carers and then reviewed with the team at the earliest opportunity.

2.5 All risk incidents must be recorded in the Risk Incident section of the Health & Social Care Notes to form a chronology of risk. Each risk incident should include the incident date, an incident heading and reference the date when the progress notes detailing the event was completed.

As part of each CPA or Cluster Care review the Care Coordinator/ Lead Professional should review the Risk Incident section of the Health and Social Care notes and ensure that it is up to date.

3. Specific Risk Issues for Inpatient Care

3.1 A service user is usually admitted to an inpatient area, as part of the management and treatment plan, as a result of increased risk to themselves or others in the community. With the change in care setting, the nature of the risk changes. When completing a risk assessment in an inpatient setting it is important to recognise how these factors changed. Where a service user has been identified as being high or medium risk prior to admission this should only be reduced following a discussion with the MDT.

3.2 Where a service user has been identified as being medium risk or higher through the risk assessment process, this information should be communicated to the MDT as soon as practically possible.

3.3 When risks are discussed a contemporaneous entry should be made in the health and social care notes to document that this has taken place. A risk assessment will then be undertaken as detailed above.

3.4 Where a service user has been identified as having a medium level of risk whilst as an inpatient, the identified level can only be reduced following a documented discussion involving at least two qualified members of staff.

3.5 Where a service user has been identified as having a high level of risk whilst as an inpatient, the identified level can only be reduced following a documented discussion involving the MDT.

4. Specialist Risk Assessment

4.1 Following an initial Risk assessment, it may be appropriate to conduct a specialist risk assessment.

4.2 These assessments are conducted by a consultant, a clinical specialist or a clinician with extra training, who has been trained to assess a particular risk area, for example, using the Historical, Clinical, Risk Management tool (HCR-20). In addition, a specialist risk assessment may be completed by clinicians such as Speech and Language Therapists and Physiotherapists who also carry out assessments related to risk.

4.3 These will be recorded in the appropriate section of the Health and Social Care notes and added to the risk history section.

Part 4 Managing Risk

Covered in this section –
Positive Risk Management
Crisis and Contingency plans for Service Users with a low or medium risk
Risk Management plans for someone who is high risk
Dealing with differences of opinion around a risk management plan
Principles of working with other agencies
Principles of working with diversity

1. Positive Risk Management

(Adapted from Best Practice in Managing Risk DoH 2007, page 10)

1.1 Positive risk management means being aware that risk can never be completely eliminated, and aware that the best management plans have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user. A key feature is developing positive relationships between the care team, the service user receiving support and treatment and others involved or affected.

1.2 Positive risk management includes:

- working with the service user to identify what is likely to work;
- paying attention to the views of carers and others around the service user when deciding a plan of action;
- weighing up the potential benefits and harms of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- being clear to all involved about the potential benefits and the potential risks;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others;
- ensuring that the service user, carer and others who might be affected 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 outcomes and minimising the potential harmful outcome.

2. Crisis and Contingency Plans

2.1 Everyone receiving care should have as part of their care plan, information about recognising any signs of relapse and what to do in an emergency. This should be recorded in the ‘crisis, relapse and contingency’ (My safety plan) section of the service user’s Health and Social Care notes.

This should include -

- any early warning signs or relapse indicators
- who to contact in an emergency
- who the service user is most responsive (including for children who has parental responsibility) to and how to contact them
- any strategies that have worked previously

    - any agreed strategies, interventions or advanced decisions including changes to medication, admission etc.
    - who will care for dependants
    - who can be involved, their contact details

2.2 The type of Crisis and Contingency plan used will vary depending on where the service user is currently receiving support within the Trust. Essentially the following guidance will be followed in relation to this:

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

3. Risk Management Care Plans

3.1 The Trust operates integrated care planning; where a service user Risk Assessment is rated as a **High Risk** there must be a dedicated Risk Management Care Plan with appropriate Interventions detailed within the Care Planning section of the Service User's Health & Social Care Notes.

3.2 Wherever possible the service user and any other relevant individuals should be involved in developing the risk management care plan. Where they are not involved, the reason should be clearly documented.

3.3 Everyone involved in or affected by the care plan, should receive a copy. Detailed guidance on sharing confidential information can be found in the Trust assessment, care coordination and care planning (CPA) policy.

3.4 Where the Risk Assessment rating is a **low or medium risk**, and it is appropriate, risk issues can be covered as a single intervention within the Care Planning section of the Service User's Health & Social Care Notes.

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

3.5 The care plan should include how the risks are to be managed; and who will be involved.

3.6 If the service user is an inpatient, the care plan must also include the observation level and any other arrangements i.e. leaving the ward

4. Dealing with differences of opinion around a risk management plan

4.1 Whilst not always associated with secondary risks, disagreements around a risk management plan do occur and it is important to ensure that these are addressed consistently for the benefit of the service user.

4.2 If the service user disagrees with the risk management plan or the accuracy of information used to inform and direct the plan this should be explored in detail to ensure that information being used for this risk management plan is indeed accurate and it is a true reflection of risks associated with the service user.

4.3 As part of multi-disciplinary working, no one person has the right to veto a decision. However, where a significant minority of the group disagree with the proposed risk, further steps should be taken to ensure there is an agreement around the plan.

4.4 The formal role of the Responsible Clinician is fully recognised and the explicit commitment of consultants working in community and inpatient areas to this multi-disciplinary approach to risk taking is vital to ensuring agreement is reached.

4.5 <u>If an individual or group disagrees strongly, their objections should be clearly recorded</u> and discussed in an attempt to see whether a compromise can be reached. Such discussion may centre on either the goals or methods of intervention and those arguing against the majority view must present their arguments in the context of possible effects on the client. Consideration of any possible secondary risk factors must also be considered underlying any disagreements around the implementation of an agreed plan.

4.6 <u>The possible risk involved in taking no action at all must also be an important consideration.</u>

4.7 If agreement cannot be reached, the dissenting views must be clearly recorded in the Health and Social Care notes and the person or people concerned must be committed to support the actions agreed until the next review date. At the agreed review date, information raised in the light of the disagreement in relation to the success of the plan should be considered.

4.8 Once the decision is taken at such a meeting, it becomes the collective responsibility of the Clinical Team. Key people to take action must be identified and as long as they implement the decision faithfully and take reasonable care, they should not be held individually responsible in the event of an accident occurring.

5. Principles of working with other agencies

5.1 Other agencies may play a crucial role in support and meeting a service user's needs. Disclosure must always occur if other agencies or the public are deemed to be at risk. Safeguarding Children or Adults Procedures may be used at any stage of the risk assessment/ management process and may be of use in the development of a management plan. Multi Agency Public Protection Panels (MAPPA) may also apply.

6. Principles of working within diversity

6.1 Assumptions around age, gender, sexual orientation, religion, marital status, race, culture or ethnicity may affect judgement around risk and determine a subsequent risk management plan. It is important that those developing plans within the principles described consider all of these factors. It is a process of personal reflection coupled with consideration of available research relating to stereotypes.

Appendices

Appendix 1: Abbreviations

Band	A system used by the NHS to group staff from different backgrounds and professions according to their role, experience and qualification. A typical nurse will be a band 5.
Care Coordinator	A named professional who ‘coordinates’ the care of a specific service user. This is usually done through a care plan
CPA	Care Programme Approach. A nationally set framework to manage the care that is planned and delivered, within mental health services. It is also used for Learning Disability services.
CJLS	Criminal Justice Liaison Service. A dedicated team of mental health specialists who work with people in contact with the Courts.
Cluster/Care Review	
Clustering	Part of PBR. Within Payment by Results, there are 22 groups of treatments that a service user can receive. The most appropriate group for a service user is worked out by completing a HoNOS PBR assessment
CQC-	Care Quality Commission. A Government approved body that regulates and licences health and social care organisations.
HCR-20	Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a service user's probability of violence
HoNOS	Health of the Nation Outcome Scales. An assessment carried out by staff to identify the needs of a service user and to monitor improvement during treatment.
IAPT	Improving Access to Psychological Therapies
IAPTus	A national approved electronic health record system used by the IAPT Services
Liaison Service	A Team of staff who assess and advise people with mental health problems or have specific needs arising from a learning disability in Adult Acute Hospital
MAPPA	Multi Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team – a meeting where the different professional work and plan together
MHARS	Mental Health Acute Response Service
MHICT	Mental Health Intermediate Care Team
NICE	National Institute of Clinical Excellence
PbR	Payment by Results. A national system used to match funding to the needs of the patient.
RiO	A national approved electronic health record system used by Adult MH Services CYPS, and Learning Disability Services
PMHS	Primary Mental Health Service
CRHT	Crisis Resolution & Home Treatment Team
WRAP	Wellness Recovery Action Plan

Appendix 2: References and Further Reading

References

1. *Best Practice in Managing Risk, Department of Health (2007)*

2. *Patient Assault: a comparison of reporting measures, Lanza M Campbell R, (1991) Quality Assurance no 5*

3. *Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, CG16, National Institute of Clinical Excellence (2004)*

4. *The National Patient Safety Agency (2004): Psychiatric Bulletin (2004), 28, 193-195*

4 *"Hidden data provide new insights into life at the end…" , Bazalgette, L. Bradley, W. Ousbey, J. Demos (2011)*

5 *Gloucestershire Suicide Prevention Strategy (2010-2015)*

6 *Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2013)*

7 *Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature, International Journal of Mental Health Nursing (2012), 21, 4, 301-309*

Further Reading

Living with risk Mental health service user involvement in risk assessment and management. Langan, J. Lindow, V. Joseph Rowntree Foundation/The Policy Press (2004)

The risks of risk assessment Undrill G *Advances in Psychiatric Treatment (2007),*

Independence, choice and risk: a guide to best practice in supported decision making Department of Health (2007)

'Giving up the Culture of Blame' Risk assessment and risk management in psychiatric practice. Morgan J Royal College of Psychiatrists (2007)

Avoidable Deaths- National confidential inquiry into suicide and homicide by people with mental illness (2006)

Appendix 3: <u>Risk factors</u> for violence – Working Age Adults

(Taken from Best Practice in Managing Risk (2007) Department of Health)

Demographic factors

- Male
- Young age
- Socially disadvantaged neighbourhoods
- Lack of social support
- Employment problems
- Criminal peer group

Background history

- Childhood maltreatment
- History of violence
- First violent at young age
- History of childhood conduct disorder
- History of non-violent criminality

Clinical history

- Psychopathy
- Substance abuse
- Personality disorder
- Schizophrenia
- Executive dysfunction
- Non-compliance with treatment

Psychological and psychosocial factors

- Anger
- Impulsivity
- Suspiciousness
- Morbid jealousy
- Criminal/violent attitudes
- Command hallucinations
- Lack of insight

Current ‘context’

- Threats of violence

- Interpersonal discord/instability
- Availability of weapons

Based on .

The MacArthur Violence Risk Assessment Study, *Update of the Executive Summary*, September 2005. Available from: macarthur.virginia.edu/risk.html

Farrington, D., ‘Predicting adult official and self-reported violence’. In Pinard, G. and Pagani, L. (eds) *Clinical Assessment of Dangerousness. Empirical Contributions*, Cambridge University Press, Cambridge, 2001

Appendix 4: Risk factors for suicide – Working Age Adults

*(Adapted from Gloucestershire Suicide Prevention Strategy 2010, unless there is marked * in which case taken form Best Practice in Managing Risk (2007) Department of Health)*

Clinical factors:

- Previous suicide attempt (this is strongest predictor);
- Previous history of deliberate self-harm;
- Mental illness (depression, bi-polar disorder, personality disorder, schizophrenia);
- Substance misuse;
- Mental health patients shortly before, or shortly after discharge from in-patient care;
- Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes[5])*
- A family history of suicide/mental disorder
- Have experienced a number of stressful events;
- Psychological factors- Hopelessness, Impulsiveness, Low self-esteem*

Socio-demographic factors:

- Male*
- Social isolation (gay men, lesbians, bisexuals and transgender communities, students, older people, living in rural location)
- Homelessness; poor socio-economic backgrounds
- Loss; (recent / or adversary of bereavements; relationship breakdown; widowed)
- Unmarried, cohabitation,
- Sudden death of loved one;
- Occupational group; (doctors, farmers, vets, dentists and pharmacists)
- Service veteran;
- Being unemployed, retired or insecurely employed;
- Breakdown or low levels of social support (prisoners, immigrants and refugees)

Adverse events such as

- Financial concerns,
- Conflict,
- Abuse, (physical and/or sexual abuse)
- Legal problems
- Interpersonal losses

Resilience –

- poor emotional health in childhood and/or abuse;
- impaired problem solving skills

Young people –

- parental separation and divorce; parents with a mental illness; caring for parents with a physical illness; impaired parent/child relationships (high expressed emotions, parental expectations and control);

Current 'context'*

- Suicidal ideation*
- Suicide plans*
- Ease of access to a lethal method
- Lethality of means*

Appendix 5: Risk factors / indicators for Neglect – Older Adults

(taken from National Committee for the prevention of Elder Abuse (USA) 2008)

Signs of neglect observed in the home

- Absence of necessities including food, water, heat
- Inadequate living environment evidenced by lack of utilities, sufficient space, and ventilation
- Animal or insect infestations
- Signs of medication mismanagement, including empty or unmarked bottles or outdated prescriptions
- Housing is unsafe as a result of disrepair, faulty wiring, inadequate sanitation, substandard cleanliness, or architectural barriers

Physical indicators

- Poor personal hygiene including soiled clothing, dirty nails and skin, matted or lice infested hair, odours, and the presence of faeces or urine
- Unclothed, or improperly clothed for weather
- Decubiti (bedsores)
- Skin rashes
- Dehydration, evidenced by low urinary output, dry fragile skin, dry sore mouth, apathy, lack of energy, and mental confusion
- Untreated medical or mental conditions including infections, soiled bandages, and unattended fractures
- Absence of needed dentures, eyeglasses, hearing aids, walkers, wheelchairs, braces, or commodes
- Exacerbation of chronic diseases despite a care plan
- Worsening dementia

Behavioural indicators

Observed in the caregiver/abuser

- Expresses anger, frustration, or exhaustion
- Isolates the elder from the outside world, friends, or relatives
- Obviously lacks care giving skills
- Is unreasonably critical and/or dissatisfied with social and health care providers and changes providers frequently
- Refuses to apply for economic aid or services for the elder and resists outside help

Observed in the victim

- Exhibits emotional distress such as crying, depression, or despair
- Has nightmares or difficulty sleeping
- Has had a sudden loss of appetite that is unrelated to a medical condition
- Is confused and disoriented (this may be the result of malnutrition)
- Is emotionally numb, withdrawn, or detached
- Exhibits regressive behaviour
- Exhibits self-destructive behaviour
- Exhibits fear toward the caregiver
- Expresses unrealistic expectations about their care (e.g. claiming that their care is adequate
- when it is not or insisting that the situation will improve)

Appendix 6: Risk factors to be considered for all CYPS Deliberate Self Harm/DSH assessments – Children and Young People

Demographic and historical factors	**No evidence seen**	**Low**	**Med**	**High**
Gender				
Age				
Ethnicity				
Family/relationship crisis				
Recent change of living arrangements				
Problems at school/work				
Social isolation				
Coping style/personal resources				
Medical history				
Family/peer history of suicide				
Parental mental health and/or substance misuse problems				
History of antisocial behaviour				
History of abuse, severe victimisation and/or exploitation from others (inc child protection concerns)				
Previous attempts/acts of Deliberate Self Harm				
Risk Management factors	**No evidence seen**	**Low**	**Med**	**High**
Current mental state and psychiatric history				
Change in clinical features				
Recent actual or threatened loss				
Current concerns expressed by significant others				
Current substance misuse				
Failure to comply with medication and/or care plan				
Suicide Plan e.g. method, availability, time/place, lethality, final arrangements,				
Unplanned disengagement with support services				
Reoccurrence of circumstances associated with risk				

Appendix 7: Additional childhood clinical actuarial risk factors to be considered as part of the risk assessment process - Children and Young People

A CYPS risk assessment should consider the following childhood actuarial risk factors when completing the final summary section within the overall RiO Risk Summary screen. Evidence of such risk factors may help to inform the subsequent clinical risk decision making process.

