Llywodraeth Cynulliad Cymru
Welsh Assembly Government

MENTAL HEALTH POLICY GUIDANCE

The Care Programme Approach for Mental Health Service Users

A Unified and Fair System for Assessing and Managing Care

February 2003

IMPROVING HEALTH IN WALES

NHS WALES GIG CYMRU

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Mental Health Policy Wales Implementation Guidance

The Care Programme Approach for Mental Health Service Users

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SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

As part of its commitment to a modern, decent and inclusive society, the Welsh Assembly Government has set out plans for the NHS and its partners, requiring these agencies to work to provide integrated services which will improve the quality of life for everyone.

'Improving Health in Wales A Plan for the NHS with its Partners' set out a programme for tackling inequalities, improving health and service performance and working in partnership. Specifically it gave a commitment to the development of a co-ordinated system of care management in partnership with relevant interests. This is to provide co-ordination between health and social care and primary and secondary care particularly for people with complex problems.

The Adult Mental Health Services Strategy along with the National Service Framework (NSF) sets out the direction and standards for mental health services in Wales. Key Action 29 of the NSF gives a commitment that the Care Programme Approach (CPA) will be introduced across Wales for all people with a serious mental illness and/or complex enduring needs. Services therefore need to be:

- more accessible
- more responsive to provide help and support quickly
- enabled to seek out those who are difficult to engage
- capable of involving service users and carers in all aspects of planning
- effective in using care processes.

Evidence and experience has shown the benefits of providing well co-ordinated care to those suffering with a mental health problem. Mental health service users, particularly those with more complex and enduring needs, often require help with other aspects of their lives such as housing, finance, employment, education and physical health needs.

This places demands on services that no one discipline or agency can meet alone and it's therefore necessary to have an integrated system of effective care co-ordination for all services to work together for the benefit of the service user.

Although the NSF applies to adults of working age the CPA principles also apply to those above the age of 65 and adolescents between 16 and 18 years of age who also meet the eligibility criteria for standard or enhanced CPA as described in the following chapters. Use of CPA in such cases is therefore recommended.

1.2 Background to the Care Programme Approach (CPA)

The CPA was introduced in England in 1991 to provide a framework for effective mental health care. This was mirrored in Wales by the introduction of Guidance on Care Planning process and documentation in February 1998.

A review of CPA was recently undertaken in England and further guidance issued most of which has been adopted and incorporated into this guidance. Some mental health professionals and service users and carers in England had previously expressed concerns concerning the over bureaucratic nature of CPA and its lack of consistency in its application.

In Wales, adoption of a care planning process was not without problems, with many audits indicating that service users did not hold a care plan, and little evidence of any care planning apparent in case notes.

The Welsh Assembly Government is committed to CPA being integrated with the Unified Assessment Process to provide a framework for care co-ordination in mental health care, with service users themselves providing the main focal point for care planning and delivery. Service users are at the centre of this process.

Whatever agency or organisation is first approached must ensure that the individual is not passed inappropriately from one agency to another, and must ensure a corporate and joined up approach is adopted.

Standard 7 of the NSF commits the NHS and Local Authorities to fully introducing CPA across Wales by December 2004, although it is hoped that sufficient progress will be made to enable this target to be met by December 2003.

This guidance does not seek to provide standardised documentation or a single information systems approach across Wales, but rather to set out what the minimum requirements should be. Compatibility between Unified Assessment and CPA documentation should be achieved at a local level.

Included in this guidance are appendices that give examples of documentation, such documents should be adapted by local services to meet their own requirements. Their content represents a minimum requirement that should be evident in any other documentation used.

Social Services and NHS Trusts should aim to standardise documentation wherever possible to reflect natural patient flows between agency and geographical boundaries.

Training seminars have taken place across the whole of Wales during the early part of 2003 to help facilitate local implementation of CPA and to identify any further training needs.

1.3 Integrating the Care Programme Approach and the Unified Assessment System

"Authorities will need to ensure a fully integrated approach to the CPA and the health and social services Unified Approach to Assessing and Managing Care"

A National Service Framework for Wales: April 2002.

"There will be a need to ensure that CPA and the Unified Assessment and Care Management System are fully integrated"

Creating a Unified and Fair System for Assessing and Managing Care.
NHS Wales/Welsh Assembly Government.

How will these approaches be integrated?

The NHS in Wales and the Welsh Assembly Government published 'Creating a Unified and Fair System for Assessing and Managing Care', (UACM) in April 2002. This guidance is designed to support and develop a fully integrated seamless approach to the assessment and care management of all adult service-users and patients, this of course includes adults with Mental Health related needs.

The UACM guidance anticipated the future development of the CPA in Wales and its subsequent integration with UACM System. The UACM guidance currently specifies 'Mental Health' as an area of assessment/domain. (See page 32 of the UACM guidance).

How will this work in practice?

Mental Health assessment area/domain

This domain is retained and CPA will be incorporated within it as appropriate. Some individuals with problems with cognition and dementia, or who do not meet the criteria for CPA may require services under UACM. The domain of mental health will then be assessed. Others who meet the criteria for CPA at Standard or Enhanced levels will go on to this more specialist assessment and management approach.

Care Programme Approach Domain

Health Services, Local Authorities and other agencies should explore the 'Care Programme Approach' domain where it appears that an individual would meet the criteria for Standard or Enhanced CPA. Where a service user does meet the criteria, a specialist/in-depth or more comprehensive assessment will be required. Agencies will need to ensure that they review and adjust current practice to reflect the requirements of the CPA and UACM Guidance.

Care Co-ordinator role and process

Both the CPA and the UACM state that a care co-ordinator should be allocated and that they should have clear responsibility to co-ordinate the service user's care and be the main point of contact for the service user. The decision about who should take on the care co-ordination role should be determined by locally agreed protocols and should take into account professional issues, the views of the service user and local agreements. It will be helpful if health and social services work together locally to incorporate the minimum requirements for the CPA and the UACM paperwork, so that the two processes are combined into one set of documentation at the local level.

1.4 Guiding Principles

This Care Programme Approach is based around the following principles:

- A person centred focused approach determined by the needs of the individual.
- Providing a framework to prevent clients "falling through the net".
- Recognising the role of the carer and the support they need.
- Facilitating the movement of service users through the CPA according to need and service availability.
- Embracing the "best practice".
- Involving all relevant agencies and advocacy services.
- Full integration of health and social care, wherever appropriate.
- Ensuring copies of the care plan are accessible to all relevant parties.
- Including an assessment of risk.
- Including crisis and contingency plans, where appropriate.
- Including the identification of unmet needs.
- Monitoring of the role of the care co-ordinator and the effectiveness of this approach.

1.5 Standard CPA

People accepted to the service will need to meet the eligibility criteria. There are two sub domains to the Care Programme Approach:

STANDARD and ENHANCED

Those service users covered by the Standard Care Programme Approach will be likely to:

- Require the support or intervention of one agency or discipline;
- Or, require low key support from more than one agency or discipline;
- Be more able to self-manage their mental health;
- Have an informal support network;
- Pose little danger to themselves and/or others;
- Be more likely to maintain contact with services.

What does the Standard Care Programme Approach involve?

This sub domain of Care Programme Approach will involve the service user maintaining contact with one or more mental health workers, one of whom will fulfil the role of Care Co-ordinator. All service users will have an initial assessment and care plan. In cases where the service cannot meet the needs of the user, a record of unmet need form will be completed. The need for contingency and crisis plan and the completion of a carer's assessment should also be considered where appropriate.

1.6 Enhanced CPA

Those included on the Enhanced Care Programme Approach will be service users who present with all or some of the following:

- Multiple care needs, including housing, employment etc. requiring inter agency co-ordination.
- Willing to co-operate with one professional or agency, but have multiple care needs.
- May be in contact with a number of agencies (including the Criminal Justice System).

- Likely to require more frequent and intensive interventions.
- More likely to have mental health problems co-existing with other problems such as substance misuse.
- More likely to be at risk of harming themselves and/or others.
- More likely to disengage with services.

What does the Enhanced Care Programme Approach involve?

All service users assessed as requiring to be placed on the Enhanced Care Programme Approach will:

- Have received a holistic initial assessment of their needs, which includes a risk assessment.
- Receive a comprehensive multi-disciplinary/multi agency care plan as appropriate to meet their needs, agreed between the team, the service user (and carer/s where appropriate) and this will include detailed contingency and crisis plans;
- Receive a copy of their care plan
- Have a care co-ordinator allocated with clear responsibilities and tasks as agreed by the care team
- Have regular reviews.

Note that all service users admitted to mental health in-patient services should be considered for the Enhanced Care Programme Approach at least for the duration of the in-patient episode.

It must also be noted that a practitioner may deem it appropriate to place a service user on the Enhanced Care Programme Approach even though they do not meet the above criteria. In such circumstances the reasoning behind this decision must be fully documented.

1.7 Welsh Language

The Assembly Government is positive about the Welsh language and the benefits of bilingualism. Key service areas such as health and social care should be delivered in the service users' language of choice wherever possible.

SECTION 2: THE CARE CO-ORDINATION PROCESS

2. Referrals

2.1 Appendix 1 gives an example of a referral form. All referrals accepted by the Specialist Mental Health Services will have a unified assessment in line with the 'All Wales Guidance for Creating a Unified and Fair System for Assessment and Management of Care'.

2.2 Following this assessment a decision will be made for the person to be offered a continuing service, or be referred back to the referring agency with recommendations relating to their care.

2.3 If a person becomes a service user (i.e. is accepted for continuing care by the Specialist Mental Health Services), the most appropriate professional will be allocated the role of care co-ordinator, with their and the service user's agreement. This person will ensure that:

- An assessment of all the service user's needs has been performed in order to establish the type of service required.
- Referral on to other services is made, where appropriate.
- The case is not closed until acceptance by the agency to which an onward referral has been made, unless the service concerned is beyond the provision of the Specialist Mental Health Services.
- All needs that cannot be met by current service provision are documented and processed using the agreed guidelines.
- All written clinical-practice records are maintained and that all Care Programme Approach documentation is completed accurately and as fully as appropriate.
- Care Programme Approach reviews are arranged and completed appropriately.