- Family/relationship crisis
- Recent change in living arrangements
- Current vulnerability status including teenage mothers, homelessness, runaways, asylum seekers and refugees
- Persistent problems at school/work
- History of maltreatment/abuse/exploitation/victimisation (including significant harassment and bullying) either from home/ school/ community/ cyberbullying from a range of social networking media)
- Social/peer isolation
- Maladaptive coping style/personal resources
- Family history of suicide
- Peer history of suicide or unexpected death (especially concerning recent events)
- Recent actual or threatened loss
- Parental mental health and /or substance misuse problems
- Current substance misuse problems (including use of solvents)
- History of intentional harm to animals (if known)
- History of parental/carer maltreatment of animals (if known)
- History of risk taking behaviours (eg. persistent antisocial behaviour, previous attempts/acts of Deliberate Self Harm)
- Chronic physical health issues
- Experiencing a series of stressful life events

Appendix 8: Risk Indicators for Self Harm

D - Demographic, B - Background history, C - Clinical History, CC – Current ‘context’

D	Aged 14-35
D	Female
CC	Emotional distress
C	Anxiety
C	Depression
B	Young people living within a residential care setting (12-24 yrs)
C	Substance misuse
C	Eating disorder
C	Diagnosis of BPD
B	Previous Hx
B	Victims of domestic/sexual abuse past, present
CC	Suicidal intents
CC	Loss, separation or receiving bad news
B	Relationship problems
D	Unemployed

Based on: Literature used/Best Practice in Managing Risk (2007) DoH, Royal College of Psychiatry, improving the lives of people with mental illness (2012). Fox & Hawton (2004), Klonsky (2007), Dickson et al (2009).

Appendix 9: Risk Factors for Self Neglect

This assessment needs to consider both the individual’s ability and willingness to care for themselves adequately. This is a difficult area of risk to assess, one which may depend on an assessment of the individual’s physical, cognitive and psychological levels of function.

“*Determining the competence is crucial to determining the passive or active nature of self-neglect” Baumhover 1996*

The individual may be in a position where they have to be responsible for the care of another, whether spouse or children. If this is the case, then the assessor should take into account the needs of all involved, and the identified patient/clients ability to care for themselves and others safety within the specified situation.

Historical factors of self neglect

Previous self-neglect
If the patient/client has experienced difficulties in self-care in the past, this may indicate greater risk of self neglect in future.

General health status
Physical health problems such as arthritis, a stroke or other illness may affect the individual’s ability to perform activities of daily living effectively. Conditions such as depression or anxiety can affect the individual’s levels of motivation and cognitive difficulties may mean the individual is less able to understand and complete activities of daily living safely.

Some conditions may present specific difficulties such as reduced mobility, poor co-ordination, or impaired understanding.

Alcohol/drug abuse is associated with reduced self-care and compliance with medication and treatment. The individual’s levels of motivation and initiative may be impaired.

Current status factors of Self Neglect

Presenting levels of function
What is the individual able to do for themselves? Are they demonstrating adequate problem solving skills or ability to carry out activities of daily living safely?
They should also consider an individual’s ability to communicate their thoughts, feelings and needs as well as their ability to understand what is being communicated to them.

Current mental state
If there is evidence of reduced levels of cognition, then the individual is at greater risk of being unable to care for themselves adequately. With reference to the CPA core assessment, assessors need to consider the following components of mental state:

- Appearance and behaviour
- Speech
- Thought
- Mood
- Insight
- Memory
- Concentration
- Sleep

- Appetite

Levels of insight
If the individual is able to recognise their limitations and accept appropriate levels of support then the risk of self-neglect is lowered.

Risk management factors of self neglect

Lives alone – the risk is higher when the individual lives alone.

Appropriate informal support, family/other – whether living alone or with others, if the individual receives support and encouragement from family and friends, then the risk is lowered. If they are not supported or perceive themselves to be under pressure from their family, then the risks are higher.

Formal support – whether living alone or with others, the risk is lowered if help and assistance is accepted. This may be from Social Services or other agencies.

Compliance with treatment/interventions – the risk of self-neglect is lowered if they are able to comply with treatment and medication regimes.

Suitability of environment – the risks are increased if the environment does not meet the physical needs of the individual. Risks are increased if the individual has problems in moving around their home, staying warm, or having access to facilities such as shops or a laundry.

Clinician's assessment of self neglect

Give your own subjective overall assessment of the risk of self-neglect - a lack of adequate self-care and/or access to appropriate facilities which would ensure the individual's safety and care of themselves in activities of daily living.

Information taken from Baumhover, L and Beall, S *Abuse, Neglect and Exploitation of Older Persons* London, Jessica Kingsley

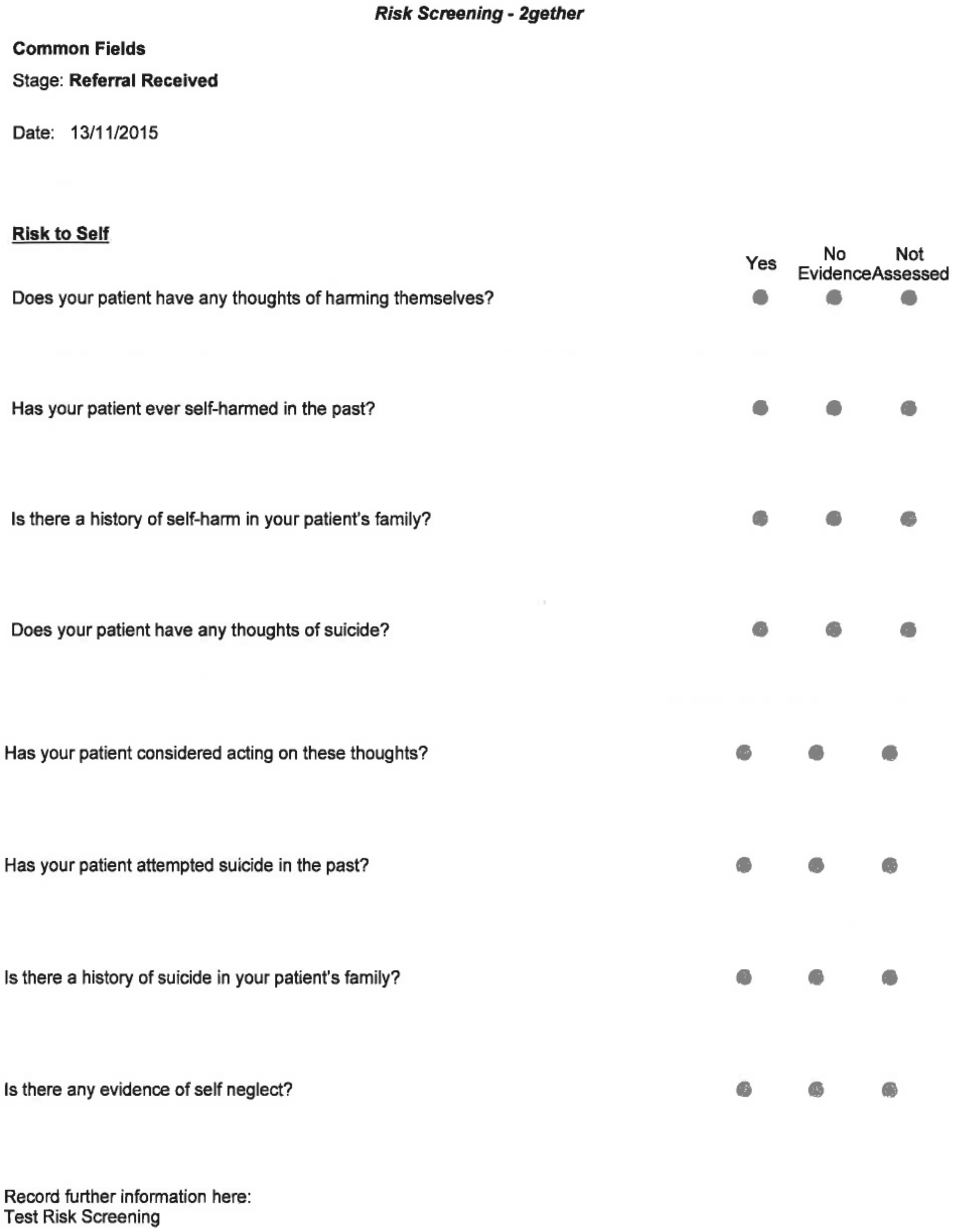
Appendix 10: Actuarial Indicators for increased risk of absconding

- Previous absconding behaviour (the most important factor in prediction).
- Under 40 years old.
- Male.
- Detained.
- Psychosis.
- MHA detention.
- Unemployed.
- Dependency on alcohol / illicit substances.
- Negative feelings, stress and/or anger about admission.
- Early days of admission (especially first 3 weeks).
- Warmer months.
- Weekend.
- Boredom / frustration.
- Following bad news.
- Homesickness.
- Concerns regarding safety of accommodation.
- Domestic concerns – including animals
- Between mid-day and 11pm.
- Shift handover times.

Taken from : **Absconding from psychiatric hospitals: a literature review** Report from the Conflict and Containment Reduction Research Programme Duncan Stewart, Institute of Psychiatry, Len Bowers Institute of Psychiatry, Nov 2010.

List compiled by Chris Betteridge 16/07/13.

Appendix 11: Template: IAPTus Risk Information – Risk Screening MHICT Glos and IAPT Hereford



Risk Screening - 2gether

Common Fields

Stage: **Referral Received**

Date: 13/11/2015

Risk to Self

	Yes	No Evidence	Not Assessed
Does your patient have any thoughts of harming themselves?	●	●	●
Has your patient ever self-harmed in the past?	●	●	●
Is there a history of self-harm in your patient's family?	●	●	●
Does your patient have any thoughts of suicide?	●	●	●
Has your patient considered acting on these thoughts?	●	●	●
Has your patient attempted suicide in the past?	●	●	●
Is there a history of suicide in your patient's family?	●	●	●
Is there any evidence of self neglect?	●	●	●

Record further information here:
Test Risk Screening

	Yes	No	Not Assessed
Would there be anyone or anything stopping your patient from posing a risk to themselves?	●	●	●

Record further information here:
Test Risk Screening

	0	1	2	3	4	5	6	7	8	9	10
What is the likelihood of your patient attempting to harm themselves at the moment?	●	●	●	●	●	●	●	●	●	●	●

What support does your patient currently have around them?
Test Risk Screening

Risk from others

	Yes	No Evidence	Not Assessed
Is your patient currently at risk/do they feel threatened by others around them? (E.g. violence, abuse, exploitation)	●	●	●

Record further information here:
Test Risk Screening

Risk to others

	Yes	No Evidence	Not Assessed
Does your patient currently pose a risk to others or perceive others to be at risk from them? (E.g. physical violence, threats of violence, verbally violent, sexually inappropriate, neglect of others, driving. Do they pose a safeguarding risk to others?)	●	●	●

Record further information here:
Test Risk Screening

Risk of accidents

	Yes	No Evidence	Not Assessed
Is your patient at risk of accidents? (E.g. wandering, falls, unsafe use of medication)	●	●	●

Record further information here:
Test Risk Screening

Other Risk behaviours

	Yes	No Evidence	Not Assessed
Does your patient present with other risk behaviours? (E.g. hoarding tablets, dangerous driving)	●	●	●

Record further information here:
Test Risk Screening

Risk tips:

Take self out if situation

Talk to someone

Calm self down by ...

Discuss problem with .... when calm

Speak to GP if concerned

Use Samaritans if needed (National no: 116 123; Glos: 01452 306333; Hfd: 01432 269000)

Use Out of hours GP if needed (Glos: 0300 4120220; Hfd: 0330 123 9309)

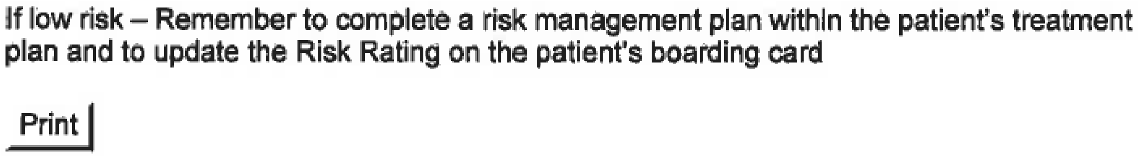
	0	1	2	3	4	5	6	7	8	9	10
How likely is your patient to use these numbers / tips?	●	●	●	●	●	●	●	●	●	●	●

The above indicators are intended to screen for risk factors at the time of the assessment; please take into account other relevant information and the extent to which information is available to you.

Screening Results

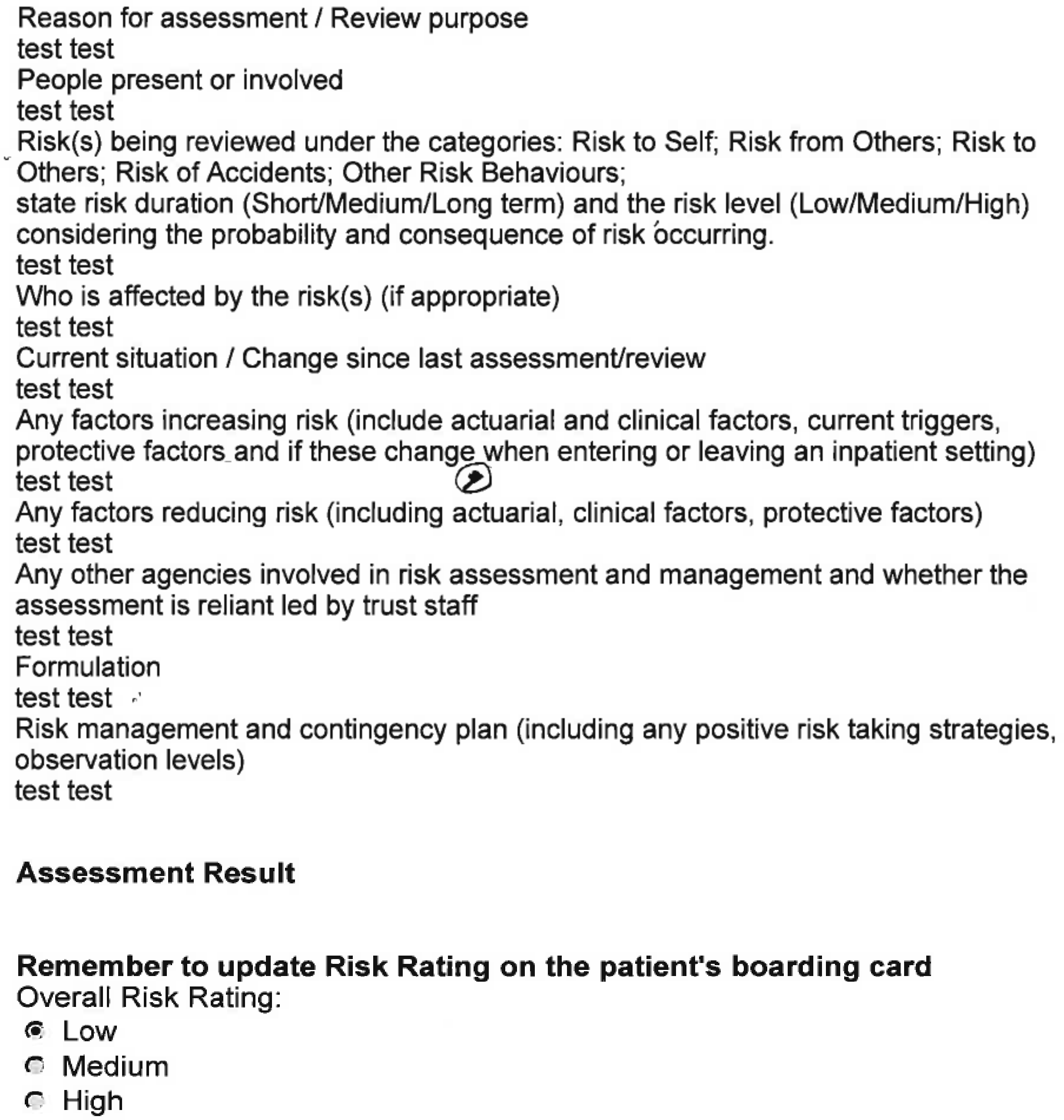
	Low	Medium	High
Overall Risk Rating:	●	●	●

If medium or high risk - remember to complete a Risk Assessment



If low risk – Remember to complete a risk management plan within the patient's treatment plan and to update the Risk Rating on the patient's boarding card

Appendix 12: Template: IAPTus Risk Information – Risk Assessment MHICT Glos and IAPT Hereford



Reason for assessment / Review purpose
test test
People present or involved
test test
Risk(s) being reviewed under the categories: Risk to Self; Risk from Others; Risk to Others; Risk of Accidents; Other Risk Behaviours;
state risk duration (Short/Medium/Long term) and the risk level (Low/Medium/High) considering the probability and consequence of risk occurring.
test test
Who is affected by the risk(s) (if appropriate)
test test
Current situation / Change since last assessment/review
test test
Any factors increasing risk (include actuarial and clinical factors, current triggers, protective factors and if these change when entering or leaving an inpatient setting)
test test
Any factors reducing risk (including actuarial, clinical factors, protective factors)
test test
Any other agencies involved in risk assessment and management and whether the assessment is reliant led by trust staff
test test
Formulation
test test
Risk management and contingency plan (including any positive risk taking strategies, observation levels)
test test

Assessment Result

Remember to update Risk Rating on the patient's boarding card
Overall Risk Rating:
- ● Low
- ○ Medium
- ○ High

Referrals made?

- ● Yes
- ● No

Date Referral made:

23/11/16

Multiagency Referral: (select as appropriate)

- ■ Advocacy
- ■ Local Authority Safeguarding Team
- ■ MAPPA
- ■ MARAC
- ■ Other Organisation
- ■ Police
- ■ PREVENT
- ■ Social Care

Print

Appendix 13: Structured Assessment Template from RiO

Risk of Suicide	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Act with suicidal intent ☐	Suicidal ideation ☐
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm to Self	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Self-injury or harm ☐	Self-neglect ☐
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm from Others	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Child Protection Plan (CPP) indicator: Has never been subject to a CPP/ Has previously been subject to a CPP/ Is currently subject to a CPP/ Not Known	
Domestic Abuse: Disclosed / Not disclosed / Not assessed at this time	
Risk caused by medication/services/treatment ☐	Risk of emotional/psychological abuse including bullying ☐
Risk of financial abuse ☐	Risk of neglect ☐

Risk of physical harm ☐	Risk of unlawful restrictions (locks on doors, physical restraints etc.) ☐
Risk of sexual abuse/exploitation ☐	Vulnerability ☐
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm to Others	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Exploitation of others (e.g. financial, emotional) ☐	Fire setting ☐
Hostage taking ☐	MAPPA ☐
Probation service involvement ☐	Risk to children ☐
Risk to vulnerable adults ☐	Sexual Assault (including touching/exposure) ☐
Schedule 1 or Sex Offenders Act 2003 ☐	Access to Weapons ☐
Stalking ☐	Violence/aggression/abuse to family ☐
Violence/aggression/abuse to general public ☐	Violence/aggression/abuse to other clients ☐
Violence/aggression/abuse to staff ☐	
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
Victims to be notified of Leave/Discharge?	Yes/ No/ Not applicable
RISK RATING: Low/Medium/High	

Risk of Accidents	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Accidental harm outside the home (e.g. wandering) ☐	Driving/Road safety ☐

Falls ☐	Fire ☐
Unsafe use of medication ☐	

Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:

RISK RATING: Low/Medium/High

Other Risk Behaviours and Issues	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Absconding/Escape ☐	Correspondence ☐
Damage to property ☐	Incidents involving the police ☐
Phone Calls ☐	Social Media ☐
Theft ☐	Visitors ☐
Substance/Alcohol ☐	

Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:

RISK RATING: Low/Medium/High

Summary & Any Further Details
Summary and any further details: **REASON FOR ASSESSMENT / REVIEW PURPOSE** **PEOPLE PRESENT OR INVOLVED** *in this risk assessment including any other agencies involved and whether the assessment is led by Trust staff (e.g. could include the service users carers, clinicians and other agencies)* **RISK(S) BEING REVIEWED** *(List the risks identified rather than just the broad headings i.e. deliberate self-harm, self-neglect and suicide rather than just 'Harm to self')* **WHO IS AFFECTED BY THE RISK(S)** *(Include what is known e.g. is there a risk to the general public, females or one particular person?)* **CURRENT SITUATION / CHANGE SINCE LAST ASSESSMENT / REVIEW** **FORMULATION OF RISKS** *stating the risk level (Low/Medium) and risk duration (Short/Medium/Long term e.g. if justifying a course of action that increases short term risk for longer term gain) considering the probability and consequences of the risk occurring.* **RISK MANAGEMENT AND CONTINGENCY PLAN** *(including any positive risk taking strategies, observation levels)*
OVERALL RISK RATING: Low/Medium/High

Trust Policy on

Assessment and Care Management Policy

(Incorporating the Principles of the Care Programme Approach)

Version:	**1st March 2017 V. 12**
Consultation:	CPA Review Group, Heads of Profession, Trust Wide Consultation and NPAG
Ratified by:	Director of Quality
Date ratified:	01.03.2017
Name of originator/author:	Matthew Edwards, Assistant Director of Quality, Assurance and Transformation
Date issued:	
Review date:	June 2019
Scope:	All Clinicians and practitioners in the Trust

If you would like this in another format, or if part of this is unclear and you would like it explained, please contact and ask to talk to the Trust Lead for CPA.

This document outlines the policy and procedure for applying key standards to care within the Trust. It is freely available to anyone within or outside of the Trust.

Version	Date	Reason for Change
V1	*14.02.2014*	*First Draft*
V2	16.05.2014	Second Draft
V3	22.09.2014	LESTER TOOL Updates
V4	03.12.2014	Format Amendments
V5	21.01.2015	
V6	04.03.2016	LD Amendments
V7	20.03.2016	Ratified Final Version – Agreed at Governance
V8	24.03.2016	Ratified Final Version – Agreed at Governance
V9	03.07.2016	Appendix A Amendments + Page 32 Addition of 7.3
V10	14.07.2016	Core Assessment Part 1 + 2 Changes + Appendix A Update
V11	16.10.2016	Adjustment to guidance regarding Crisis and Contingency plans
V12	25.11.2016	Adjustment to Section 8 – Transfer between teams and to reflect the change to services around the Crisis Care Concordat (URT)

Table of Contents

1. Policy Background

1. Introduction

1.1 The assessment and care management of Trust Service Users will follow the key principles of the Care Programme Approach (CPA)[1] and must have Service Users as its focus. These principles will apply to all services provided by the Trust. These include:

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

1.2 The principles of Care Management, as set out in this policy focus services on the strengths, needs and aspirations of Service Users, to assist in improving their outcomes. Care will sometimes be provided only by a single member of staff from 2gether Trust, but often it will be provided through co-ordinated systems of multidisciplinary and joint agency assessment and care planning. The care planning process is fundamental to the care provided by our Services. It places the Service User at the heart of all care planned and delivered by the Trust

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

2. Principles of Assessment and Care Management

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

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

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

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

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

2.5 The quality of relationship/communication between Service User and the Lead Professional / Care Coordinator is one of the most important determinants of success.

3. Purpose

3.1 This policy has been written to provide a clear framework for assessment, care planning, care coordination and overall care management within the Trust. It complies with national CPA guidance as well as providing a framework for the provision of services not covered by the CPA national guidance. This policy outlines how these principles will be applied within the Trust, and provides benchmark for monitoring practice against standards.

4. Duty

4.1 The Director of Quality holds Board level responsibility for the Assessment and Care Management Policy. The day-to-day responsibility for this Assessment and Care Management Policy is held by the Assistant Director of Quality, Assurance and Transformation. Together they will be responsible for developing and maintaining the policy, offering advice and guidance to staff, ensuring that training is developed and delivered, and monitoring Trust wide compliance with this policy.

4.2 The Trust Governance Committee will be notified of, and will ratify any changes to this policy. The Committee will also receive copies of any reports and audits relating to standards and practises in this policy, as a minimum this must include an annual report.

5. Scope

5.1 The contents of the policy are mandatory across the whole Trust.

5.2 This Assessment and Care Management Policy applies to all staff who are employed by ²gether and they are responsible for adhering to this policy.

5.3 It is the responsibility of all those providing care to Service Users and Carers, not just the Lead Professional or Care Coordinator to ensure that all others working with Service Users are kept fully informed of all significant changes or events.

5.4 The Assessment and Care Management principles are applicable to ***all*** services provided by ²gether.

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

6. Tools

6.1 This policy is based on an agreed pathway referred to as the Pathway to Care which is detailed on page 17 of this document.

6.2 This policy describes the recording of Assessment and Care Management processes within ²gether's Health and Social Care notes. The majority of Service Users records will be recorded using the Trust's Electronic Patient Record systems (EPR) e.g. RiO, IAPTus. Staff are required to record information in all EPRs according to the latest training guidance and system updates.

7. Definitions

The Trust: ²gether NHS Foundation Trust.

Primary Care Services: Primary Care Services includes Primary Mental Health Services and IAPT in the current structure within the Trust.

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

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

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

PARTNERSHIP: Following CHOICE, a PARTNERSHIP appointment is a CAPA term to describe a detailed full CYPS mental health core assessment where CPA responsibilities commence. At the first partnership assessment, a detailed mental health assessment is completed including clinical formulation and a CPA care plan will be developed in collaboration with the child or young person. Subsequent PARTNERSHIP sessions (usually 7-10) offer core CAMHS treatment which aim to meet objectives outlined in the CPA care plan. Once the core PARTNERSHIP sessions are completed and further clinical intervention is indicated, the child or young person will receive further specialist intervention in accordance to the CPA framework. 13

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

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

Care Coordinator: The clinician or practitioner who, irrespective of their ordinary professional role, has responsibility for co-ordinating a Service User's care, keeping in touch with the Service User, ensuring the care plan is developed, delivered and reviewed as required. This can often mean working as part of a multi-disciplinary team or ensuring that the care ^{2}gether Trust provides is coordinated with the care delivered by other agencies or care providers.

AHP: Allied Health Professional

Standard Care: This refers to the treatment facilitated by a Lead Professional / Named Worker. It can be provided within primary or secondary care services for those who require less intensive involvement from ^{2}gether.

'On CPA': This refers to treatment facilitated by a Care Coordinator. It will be treatment and care provided within secondary care services, for those who require more intensive or complex involvement from ^{2}gether.

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

First Contact Assessment: Telephone or face to face contact with Service User

Core Assessment: An initial primary or secondary care assessment when the Service User is referred to the Trust, undertaken in conjunction with the Service User and/or parents and Carers where appropriate

OUTCOME MEASURES: Are measurement tools to help assess impact of the care 2gether provided on a Service User.

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

HoNOS: Health of the Nation Outcome Scale, which is the Clinical Rated Outcome Measure (CROM), used in adult mental health care packages.

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

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

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

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

ICT: Intermediate Care Team (this is an integrated service for Primary Mental Health and IAPT services delivered in Gloucestershire)

2. Assessment

1. Introduction

1.1 This section covers the standards associated with assessment. It describes what should be included in an initial screening and assessment, who can complete it and the time frame standards according to the Pathway to Care process map (Page 17)

1.2 All screening will be undertaken by suitable trained staff and all assessments will be undertaken by a registered/qualified practitioner as detailed in Appendix A.

1.3 The Pathway to Care process map sets out the process for all Service Users accessing ²gether services from referral through to the completion of core assessments (part 1 and 2), following the first contact with the Service User. The core assessment process can take up to a maximum of 28 days. This is detailed on page 14 of this document

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

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

2. Prior to the Assessment

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

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

2.3 Where direct booking on psycho-educational courses takes place using the online booking system, the patient through the self-selection of courses available will complete a self-evaluation and therefore through informed decision making, enlist themselves on a pre-determined course outline which will inform their care. In such cases the service will ensure that any changes in their care needs that are brought to the attention of the course facilitator are responded to.

2.4 Following the completion of the self-evaluation and direct booking requirements, the Service User will have entered their pre-determined course and this will be the first stage of their treatment plan in primary care services.

3. Who to involve in the assessment?

3.1 The assessment will be undertaken as either a face-to-face meeting, telephone appointment or by the use of a self-assessment tool when -referring themselves using the online facility for courses (IAPT). This can be in any location, but the staff member leading the assessment should ensure that the location offers privacy, and also minimises any risk to everyone involved.

3.2 If it is appropriate, in terms of age and capacity to consent, and where it is therapeutically advisable, parents, Carers and anyone else directly involved with the Service User's care and welfare can be involved in the assessment. At all times, the Service User's wishes must be carefully considered.

3.3 If the Service User is known to be pregnant the Service User's Midwife should be contacted wherever possible as part of the information gathering. If the Service User has recently given birth, then the midwife or health visitor must be contacted.

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

3.5 If the service user has been referred to Trust services three times within a two month period and not accepted by the assessing service, Community Services Manager should review the reasons and rationale for the team not accepting the referral.

4. Sources of information for the Assessment

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

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

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

4.4 Where substance misuse services are provided by external organisations (e.g., Turning Point), contact should be made to ensure that key information is shared.

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

5. Self-Assessment

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

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

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

6. Skills and Competency of the Assessor

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

- A health or social care clinician or practitioner who is qualified and registered with approved professional bodies.
- Must have completed, and be up to date with, the relevant Trust training in:-
    - Assessment and Care Management
    - Risk Assessment
    - Child and Adult Safeguarding
    - Mental Health Act[9] (if relevant to the area of practice)

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

7. Pathway to Care

7.1 The Pathway to Care process map outlines the assessment and care management pathway for all Service Users referred to the Trust and contains key decision points and forms the basis of this policy. This is detailed on page 13 of this document

8. Core Assessment Process

8.1 The assessment process contains two parts:

- Core Assessment Part 1
- Core Assessment Part 2.

8.2 Within this assessment process, there are three care management decision points to decide whether the Service User should undergo further assessment, go into treatment or whether the Service User should be discharged, as detailed in the Pathway to Care process map on page 15 of this policy.

8.3 **Decision Point 1:** At the first contact appointment, part 1 of the core assessment will be completed for all Service Users. In all services a decision will then be made as to whether ^{2}gether services are required. If ongoing services are required, part 2 of the core assessment will be started and completed in line with the assessing service (i.e., primary or secondary care).

8.4 **Decision Point 2:** Part 2 of the Core Assessment may also be completed at the first contact appointment and a decision made whether ^{2}gether services are still required.

8.5 **Decision Point 3:** Part 2 of the Core Assessment may take up to a maximum of 28 days following the first contact (to allow for further information gathering or additional appointments). At this point a decision must be made as to whether to discharge, or the Service User will be deemed as being 'in treatment'.

8.6 Following the completion of the core assessment Service Users will be considered as 'in treatment' with ²gether services, even if further more specialist assessments are required as part of the treatment plan. The process also identifies three decision points for clinicians, to further asses, to treat or to discharge. Following acceptance into ²gether services, the pathway to care defines the process for review and discharge.

8.7 For CYPS or CAMHS, a full CHOICE assessment must be completed within 28 days of the first contact appointment.

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

9. Core Assessments Part 1 and 2 requirements for All Services Provided by the Trust

9.1 The Tables below set out the required information to be collected for Service Users accessing Trust services, excluding self-referrals to IAPT group psychological / educational courses.

9.2 ICT Gloucestershire and IAPT Herefordshire and MHARS will complete a Risk Screen for all Service users. Where overall Risk is LOW, no Risk Assessment is required. Where Risks have been identified the completion of a FULL Risk assessment will need to be undertaken.

9.3 If following Core Assessment part 2, ²gether services are not required, follow the discharge procedure as detailed in the Discharge section of this Policy

Table 1: Core Assessment Part 1

Core Assessment **Part 1**	**Presenting Situation** – reason and background for referral include level of distress/instability or disengagement.	**Medication History**	**Mental State Examination,** including Capacity if required	**Clinical Risk Screening**	**Full Clinical Risk Assessment** proportionate to risk and presentation including Safety issues around driving	**Physical Health problems/disability**	**Needs Assessment**
IAPT on-line Self-Referrals	***Self-referral includesGAD-7 and PHQ-9, alongside demographic information prior to attending a course***						
IAPT Services **Let's Talk (Hereford) & MHICT Therapy (Glos)**	√	√		√	**Where appropriate**	√	
Urgent Response Team (URT)	√	√	√	√	**Where appropriate**	√	
MH ICT Nursing (Glos)	√	√	√	√	**Where appropriate**	√	
Primary Care Services	√	√	√		√	√	
CHOICE for CAMHS/CYPS	√	√	√		√	√	
LD Services	√	√	**Where appropriate**		√	√	√
Secondary Care MH Services	√	√	√		√	√	

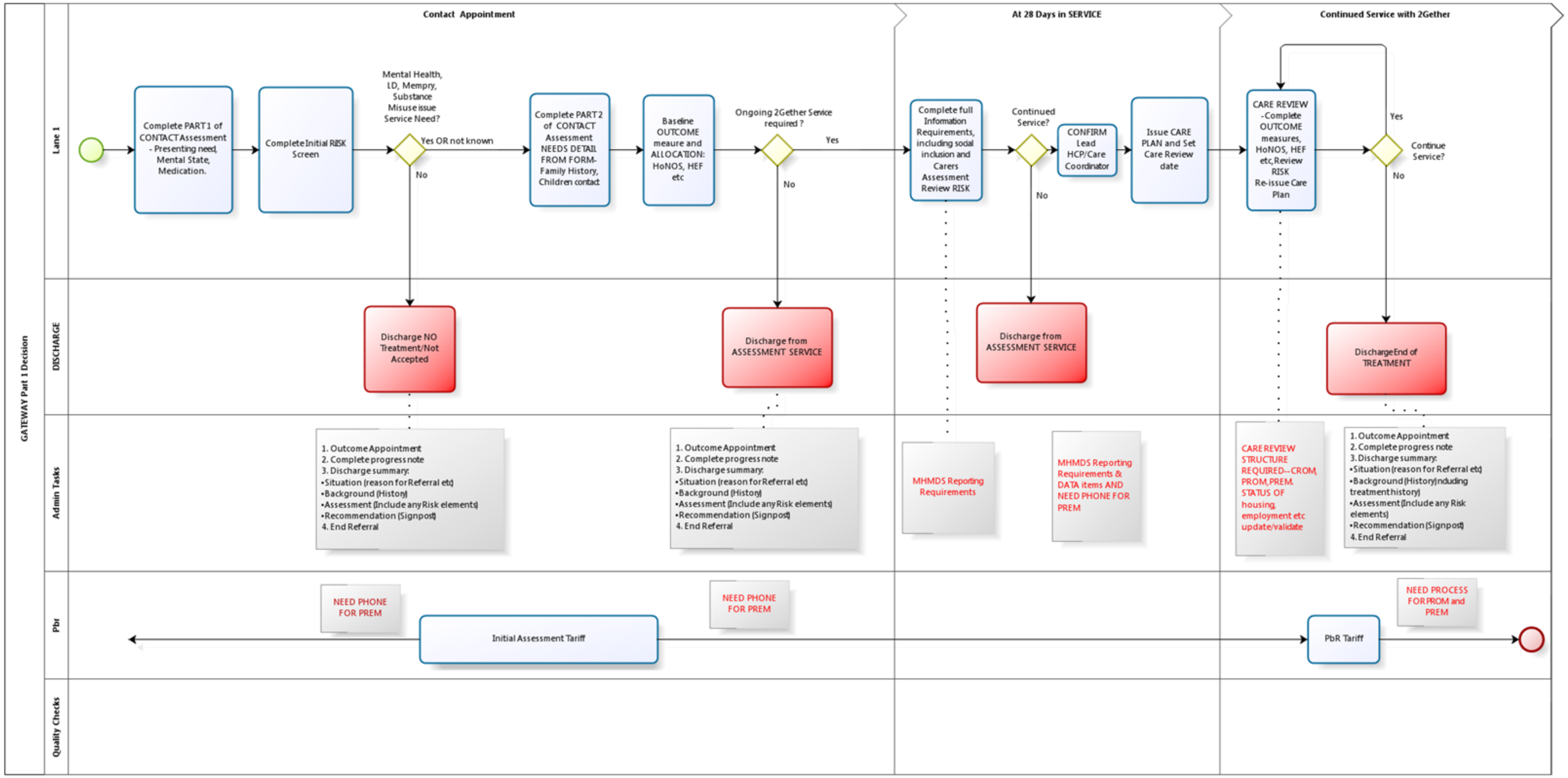
Table 2: Core Assessment Part 2

Core Assessment Part 2	**Personal and family history,** including MH History, next of kin & Spirituality	Personal, peer and family relationships - including sexual relationships where applicable - i.e. partnerships/marriage , gender and ethnicity	Any other people living at the service users address and other children who the service user may have regular contact with	**Physical health** monitoring-use of Lester Tool	History of physical/sexual/emotional abuse	Identify if there is a carer or young carer and then arrange for them to be offered a carer's assessment	Reliance on carers/offer a carer's Assessment (if applicable) see page 46 for service responsible for providing assessment	**Social History** including normal activities , interests and hobbies	Financial circumstances-including benefits	Social inclusion- accommodation and housing	Employment, Education, Work, Leisure , Language communication and literacy	Own caring responsibilities	Parenting responsibilities including additional support required to parent/children including social and physical educational support	Aspirations and strengths	Presenting diagnosis (CD10) and *provisional diagnosis (IAPT only)	Allergies	Complete baseline outcome measure and allocation e.g. HoNOS, ROM,HEF, & GAD7, PHQ-9	Collect PROM (Patient rated outcome measure WEMSEBS)	Consent to share	Care management in Mental Health Act status	Service provision from different agencies	Crisis Contingency Management plan
<u>IAPT Services</u> Let's Talk (Hereford) & MHICT Therapy (Glos)	√*	√*	√		If appropriate	√			√	√					√*		√	√	√			√
MH ICT Nursing (Glos)	√	√	√	If appropriate		√	√	√	√	√				√	√		√	√	√			√
Primary Care Services	√	√	√	If appropriate		√	√	√	√	√				√	√		√	√	√			√
CHOICE for CAMHS/CYPS	√			If appropriate						√							√					√
PARTNERSHIP for CAMHS/CYPS		√	√	If appropriate		√	If appropriate	√			√	√	√	√	√	√			√	√	√	√
LD Services	√	√	√	If appropriate		√	√	√		√	√	√	√	√	√	√	√		√	√	√	√
Secondary Care MH Services	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	* Next of kin	* Gender & ethnicity																				+

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

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

Pathway to Care



10. On-going Services required

10.1 With the exception of IAPT services, service Users not discharged within 28 days of the first contact appointment will be considered to be ‘In Treatment’ with ²gether services.

10.2 Following completion of the core assessment part 1 and part 2, a Lead Professional/Named Worker (the latter for IAPT) or Care Coordinator needs to be identified. At this point, a care plan is developed with the Service User and they are given a copy. Where a treatment intervention does not have a fixed number of sessions (PMHS/IAPT short term engagement) or exceeds 4 weeks a care review date is set.

11. Consent to Sharing information

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

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

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

11.4 We often have to ‘share’ information about Service Users receiving services with a number of different people. These may include family, friends, neighbours, and professionals from organisations such as social services, schools or from the voluntary and community sector. It is important that the Service User’s views and wishes about what can be shared, and with whom, are properly recorded. This is called ‘Consent to Share Information’.

11.5 Adult Service Users and those young people deemed to be Gillick competent, have a right to confidentiality. In principle, younger children also have the right to confidentiality but the parent(s) with legally defined parental responsibility are able to make decisions on their behalf. Information sharing with anyone not directly involved in the Service User’s care, must be done in line with the principles outlined in ‘Confidentiality: NHS code of Practice’ [12]. This is shown below along with further information relating to sharing of information, from the leaflet ‘How we handle your information’. Individuals are entitled to be advised:-

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

- given a copy of the information comprising the data; and
- given details of the source of the data (where this is available).

12. Documenting Consent to Sharing Information

12.1 A Service User's wishes, network and situation may vary on a regular basis. Therefore, consent to sharing information needs to be a dynamic rather than fixed-point process.

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

- *When there is specific information to be shared, such as distribution of care plans, or sharing of information with other agencies.*
- *When someone is admitted to an inpatient setting, a signed copy will be saved within the health and social care records and reviewed regularly throughout the inpatient stay.*

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

12.4 This information needs to be clearly labelled as 'consent to share information'.

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

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

- Ensure that the person has considered the risks and benefit of the decision without seeking to influence;
- Regularly confirm the Service User's wishes;
- Document these discussions in the health record;
- Continue working with a Carer and family even when there is consent to sharing concerns.

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

12.7 Where there are explicit instructions not to share information with a Carer, the Trust will still listen and offer support as appropriate to the Carer and explain why information is not being shared. If it would compromise the therapeutic work being undertaken with the Service User receiving treatment so that the Lead Professional or Care Coordinator cannot liaise with and support the Carers, another member of the staff team should be identified to do this, as set out by the Mental Health Act Code of Practice11.

13. Sharing Information and issues of capacity

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

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

13.3 A Service User is presumed to have capacity unless he/she is:

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

13.4 It must be remembered that:

- Any assessment to an Service User’s capacity has to be made in relation to a particular request to share information;
- Capacity in an individual can be variable over time and should be assessed whenever the issue of information is raised;
- Every effort should be made to ensure that the request for consent to share information was made using a range of communicable means;
- All assessments of an individual’s capacity should be fully documented in the health and social care record and clearly labelled ‘consent to share information – capacity assessment’.

14. Assessing Spirituality

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

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

14.3 One definition of spirituality is as follows:

> *"In Health Care, spirituality is identified with experiencing deep seated sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration and wholeness".* [10]

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

14.5 To help the Trust meet its commitment, the following questions are to be asked of all Service Users, excluding CYPS and CAHMS. When a Service User answers "yes" to Question 4 contact is made with the relevant spiritual leaders.

Questions are as follows:

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

14.6 Other aspects of assessment are outlined in specific policies.

3. Care Levels

1. Introduction

1.1 There are two levels of care management offered to Service Users which is proportionate to the intensity and complexity of support required. These are detailed in Appendix C.

1.2 <u>'Standard Care':</u>

- This is the care level where a lower intensity of support is needed; care will be facilitated by a Lead Professional/Named Worker (the latter for IAPT/SM services).
- All Service Users accessing primary care will be managed by a Lead Professional/Named Worker
- For CYPS, children and young people accessing level 2 Primary Care Services will be managed by a Care Coordinator

1.3 <u>'On CPA'</u>

- Where Service Users require more intensive support and / or there are medium or high levels of risk involved, they will be allocated a Care Coordinator who will manage their care. This level of care equates to 'on CPA'.
- All Service Users admitted to any inpatient services will be 'on CPA' on admission and the level is then determined upon review prior to discharge'. (CPA and Care review handbook, 3rd Edition, 2008)

1.4 All individuals referred, assessed and accepted into the Trust's services for secondary care will be allocated either a Lead Professional or Care Coordinator.

1.5 Service Users in secondary care may require either a Lead Professional or a Care Coordinator to facilitate their care depending upon complexity and level of risk.

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

1.7 All Service Users should have access to high quality evidence-based services.

2. Lead Professional / Care Coordinator allocation

2.1 All Service Users accessing primary care services or IAPT will be allocated a Lead Professional/Named Worker.

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

2.3 All Service Users accessing secondary care services will have either a Lead Professional or a Care Coordinator.

2.4 A band 5 or above Clinician or Practitioner; as detailed in Appendix A, can act as either a Lead Professional and/or a Care Coordinator, depending upon the care level (e.g., 'Standard care', or 'on CPA') of each service user on their caseload.

2.5 The criteria for allocation in secondary care is as follows:

3. Lead Professional – Standard Care:

3.1 The Service User would be assessed as having:

- Minimal needs of low complexity in Mental Health Services
- Low risk to themselves or others
- Low intensity of support required from Trust services or support is easily organised and largely provided by a single Trust Worker

4. Care Coordinator – 'On CPA':

4.1 The Service User would be assessed as having:

- moderate to high levels of care needed from Trust services

4.2 Require multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who have higher risk. Characteristics to consider when deciding if a Care Coordinator is needed:

- Severe mental disorder (including personality disorder) with high degree of clinical complexity meaning high support needed from Trust services
- Medium to complex mental health / Learning Disability needs meaning high support needed from the Trust
- Assessed as having medium to high risk factors
    - Suicide, self-harm, harm to others
    - Current or potential risk(s), including:
        - Suicide, self-harm, harm to others (including history of offending)
        - Relapse history requiring urgent response
        - Self-neglect/non-concordance with treatment plan
    - Vulnerable adult; adult/child protection e.g.
        - exploitation e.g. financial/sexual

        - financial difficulties related to mental illness
        - disinhibition
        - physical/emotional abuse
        - cognitive impairment
        - child protection issues
    - Current or significant history of severe distress/instability or disengagement
    - Presence of non-physical co-morbidity
    - e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies

- Currently/recently detained under Mental Health Act[9] or referred to crisis/home treatment team

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

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

4. Managing Care and Interventions

1. Managing and Co-ordinating Care

1.1 In all Trust services, care will be managed or coordinated by either a Lead Professional or a Care Coordinator, or for IAPT / Substance Misuse Services, a Named Worker.

1.2 Once a Service User has been assessed and accepted into care, they will be allocated a Lead Professional/Named Worker or Care Coordinator in accordance with their allocated care level.

1.3 Under National Guidance for Mental Health Services in England, the publication, Refocusing the Care Programme Approach (2008)2, defines the term 'Care Coordinator' as applying to Service Users whose care level is 'on CPA', and the term 'Lead Professional' is used for someone on 'Standard Care' assessed as needing primary or secondary care services.

2. Role of the Lead Professional or Named Worker when providing 'Standard Care'

2.1 The Department of Health's published National Guidance for Mental Health Services. The document named, 'Refocusing the CPA' introduced a new role of Lead Professional/ Named Worker for those who do not need CPA. The Lead Professional has:

- 'The responsibility for facilitating the delivery of care to the Service User who has been identified as having low complexity needs and has contact with only one agency; this will be the person identified as being most appropriate from that agency.'

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

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

2.4 For Service Users accessing Mental Health Services, where appropriate a copy of the electronic care plan should be given to Service Users on how their treatment and care will be carried out and delivered.

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

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

a) Discharge from services
b) Change in care level
c) Transfer to another team or agency

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

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

3. Role of the Care Coordinator when providing care for Service Users 'on CPA'

3.1 The term Care Coordinator, is specific to the Service User who is 'on CPA'. The Care Co-ordinator coproduces and reviews regularly the care plan with the Service User. Others who deliver elements of the care package must not be called Care Coordinators.

3.2 A Service User 'on CPA' can only be care coordinated by a registered /qualified practitioner in line with the standards outlined in Appendix A.

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

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

4. The Care Coordinator will:-

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

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

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

4.4 Act as a first point of contact for the Service User, Carer and other professionals

4.5 Ensure that an out-of-hours contact number is specified in the care plan for Service Users and Carers

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

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

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

4.9 Ensure that all relevant information is communicated to:

- Psychiatric inpatient health and social care professionals during admission
- Acute inpatient health and social care professionals during admission
- Wider health community where practicable

4.10 Distribute the care plan details to independent sector providers as appropriate and agreed.

4.11 Maintain contact with the Service User during any in-patient or CRHT episode and continue to act as Care Coordinator

4.12 Share information with Carers, having due regard to the Service User's wishes

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

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

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

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

5. Care Coordination in the Crisis Resolution and Home Treatment Teams (CRHT)

5.1 Under national CPA guidance, a Service User accepted into treatment by a Crisis Team (CRHT), automatically moves to 'on CPA'.

5.2 If the Service User is already 'on CPA', their existing Care Coordinator will remain unchanged.

5.3 If the Service User is on ''Standard Care'', but the existing Lead Professional has the required qualifications to care coordinate someone 'on CPA' according to Appendix A, the Care Coordinator role will be with them.

5.4 If the Service User is 'on CPA', but the Lead Professional does not have the required qualifications to care coordinate someone 'on CPA' according to Appendix A, a new Care Coordinator must be identified. If the Service User is:–

a) Receiving care from a team that does care coordinate Service Users 'on CPA', a new Care Coordinator from that team will be identified as a matter of urgency, and the previous person should remain involved to ensure continuity of relationship.

b) Receiving care from a team that does not care coordinate Service Users 'on CPA', then the CRHT will provide an acting Care Coordinator. In this case as soon as practicable, a discussion needs to take place between the CRHT and the referring team to identify whether the Service User is going to need additional support from the referring team once the CRHT episode has been completed. If this is the case an urgent referral to an appropriate service will be made involving both the referring team and CRHT.

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

6. Care Level and Mental Health Care Clusters

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

7. Care Planning

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

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

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

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

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

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

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

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

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

7.9 Where a Service User is being treated in the community, the care plan should be written by the Service User's Lead Professional / Care Coordinator with the involvement of the Service User. The care plan should be sent to the Service User's GP, and anyone else involved in the Service User's care, subject to their agreement (see also section on Sharing Information and issues of capacity).

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

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

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

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

8. Consenting to Treatment and Care plans

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

8.2 Service Users can be confident that their human rights are respected and taken into account

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

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

8.4 Where a Service User is assessed as not having capacity to consent, appropriate processes should be followed in line with the Mental Capacity Act or Mental Health Act as applicable.

- For children appropriate processes should be followed

8.5 Capacity assessment is incorporated within the care cluster care plans.

9. Content of the care plan for someone with a ‘Lead Professional’

9.1 The care plan for Service Users who have a ‘Lead Professional’ receiving standard care will reflect the type and duration of service provide.

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

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

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

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

10. Content of the care plan for someone with a ‘Care Coordinator’

10.1 All care plans must include the following, where appropriate [1], [2]

a) Name of their Care Coordinator and how to contact them

b) The name of anyone else involved in their care and their contact details

c) The Care Level

d) The Service User’s strengths, hopes and primary needs, the interventions being planned together with the expected outcome.

e) Service User and if appropriate Carer’s view of the care plan

f) A record of all the actions agreed to meet the goals

g) A clearly description of the time scales for actions to be completed

h) Details of any medication, dosage, frequency and method of delivery

i) If appropriate any issues around supporting areas of life that matter to the Service User, for example, parenting, vocation, finances, religion

j) Any physical health concerns or disability

k) The date of the next care review

l) Details of any other agencies or staff involved

m) Any early warning signs or relapse indicators

n) Crisis and contingency arrangements, including who to contact in an emergency

o) Any arrangement for managing risk

p) How to respond if the Service User misses an appointment or contact

q) A crisis, relapse and contingency plan including –

- who the Service User is most responsive to and how to contact them
- any strategies that have worked previously
- any agreed strategies, interventions or advanced decisions including changes to medication, admission etc.
- who will care for dependants and any animals
- who can be involved and their contact details

r) Additional support required for social inclusion and contributing to hope and well being

s) Needs associated with faith, culture, gender, ethnicity or disability

t) Referral to other interventions indicated for the Service User/care cluster, such as psychological therapy

u) Any specific issues around parenting/ caring the any needs of the child(ren) or those being cared for.

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

10.3 The Service User's consent should still be sought and documented in the usual way.

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

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

11. Care Plans and Copying Letters to Service Users

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

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

5. Care Review

1. Review of Care

1.1 One of the essential elements for the Service User receiving prolonged treatment and support from the Trust is that their care be reviewed. Every time the Service User's care is reviewed and a new plan of care is developed, these should be recorded as a CPA review for Service Users who's care is managed by a Care Coordinator. For Service Users whose care is managed by a Lead Professional, this will be recorded as a care review.

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

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

2. Purpose of the Review

2.1 The purpose of a Care Review or cluster review is to consider:

a) Progress the Service User has made

b) The view of the Service User, Carer and professionals

c) How the Service User has responded to services being provided

d) Reassessment of risk factors (completion of a full risk review as detailed in the Trust's Clinical Risk and Safety Policy)

e) Ways in which their needs may have changed

f) If the needs have changed, the extent to which the care plan (including the crisis and contingency plan) requires amending.

3. Frequency of the Review

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

a) If the Service User requests it

b) When the Service User's care cluster package indicates a review- (see Appendices B-D)

c) If there are significant changes in the Service User's mental or behavioural state – positive or negative

d) Significant changes in their social or vocational situation

e) Before discharge from an inpatient unit

f) If a Community Treatment Order is being removed or section 117 aftercare is being discharged

g) When transferring from one team to another

h) When relocating out of area

4. Conducting a Care or Cluster Review Meeting

4.1 A Service User’s Care or Cluster Review meeting can be informal or formal according to the needs of the Service User being reviewed.

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

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

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

5. Formal Review

5.1 For a ***formal*** review the Service User should be:-

- Consulted on who attends
- Offered the services of an advocate (where there are issues relating to the Mental Health Act)
- Involved in deciding the location of the meeting
- Involved in deciding the timing of the meeting
- Given a letter for the reason for the meeting and the place and time of its occurrence

5.2 There may be occasions where this is not possible i.e.-

- If the Service User’s mental health would be compromised
- Where there are legal obligations for certain people to attend
- There are obligations under the Mental Health Act e.g. Sec 117
- If significant risk issues are present
- When they are a young child without Gillick Competency

5.3 Where the Service User is not involved in the meeting, the Lead Professional or Care Coordinator must ensure that it is clearly documented why this was necessary, reasonable and in the best interests of the Service User and or Carer.

5.4 Where a Service User requires several meetings every effort should be made to combine them e.g. MAPPA/CPA/Sec117/Discharge from an Inpatient Unit /CAF / Statement preview

5.5 Prior to the meeting and where appropriate a copy of the current care plan should be given to the Service User so that they can review it.

6. Involving Carers in Reviews

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

6.2 The Care Coordinator must ensure that Carers and families should be advised of any risk to them, or to the Service User using the services which may arise from the treatment / care plan13

6.3 Further guidance on working with Carers please see part 6 of this policy.

7. Documenting a Care or Cluster Review

7.1 Details of the formal review need to be fully documented in the health and social care record. The Care Review field in the health and social care record, must also be populated with a minimum of the following information:

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

8. Review of Care

See table below:

Care and Cluster Reviews	Primary MH Services	Secondary MH Services	CAHMS / CYPS Services	LD Services	IAPT	MHARS
Marital Status	√	√	if appropriate	√	√	√
Social Inclusion	√	√	√	√	√	√
As relevant: Cluster assessment/Allocation (HoNOS) Outcome Measure (ROM's, HEF)	√	√	√	√	√	√
Consent to share	√	√	√	√	√	√
Risk Review	√	√	√	√	√	√
Allergies		√	√	√		√
Care Level	If care level is changed	√	√	√		√
Review care plan	√	√	√	√	√	√
Outcome Care / Cluster Review	√	√	√	√	√	√
Outcome appointment in the health and social care records	√	√	√	√	√	√
Make a clinical entry in the health and social care record	√	√	√	√	√	√
Letter and copy of care plan to Service User and copy to GP	√	√	Dependent upon Guillick Competency	√	√	√
Presenting Condition	√	√	√	√	√	√

6. When Service Users Do Not Attend (DNA) and approach to Missing Persons

1. Loss of Contact with a Service User Receiving a Service

1.1 As a routine part of the assessment and treatment of the Service User, the Lead Professional/Care Coordinator should consider whether there are any indications that the Service User may disengage from services. Any such concerns should be documented in the progress notes and a specific management plan including timescales should be developed and recorded in the Crisis and Contingency section of the Service User's care plan.

1.2 If a Service User does not attend an arranged appointment simple steps such as, attempting to contact the Service User by phone must be taken. If there is still no contact, the Lead Professional / Care Coordinator and the team manager must decide whether there are any risks or concerns relating to the individual or others.

2. If there are no risks or concerns

2.1 Where a Service User's care is being managed by a Lead Professional / Named Worker, a letter should be sent to the Service User asking them to contact the Lead Professional / Named Worker to discuss further involvement. This letter must be sent within 48hrs of the missed appointment/contact. If the Service User does not contact the team within 14 days, the team leader will have the discretion to discharge subject to previous history of engagement.

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

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

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

3. If there are risks or concerns to self or others then the following should occur:

3.1 Follow the agreed Service User’s Crisis and Contingency plan

3.2 The Missing Person’s procedure should be referred to and used if the Service User is an inpatient, a child or a vulnerable adult.

3.3 The Service User’s last known address should be visited. If unsuccessful the Service User’s regularly visited places should also be visited.

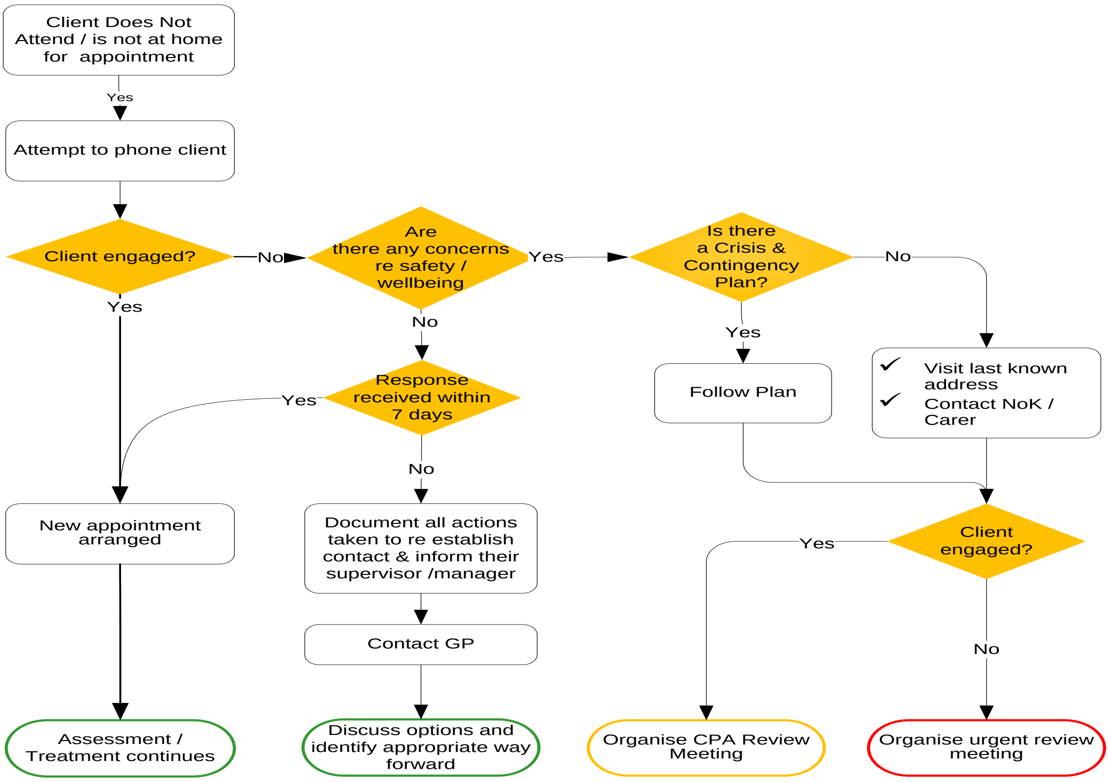
3.4 Contact should be made with the Service User’s nearest relative and/or friends (as appropriate, using principles on sharing information as outlined in this procedure).

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

3.6 If, having taken all reasonable steps, contact is not re-established; the Lead Professional / Care Coordinator must convene an urgent review meeting. This will establish:-

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

4. Loss of contact with a Service User Pathway



5. Sending a Missing Person's Alert

5.1 Having followed the process in paragraph 4 above, it may be considered necessary to issue a missing person alert. These alerts can be sent to other NHS organisations, where it is appropriate to do so. It should be recognised that by sending an alert the Service User's confidentiality will have been breached in a significant way, and this should only been done in rare and exceptional circumstances.

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

The Service User affected is either –

a) a significant current risk to themselves or others

b) is likely to present a significant risk to themselves or others from discontinuing treatment

And both of the following -

a) It is likely that they have travelled outside of the counties of Herefordshire and Gloucestershire.

b) All other reasonable steps have been followed to find and engage with the Service User

If it is appropriate then the following must happen:-

a) The Care Coordinator must discuss this with their team manager.

b) They should discuss this with the Trust Local Security Management Specialist and follow the agreed processes

c) The team responsible for the Service User's care will discuss this with the Service User's Carer or nearest relative to check that they are happy for the alert to be sent.

d) The Care Coordinator will complete a copy of the missing person's alert form. A progress note should be made in the Service User's record stating what has happened.

5.3 A copy of the original, unprotected document must be uploaded to the Service User's file.

5.4 A copy of the email with the alert, clearly identifying the address of who the email has been sent to, should also be uploaded in PDF or similar format.

7. Carers

1. Definition of a Carer

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

1.2 Parents who have school age children that are frail or have a physical or mental illness, disability or substance misuse issues, are also carers.

1.3 A Young Carer is a child or young person who takes on responsibility at home or offers emotional support because a family member, usually a parent or sibling, suffers from an illness, disability, mental ill health or substance abuse.

2. Rights of the Carer

2.1 Whatever the views of the Service User, anyone identified as a Carer is entitled to:

- A proactive response from clinicians/practitioner's to contact or meet professionals without the Service User present
- Continuing support in their caring role
- Be told they have a legal right to an assessment of their caring, physical and mental health needs, repeated at least annually and the right to formal or informal support during the assessment
- Their own written support plan, implemented in collaboration with them
- Request a review of their support plan at any time

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

- Be heard, listened to and believed
- Information and advice
- Be consulted and fully involved in discussions which affect their life
- Be protected from physical and psychological harm

Remember the fundamental principle that "No care package should depend on the inappropriate caring role of a child."

- (Carers (Equal Opportunities) Act 2004 Practice Guidance)

3. Carer's Assessments

3.1 Carers of people receiving Trust services should be offered the opportunity to talk to a senior member of the care team about their own needs, including how the team can support the carer in their caring role and how the carer wishes to be involved in the care offered by the team. This discussion should include information about accessing a formal Carer's Assessment

3.2 Those entitled to a Carers Assessment include

- Adult Carers (over 18)
- Young Carers (under 18). Taking a "whole family approach" in the first instance should identify young Carers and identify whether they have any unmet needs. If any issues relating specifically to the young Carer remain unresolved through working with the family a Young Carer's Assessment may be sought through referral to Young Carer's Gloucestershire or Herefordshire Carer's Support
- New Carers who will be providing care in the near future
- People whose caring responsibilities have changed (review)

4. Identifying Carers

4.1 Regardless of whether the care we are providing is 'Standard Care' or 'on CPA', assessments should always review the social and family network around each Service User to identify anyone who provides unpaid practical and/or emotional support and who's caring may have an impact on their own lives.

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

4.3 When a Service User is referred to the Trust as part 2 of the Core Assessment we will attempt to identify if the Service User has a Carer. Where a Carer is identified, they will be contacted and, informed by the Lead Professional or Care Coordinator of their right to a formal assessment under the Carer's (Recognition and Services) Act 1995[14] and the Carers and Disabled Children's Act 2000[15] and generally made aware of the services that are available, including those such as funded Carer Breaks and Emergency Care schemes which may not be accessed without a Carer Assessment in place. Reassurance should be offered that a Carers Assessment does not involve an assessment of the person's capability to care and is not an assessment of finance and savings.

4.4 As a Trust we need to ensure that we record in the patient record:

- Their name and contact details
- Their relationship to the Service User receiving treatment
- Whether or not they are accepting a Carers Assessment (this should be reviewed periodically)

4.5 Where a Service User states that they do not have a Carer this must be regularly reviewed as they may not yet recognise that a family member or friend is acting as their Carer.

4.6 If the Carer accepts the offer of a formal assessment the Care Coordinator will ensure that this is completed. This can be completed either by themselves or delegated to another (see below “Responsibilities of the Care Coordinator”)

4.7 To meet the requirements of the Data Protection Act, Carers must have their own health and social care record in which to store all information relating directly to them as Carer’s. Carer’s assessments are stored in the Carer’s records and must not be stored in the health and social care record of the Service User they care for.

4.8 The Carers Needs Assessment may identify a range of needs within the remit of those organisations commissioned to support Carers. Services should ensure that where it is the Trust’s responsibility to facilitate this, appropriate partner agencies are involved during or after assessment to ensure effective follow up of identified Carer need. This will form part of a care plan, which is appended to the Carers Assessment form. The care plan will be reviewed on at least a yearly basis or at the request of the Carer. Where a Carer Support Worker from a partner organisation may be involved Care Coordinators should seek permission from the Carer to liaise with them to assist in formulating and implementing a care plan.

5. Regular and Substantial Care:

5.1 Legislation gives particular entitlements to people providing ‘regular and substantial’ care. The meaning of ‘regular and substantial’ care is not always straightforward. The Trust expects staff to use a broad definition of caring, recognising:

- Caring includes practical care and support, such as personal care, preparing meals, looking after the home, shopping, laundry, paying bills etc.
- Caring includes emotional care and support
- Caring is not just about how much time is given to caring activities - the impact of being a Carer fluctuates over time, and can be affected by other circumstances affecting the Carer
- Carers may still continue to provide commitment and emotional support when a Service User needs little practical help, or practical help is provided by paid homecare workers or residential services or the Service User lives elsewhere from the Carer
- Service Users will often have more than one Carer. Young Carers needs should not be overlooked even if there is another adult in the home.

- Carers may have more than one role as a Carer, for example as a parent of young children and the Carer of an older relative
- The Service User being cared for by Mental Health Services may also have needs as a Carer

6. Provision of Carers' Assessments

6.1 A variety of commissioned arrangements are in place to conduct formal Carers assessments. The following table provides some guidance.

Service	Intermediate Care Team	Secondary Mental Health Services	CYPS	LD	SM	Young carers
Carer's Assessment Provider ^{2}gether NHS Foundation Trust Gloucestershire Services	All: Carers Glo'shire	Adults with functional conditions in services of all ages Trust responsibility Organic Conditions all ages Carers Glo'shire Adults with Functional Conditions using One Stop Later Life Services (no social care provision) Carers Glo'shire	GCC Children and Families Social Care • Parent Carers • Young Carers (as part of the Common Assessment Framework)	Carers Glo'shire	N/A	Glos Young Carers (where a support need not addressed by whole family approach is identified)
Service	**Lets Talk/PMHS**	**Secondary Mental Health Services**	**CAMHS**	**Learning Disability**	**DASH**	**Young Carers**
Carer's Assessment Provider ^{2}gether NHS Foundation Trust Herefordshire	All: ART team Herefordshire Council	All: ART Team Herefordshire Council	Parent Carer need will be assessed by Social Care Team workers in the CAMHS team the child is under as part of a whole family approach	Social care Team workers Co-located with the Learning Disability Team conduct Carer Assessment	All: ART Team Herefordshire Council	Herefordshire Carers Support - all Young Carers should be registered with the Young Carers team at HCS

7. Responsibilities of the Lead Professional / Care Coordinator

7.1 The Care Coordinator will know:

a. who the Service User's Carer is and any young Carers involved

b. what the Carer's relationship to the Service User they care for is

c. how to contact the Carer

7.2 The Lead Professional or Care Coordinator should:

- Ensure that the Carer knows who they are and how to contact them and how to get support in an emergency or out of hours
- Offer to meet with the Carer to discuss their understanding of the situation and share their views and/or concerns regarding the Service User they care for, to introduce the service and discuss the Carer's perception of their own needs, taking into account the level of consent to share given by the Service User
- Ensure that, wherever possible with consent, the Carer is provided with the relevant information about the care management process and the particular care, diagnosis and medication needs of the Service User they care for and are invited to be involved in the Service User's care planning, treatment, review and discharge planning. Acknowledging the important role that Carer's can play in working alongside the Service User to promote good physical and mental health and in the prevention of deterioration or relapse.
- Offer the Carer under the Carer's (Recognition and Services) Act 1995 and the Carers and Disabled Children's Act 2000 a Carer's Booklet or information on how to access the resource from the Trust website in a timely way.
- Inform the Carer of their right to a formal Carer's Assessment and either complete this if the service is commissioned to do so or make the appropriate referral if not
- work with other agencies in a co-ordinated way to support Carers

7.3 Please note that Carers and families should be advised of any risk to them, or to the Service User using the services which may arise from the treatment /care plan' and involved in any contingency planning in place to manage risk

8. Involvement of others in Service User's Care

8.1 The Service User must always be involved in the planning and provision of his or her care where capacity allows. Relatives and/or others important to the Service User must also be involved wherever possible, with the agreement of the Service User.

8.2 The obligation to maintain confidentiality must not prevent staff asking relatives and others for information or for their opinions and concerns, which should always be fully documented. However, no aspect of an individual's personal care or treatment should be discussed with the Carer/others involved without the expressed consent of the Service User unless it is in their best interest to do so.

8.3 Where Carers and others are identified, staff should engage proactively in discussion with the Service User regarding what level of information may be shared and with whom. Such information should be recorded and regularly revisited. In the case of no disclosure consideration is needed on how Carers can still be offered support and general information according to practice guidelines

8.4 The Service User has a right to confidentiality, but this must always be seen in the context of not only the interests of the Service User but also of others. A decision to consult others, against the expressed wishes of the Service User, will be taken by the Care Coordinator / Lead Professional and recorded in the Service User's clinical record together with the reason why it was necessary to do this. The Service User will always be told this is happening and why.

8.5 Where agreement cannot be reached between the Care Coordinator and relevant others, a discussion with the multi-disciplinary team or Team Manager must take place and a team decision reached. The nearest relative (as defined in the Mental Health Act 1983) of a Service User being assessed for compulsory treatment must also be consulted under Section 11(4) of the Act. The user must be informed of this although sensitivity around where consultation takes place should be exercised

8.6 Standard Six of the Mental Health National Service Framework for Adults describes the entitlement of Carers to an assessment of their own needs and to access services. The Carers of Service Users 'on CPA' must be identified in the care plan, and given information about available services.[8]

8.7 Unless the Service User has capacity or competence and withholds consent, anyone identified as a Carer for someone receiving care from mental health or learning disabilities services is entitled to:

- Be treated with respect and dignity as part of the care team
- Be given information and have the chance to discuss the condition and/or treatment, the risks of the treatment and available alternatives
- Be involved in preparing care plans care management plans
- Be invited to review meetings and be involved in making arrangements for review meetings. Be informed of access to Carer advocacy arrangements with local organisations to support participation.
- Have their involvement acknowledged and described in Service Users' care plans

9. Transfer to and from another Team

1. Transfer between ^{2}gether Teams

1.1 Dependant on the needs of the Service User it is often necessary for care to be transferred to another team within the Trust. Any transfer of care should be sensitive to the individual’s needs. As the period around transfer can cause uncertainty and anxiety and therefore increased risk, the process should be transparent and reflect best practice in providing consistent care management. It is important to remember that the Service User’s needs are paramount and that the care we provide should not be subject to unreasonable restrictions because of the Service User’s age.

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

1.3 Where a Service User is in a primary care service, the Lead Professional along with the team manager will be responsible for contacting the other team and informing them of the impending transfer.

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

1.5 Where a referral has been made the team receiving the referral (the ‘receiving team’) must ensure that all appropriate details are available and are in keeping with the information listed in paragraph 1.6 below. The ‘receiving team’ will be responsible for ensuring that the appropriate action (i.e. assessment) is undertaken or that a more appropriate team is informed to ensure that they in turn accept the referral. There may be times where teams co-work with service users. This principle applies to all teams.

1.6 The current Care Coordinator or Lead Professional will be responsible for ensuring that the following information is up to date in the Service User’s case record:-

- Demographic and contact details
- Outcome measurements
- Carer contact information
- Core Assessment
- Risk Assessment

- Risk Incident log/Alerts
- Safe Guarding Information
- In the progress notes – including a summary of the Service User's progress to date and reason for transfer request

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

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

1.9 In the case of transfer from PMHS/IAPT (Herefordshire) and ICT/Let's Talk (Gloucestershire) to other Trust Services; until the receiving team has undertaken the additional assessment the responsibility remains with the transferring team. After assessment has confirmed the need for specialist care that responsibility will transfer to the receiving team. This is normally within four weeks. In all other cases, until the receiving team has identified a new Care Coordinator and has completed the handover of the Service User, responsibility remains with the current team and Care Coordinator / Lead Professional.

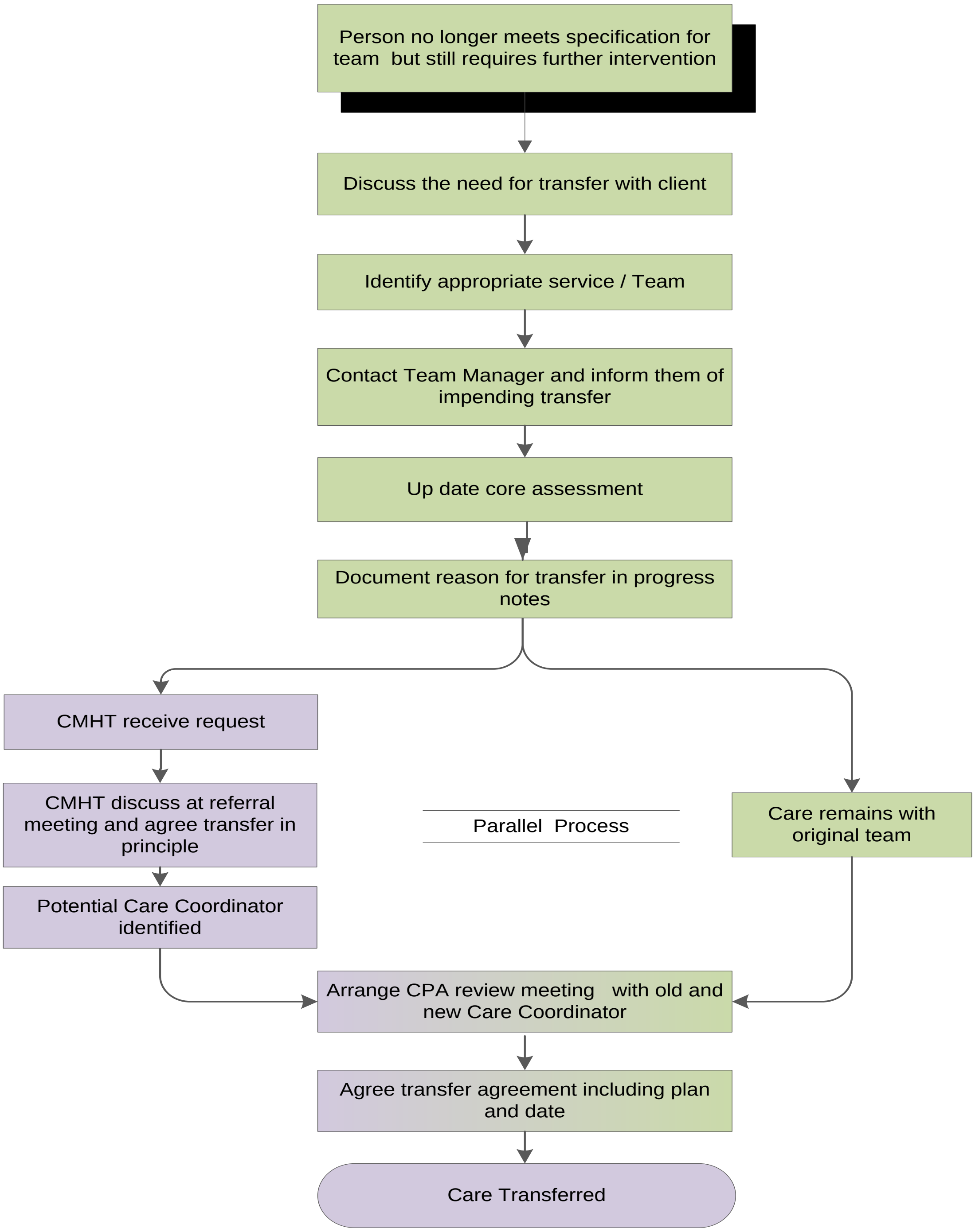
1.10 Where there is uncertainty regarding who should provide ongoing care both the 'host' and receiving teams should consider joint assessments to ensure a service is identified to meet the service users' needs.

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

1.12 The team receiving the request will review the Service User's care record and allocate an appropriate Care Coordinator. Following this a joint CPA review will be held with the current and future Care Coordinator when a clear plan for transition, including dates and any actions will be developed. This information will be clearly communicated to everyone involved in the Service User's care including their Carer if consent is given) and GP.

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

2. Transfer Pathway



3. Transfer to another Provider

3.1 Where a Service User is to be transferred to another provider, the Lead Professional or Care Coordinator should ensure that the following occurs:-

3.2 The Lead Professional or Care Coordinator or Consultant proposing the transfer identifies the appropriate provider or service. The prospective service is contacted and the situation explained

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

3.4 Where possible, a meeting will take place with the Lead Professional or Care Coordinator, the Service User being transferred, and the new care provider. If an inpatient, it may also be appropriate for the Service User to visit the new provider unit.

3.5 It is agreed when and how the transfer will take place.

3.6 Identify responsibility for commissioning arrangements

3.7 A minimum requirement for the transfer of information to the proposed provider is:-

- A covering letter from the Lead Professional or Care Coordinator or Mental Health Act Responsible Clinician
- Up to date demographic information
- Outcome measurements and if applicable HoNOS cluster
- Copy of the most recent Core Assessment
- Copies of the last 3 months of community progress notes and or/ last 4 weeks if inpatient notes
- Copies of any care plans
- Copies of the risk Incident log and alerts
- Copies of any safe guarding information
- Copies of risk assessment and management plans
- Copies of any medication cards or prescriptions

4. Transfer from another Provider

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

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

- If the Service User is subject to Section 117 or Guardianship, the Adult and Community Care Directorate (formerly Social Services) should also be contacted. Reference should be made to the local authority website for guidance regarding Section 117.
- Where possible, a meeting is arranged with the current Lead Professional or Care Coordinator and the Service User being transferred.
- If the proposed transfer is appropriate all parties will agree when and how the transfer will take place.

5. Minimum information required from another provider:

- A covering letter from the Care Coordinator or if Mental Health Act applies, a Responsible Clinician
- Up-to-date demographic information
- Outcome measurements and if applicable HoNOS cluster
- A copy of the most recent Core Assessment
- Copies of the last 3 months of community progress notes and or/ last 4 weeks if inpatient notes
- Copies of any care plans
- Copies of the risk Incident log and Alerts
- Copies of any Safe Guarding information
- Copies of risk assessment and management plans
- Copies of any medication cards or prescriptions

6. Breakdown of a relationship between a patient and their treating team

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

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

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

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

8. Discharge

1. Background

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

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

2.1 If after an initial assessment on-going ²gether services for mental health or learning disability are not required the Service User will be discharged or, if required, signposted to external services. This marks the end of the assessment and the referral will be closed.

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

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

    - End referral
- Send a copy of the discharge summary and the agreed actions to the Service User copied to the referrer/GP.

3. Discharge from Community Teams

3.1 If the Lead Professional/Care Coordinator in conjunction with the Service User believes that treatment and support is no longer required, then it is time to consider discharge. Before this can happen the following things should occur:-

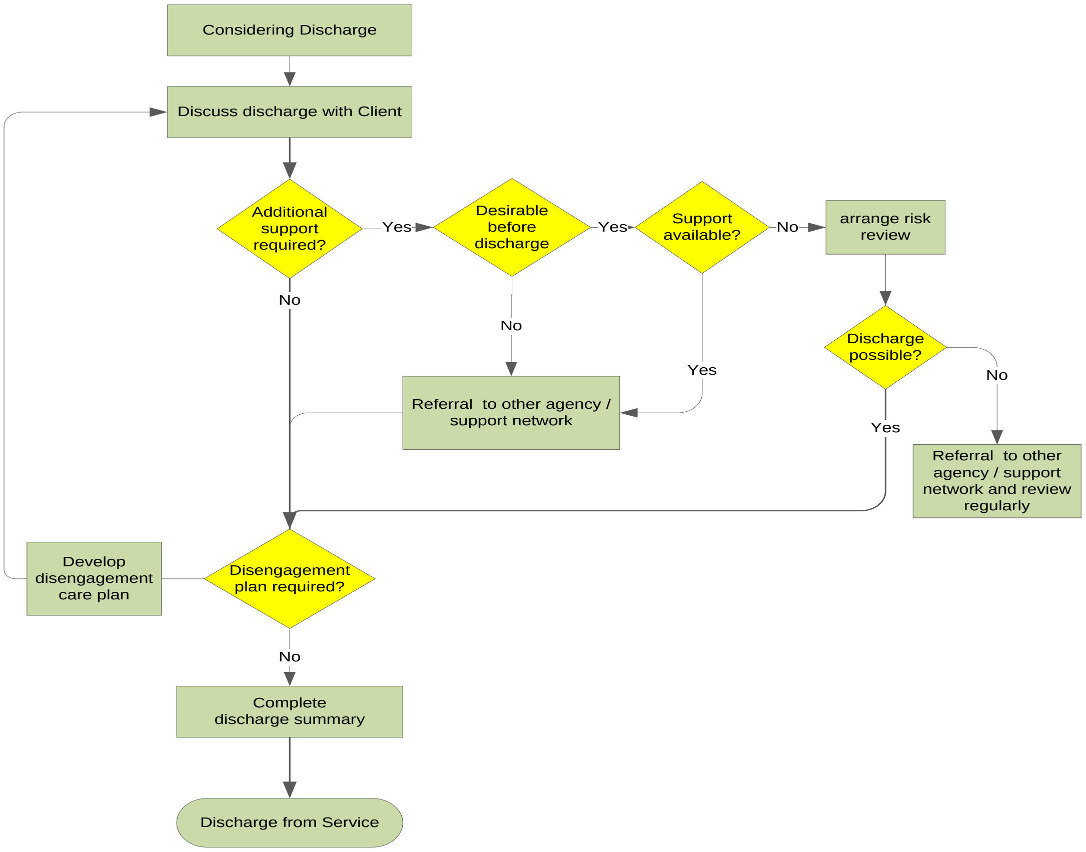
- The discharge process should be discussed with the Service User receiving treatment
- If the Service User's care is managed by a Care Coordinator then there must be a full care review meeting held to consider discharge
- It should be considered if any additional input is required from the Service User's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

3.2 Once discharge has been agreed then -

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

4. Discharge Process

Discharge



5. Discharge from Inpatient Services

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

- The discharge should be discussed with the Service User receiving treatment
- Unless there is clear justification otherwise the Service Users care will be managed by a Care Coordinator for at least 6 months post discharge, and thus a CPA review meeting should be held
- A Care Coordinator must be identified before the Service User leaves the ward
- A ‘Discharge from Inpatient Care Plan’ must be produced before discharge in practice this will be a revised CPA care plan.
- Consideration must be given to whether any additional input is required from the Service User’s support network or local community or another agency to facilitate discharge and whether this is possible.

- Any specific risks associated with discharge must be identified
- The follow up arrangements for not later than 48hrs after leaving the ward must be agreed and documented
- A discharge summary must be completed and sent to the Service User and copied to the GP **within 24hrs** of discharge (see section 4) this should be completed jointly by the ward staff and a doctor

6. Discharge Summary

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

6.2 The minimum content is:

- A clear label of 'Discharge Summary'
- The Service User's name
- The Service User's date of birth
- The Service User's consultant and their Care Coordinator if different.
- Their NHS number
- Their primary diagnosis
- Their treatment and rational for significant changes in treatment
- Any risk or safety issues
- Significant investigations and results
- Date of referral and date of discharge from service
- Details of other agencies involved
- Further action recommended to the primary care team
- Information given to the Service User / Carer / family

6.3 If the Service User is being discharged from inpatient care the following additional items are required:

- Date of admission
- The ward they were admitted to
- Date of discharge
- The ward they are being discharged from
- Where the Service User is being discharged to, and if this is not the normal

address, provide address details and phone number

- Details of when and where they are being followed up and by whom
- Medication details

9. Process for Monitoring Compliance

1. Policy Review Procedure

1.1 This policy will be reviewed every 3 years to ensure that it continues to meet the needs of the Trust, by the Assistant Director of Quality, Assurance and Transformation, under the authority of the Director of Quality, though a review can be completed sooner if any of the following are identified -

- There is a significant change in national guidance or policy
- There is a significant change in best practice
- Local practice issues are identified that are not adequately covered by this policy and need addressing.

2. Audit and Monitoring Compliance

2.1 A programme for auditing and monitoring will be carried out each year, as agreed by the Governance Committee. This will include the following:-

- all teams audited against core standards and practises outlined in this policy at least twice a year
- focused audits exploring specific standards and aspects of this policy as applied in practice

2.2 These will include:

1. The duties of clinicians and practitioners in relation to the policy
2. The compliance with training as laid out in the Trust training policy
3. Documentation and provision of information to Service Users

3. Notifications of Changes to Policy

3.1 The Governance Committee will be notified of, and will ratify, any changes to this policy. They will also receive copies of any reports and audits relating to standards and practises in this policy, as a minimum, this must include an annual report.

10. Abbreviations

CAMHS	Child and Adolescent Mental Health Service
CPA	Care Programme Approach
CQC	Care Quality Commission
CYPS	Children and Young People’s Service
EPR	Electronic Patient Record
GCC	Gloucester County Council
HALO	Electronic Patient Record System
IAPT	Improving Access to Psychological Therapies
IAPTus	Electronic Patient Record System
LD	Learning Disabilities Service
MH	Mental Health
MHARS	Mental Health Acute Referral Service
MHMDS	Mental Health Minimum Data Set
PMHS	Primary Mental Health Services
Rio	Electronic Patient Record System

11. References

1. The Care Programme Approach for people with mental illness, Joint Health and Social Services Circular — HC (90)23/LASSL(90)11, Department of Health 1990
2. Refocusing the Care Programme Approach Department of Heath 2008
3. Supplementary guidance issued to ‘Refocusing CPA’ DH 2008’ relating to Implementation of Violence and Abuse policy by CPAA, June 2008
4. CPPA Handbook 3rd edition, Care Programme Approach Association 2008,
5. Best Practice in Working with Carers, Royal Collage of Psychiatry, 2006
6. The Data Protection Act 1995
7. The Mental Capacity Act 2005
8. A national Service Framework for Mental Health:
    - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf
9. Mental Health Act 1983 (amended 2007)
10. Royal College of Psychiatrists Mental Health Information. http://www.miepvideos.org/RCP%20spirituality%20and%20MH.pdf
11. Mental Health Act Code of Practice (2008).
12. NHS Code of Practice (2003)
13. Healthcare Commission No voice, no choice (2007) Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England (December 2009)
14. Carer’s (Recognition and Services) Act 1995
15. Carers and Disabled Children’s Act 2000

12. Appendices

Appendix A: Assessment and Care Management

Appendix B: List of Policies to read in conjunction with this document

Appendix C: Care Cluster Reviews for all Trust Services

Appendix D: Individual service response times

Appendix A: Assessment Care Management

KEY to table	
A	can assist but not validate
Y*	yes if the person holds a registered and relevant qualification
Y^	once assessed as competent
Y+	Yes, Can create care plan where risk screen is sufficient
Y	yes

Appendix A: Assessment Care Management

Assessment	Band 2 HCA/Support worker	Band 3 HCA	Band 3 support worker AHP	Band 4 HCA	Band 4 support Worker AHP	Band 5 (& above) Nurse Mental Health	Band 5 (&above) Nurse Learning Disability	Band 5 (& above) OT	Band 5 (& above) Physio	Band 5 Health & Exercise Practitioner	Band 4 (& above) Social Worker	Unqualified Psychologist or Psychological Therapist (Psychology assistant level)	Band 5 CYPS PMHW	Band 5 & 6 S&LT	Band 6 CYPS PMHW	Band 6 Health & Exercise Practitioner	Trainee Psychologist or Psychological therapist	Qualified / Registered Psychologist or Psychological Therapist	Band 7 S&LT	Doctor (all grades)	Band 4 Assistant Psychological Wellbeing Practitioner	Band 5 Psychological Wellbeing Practitioner
Core Assessment						Y	Y	Y	Y	A	Y		Y*	Y	Y*	Y	A	Y	Y	Y	Y	Y
Clinical Risk Assessment						Y	Y	Y	Y	A	Y		Y*	Y	Y*	Y	A	Y	Y	Y		Y
Complete HoNOS Cluster						Y	y	Y	Y	A	Y	Y	Y*	Y	Y*	Y	Y	Y	Y	Y	Y	Y
Care Manage 'standard care'				Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	A	Y	Y	Y	Y	Y
Care Coordinate 'on CPA'						Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y		Y

Appendix A continued:

Assessment	Band 2 HCA/Support worker	Band 3 HCA	Band 3 support worker AHP	Band 4 HCA	Band 4 support Worker AHP	Band 5 (& above) Nurse Mental Health	Band 5 (&above) Nurse Learning Disability	Band 5 (& above) OT	Band 5 (& above) Physio	Band 5 Health & Exercise Practitioner	Band 5 (& above) Social Worker	Unqualified Psychologist or Psychological Therapist (Psychology assistant level)	Band 5 CYPS PMHW	Band 5 & 6 S&LT	Band 6 CYPS PMHW	Band 6 Health & Exercise Practitioner	Trainee Psychologist or Psychological therapist	Qualified / Registered Psychologist or Psychological Therapist	Band 7 S&LT	Doctor (all grades)	Band 4 Assistant Psychological Wellbeing Practitioner	Band 5 Psychological Wellbeing Practitioner	
Write care plan				Y *	Y *	Y	Y	Y	Y	A	Y	A	Y	Y	Y	Y	A	Y	Y	Y	Y+	Y	
Write 'on CPA' care plan						Y	Y	Y	Y	A	Y	A	Y*	A	Y*	A	A	Y	Y	Y		Y	
Support Delivery of care plan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Complete Carers Assessment				A	A	Y	Y	Y	Y	A	Y	A	Y	Y	Y	A	A	Y	Y	Y	A	Y	
Review Core Assessment				A	A	Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y	A	Y	

*** For service users on standard care only**

Appendix A continued

Assessment	Band 2 HCA/Support worker	Band 3 HCA	Band 3 support worker AHP	Band 4 HCA	Assistant Psychological wellbeing Practitioners Band 4	Band 4 support Worker AHP	Band 5 (& above) Nurse Mental Health	Band 5 (&above) Nurse Learning Disability	Band 5 (& above) OT	Band 5 (& above) Physio	Band 5 Health & Exercise Practitioner	Band 5 (& above) Social Worker	Unqualified psychologist or Psychological Therapist (Psychology assistant level)	Band 5 CYPS and CAMHS PMHW	Band 5 & 6 S&LT	Band 6 CYPS PMHW	Band 6 Health & Exercise Practitioner	Trainee Psychologist or Psychological therapist	Qualified / Registered Psychologist or Psychological Therapist	Band 7 S&LT	Doctor (all grades)
Review HoNOS Cluster				Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y*	Y	Y*	Y	A	Y	Y	Y
Risk Screen				Y	Y	Y															
Review Risk Assessment				A	A	A	Y	Y	Y	Y	A	Y	A	Y*	Y	Y*	A	A	Y	Y	Y
Discharge from service							Y	Y	Y	Y	Y	Y	A	Y*	Y	Y*	Y	A	Y	Y	Y
Complete ICD 10 Diagnosis							Y	Y	Y	Y	A	Y		Y*	Y	Y*	A			Y	Y
Supervise bands below							Y	Y	Y	Y	Y	Y		Y*	Y	Y*	Y		Y	Y	Y
Validate own notes	Y ^	Y ^	Y ^	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Validate the notes of others							Y	Y	Y	Y	Y	Y		Y*	Y	Y*	Y		Y	Y	Y

Appendix B: List of Policies to read in conjunction with this document

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

   - Child and Adult Safeguarding Policy
   - Missing Person's Policy
   - The Mental Capacity Act
   - The Mental Health Act
   - Clinical Risk Assessment and Safety Policy
   - The Data Protection Act
   - Record Keeping Policy
   - Interface Policy
   - Policy on Recording Information in Electronic Patient Records (EPRs)
   - The Carer's Charter
   - Equality and Diversity Policy
   - Capacity Act 2005 (same as LD/MH services ?)

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

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

Appendix C continued

Cluster Number	Cluster Description	Care Management Levels	Maximum Review Period (weeks)
7	Enduring Non Psychotic Disorders high disability	Lead Professional or Care Coordinator	52
6	Non Psychotic disorder of over-valued ideas	Lead Professional or Care Coordinator	26
5	Non Psychotic Disorder very severe	Care Coordinator	26
4	Non Psychotic severe	Lead Professional or Care Coordinator	26
3	Non Psychotic moderate severity	Lead Professional	26
2	Common Mental Health Problem (low severity with greater need)	Lead Professional	15
1	Common Mental Health Problem (low severity)	Lead Professional	8**
0	Cluster 0	Lead Professional	52**

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

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

11	Sensory Issues	Lead Professional or care coordinator	As above

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

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

Appendix C: Drug and Alcohol Services

Tier	Details	**Care Management Levels**	Maximum Review Period (weeks)
Tier 1	Non Drug Treatment Specific Services	Lead Professional	3 monthly
Tier 2	Open Access Services	Lead Professional	3 monthly
Tier 3	Structured Community Based Services	Lead Professional or Care Coordinator	3 monthly
Tier 4	Residential and Inpatient Services	Care Coordinator	3 monthly

Appendix D

Response Times

Gloucestershire Localities Services

First Point of Contact Centre

Referral	Emergency	Urgent	Routine	Comment
Initial response to referral	**N/A**	**N/A**		**The Contact Centre mirrors Team Service Specifications and referrals cannot be passed back or held by the Contact Centre**
Commencement of referral	**N/A**	**N/A**		

Intermediate Care Team

Referral	Emergency	Urgent	Routine	Comment
Initial Response to Referral	**N/A**	**N/A**	**Screening to assessment within 14 days of receipt of referral**	**Will host service users until transfer to Recovery Team, normally within 4 weeks.**
Commencement of Referral	**N/A**	**N/A**	**From referral to treatment within 28 days** **High Intensity initiated within 14 days of assessment**	**For some patients in clusters 3 & 4 who may require Recovery Services Inclusion:** **High risks, in the context of significant**

				mental disorder **Significant medical complexity** **Treatment resistance** **Continuous PMHS intervention over 9 months without progress** **<u>Requirements on Referral</u>:** **Overview of risk and presenting problem** **HoNOS score and cluster** **Medication summary** **Physical health summary** **<u>Process</u>:** **Via Contact Centre, as is.** **Young people can refer to IAPT although it is best for CYPS to offer to do this and liaise with service directly**

				Agreed cut off age for CYPS transition is 18th birthday. However, flexible dependant on clinical need. Planning could start 6 months prior and CYPS will retain care coordinator responsibility during transitional period

Recovery Team

Referral	Emergency	Urgent	Routine	Comment
Initial Response to Referral	N/A	Response available through daily rota service within 2 hours	Response available through daily rota service within 2 hours	Fast track available for patients discharged to Primary Care
Commencement of Referral	N/A	72 hours (within 48 hours for Inpatient and CRHT discharge)	ICT to recovery referrals are managed by an MDT interface meeting	For some patients in clusters 3 & 4 from ICT Inclusion: High risks, in the context of significant mental disorder Significant medical complexity Treatment resistance characterised by no progress despite interventions.

				Continuous PMHS intervention over 9 months without progress **Requirements on Referral:** **Overview of risk and presenting problem** **HoNOS score and cluster** **Medication summary** **Physical health summary** **Process:** **Via Contact Centre** **Agreed cut off age for CYPS transition is 18th birthday. However, flexible dependant on clinical need. Planning could start 6 months prior and CYPS will retain care coordinator responsibility during transitional period**

Gloucestershire Recovery in Psychosis (GRIP) Early Intervention Team

Referral	Emergency	Urgent	Routine	Comment
Initial Response to Referral	N/A	Response available through daily triage service	Response available through daily triage service	People can transition from CYPS aged 14 onwards
Commencement of Referral	N/A	48 hours	Telephone contact or face to face contact within 14 days	Agreed cut off age for CYPS transition is 18th birthday. However, flexible dependant on clinical need. Planning could start 6 months prior and CYPS will retain care coordinator responsibility during transitional period

Community Learning Disability Team

Referral	Emergency	Urgent	Routine	Comment
Initial Response to Referral	N/A		Assessment commenced within 28 days	Agreed cut off age for CYPS transition is 18th birthday. However, flexible dependant on clinical need. Planning could start 6 months prior and CYPS will
Commencement of Referral	N/A	Within 48 hours for Inpatient and CRHT discharge		

				retain care coordinator responsibility during transitional period

Later Life Community Mental Health Team

Referral	Emergency	Urgent	Routine	Comment
Initial response to referral	**N/A**	**Within 48 hours for Inpatient and CRHT discharge**		
Commencement of referral	**N/A**		**Assessment commenced within 28 days**	

Assertive Outreach Team

Referral	Emergency	Urgent	Routine	Comment
Initial response to referral	**N/A**	**N/A**	**Telephone contact or face to face contact within 10 days**	**Agreed cut off age for CYPS transition is 18th birthday. However, flexible dependant on clinical need. Planning could start 6 months prior and CYPS will retain care coordinator responsibility during transitional period**
Commencement of referral	**N/A**	**N/A**	**Assessment completed within 21 days**	

Complex Psychological Interventions

Referral	Emergency	Urgent	Routine	Comment

Initial response to referral	**N/A**	**Same day**	**Informal consultations are on a daily basis**	**Treatment commenced within 6 weeks of assessment**
Commencement of referral	**N/A**	**Urgent referrals are seen within two weeks**	**Assessment within 4 weeks**	

Autistic Spectrum Condition (ASC)

Referral	Emergency	Urgent	Routine	Comment
Initial response to referral	**N/A**	**N/A**	**Assessment within 28 days**	
Commencement of referral				

Attention Deficit Hyperactivity Disorder (ADHD)

Referral	Emergency	Urgent	Routine	Comment
Initial response to referral	**N/A**	**N/A**	**Assessment within 28 days**	
Commencement of referral				