3. Making an Assessment

3.1 When a service user has been assessed for a continuing service, an appropriate qualified professional will be responsible for the completion of the agreed CPA form. Appendix 2 gives an example of an assessment form.

3.2 For those service users who are placed on the Enhanced Care Programme Approach, specialist assessments by members of the Community Mental Health Team will be arranged as appropriate.

4. Assessment of Risk

4.1 Service users assessed at any point in their contact with specialist Mental Health services must have a risk assessment form completed.

4.2 Any further information concerning risk to self and/or others must be reflected within the Special Information section of the previously mentioned documentation.

4.3 There should be a unified risk assessment process across local services and at a minimum across Trust boundaries.

4.4 The Care Programme Approach does not prescribe that any specialist risk assessment tools must be used. Therefore professionals are at liberty to use their discretion as to what further specialist risk assessment tools they apply. However, practitioners must ensure that any such tools used for risk assessment are sound and have some research based validity. Appendix 3 gives an example of a risk assessment record.

4.5 Accurate risk assessment relies upon a high quality of history taking, sharing of information between services and locating relevant key past information which may indicate areas of future risk.

4.6 It should be appreciated that the period around discharge from in-patient services is a time of elevated risk, particularly of self-harm. This underlines the need for thorough assessment prior to discharge and effective follow up and support services after discharge.

5. Unmet Needs

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

5.2 Also where referral to another provider agency is made the need may go unmet for some time. As general guidance, where there is doubt practitioners should be advised to document this as an unmet need. Appendix 7 gives an example of a form for recording unmet needs.

6. The Care Plan

6.1 The Care Plan will reflect the assessment detail, in that identified needs are met wherever possible within the plan. Formulation of the Care Plan will involve the service user, and where appropriate their carer and/or advocate, in addition to the team who will provide the delivery of care.

6.2 The service user will be provided with information about the Care Programme Approach and a copy of their care plan, which will:

- Identify the interventions and anticipated outcomes.
- Record all the actions necessary to achieve agreed goals.
- In the event of disagreement, include reasons for this.
- Describe the intensity of planned interventions based on established categories i.e. 1=daily, 2=›3 contacts per week, etc. and give an estimated time-scale by which the outcomes or goals will be achieved or reviewed.
- Detail the contributions of all the agencies involved.
- Include contingency and crisis plans where appropriate (all service users on the Enhanced Care Programme Approach will have these as a required element of their care plan).

6.3 The Care Plan will focus on the service user's strengths as well as his/her needs, and seek to promote recovery and independence. Recognising, reinforcing and promoting strengths at an individual, family and social level will be an explicit aspect of the Care Plan.

6.4 The Care Plan will recognise the diverse needs of the service user, reflecting cultural and ethnic background as well as spirituality, gender and sexuality. It will include action and outcomes in all aspects of an individual's life where support is required, e.g. psychological, physical and social function.

6.5 A copy of the Care Plan will be provided to all personnel on the team directly responsible for care delivery and, with the consent of the service user, any other relevant parties.

6.6 The Care Plan will clearly show the name of the care co-ordinator and other providers involved in care delivery and the next review date. Appendices 4, 5 and 6 give examples of care plan forms.

7. Contingency and Crisis Planning

7.1 All service users on the Enhanced Care Programme Approach must have contingency and crisis plans as part of their care plan. These plans for key elements of the care plan must be based around the individual circumstances of the service user.

7.2 For service users on the Standard Care Programme Approach, it is considered to be good practice to have similar arrangements within their care plans where appropriate.

7.3 **Contingency Planning:** the purpose of this is to prevent circumstances escalating into a crisis by detailing the arrangements to be used at short notice in circumstances where, for example, the care co-ordinator is not available. The Contingency Plan should include the information necessary to continue implementing the Care Plan in an interim situation, e.g. by including the telephone numbers of service providers and the name and contact details of substitutes who have agreed to provide interim support such as the CALL helpline.

7.4 **Crisis Planning:** it may be helpful here to first provide a definition of crisis before outlining the requirements of a crisis plan;

'Crisis is the subjective experience of lack of control, helplessness and perceived inability to cope that a person experiences when he/she is faced with a stressful event that extends beyond their current repertoire of coping mechanisms'

The crisis plan is an explicit plan of action for implementation in a crisis or developing crisis situation. The crisis plan is an integral part of the care plan that specifies action to be taken in a crisis. This may include a number of factors that come together and may place the service user and/or others at risk (e.g. becoming homeless), or may be an agreed plan of action in response to a known relapse indicator.

Crisis situations often occur out-of-hours and can result in emergency intervention being applied. The benefit of anticipating the nature of a crisis is to ensure that appropriate action is taken. Crisis plans could set out the action to be taken, based upon previous experience, if the service user is very ill, or their mental health is rapidly deteriorating.

7.5 Crisis Plans, as a minimum, will ensure that all service users know how to contact the service out of hours.

7.6 Crisis Plans will include the following:

- Early warning and relapse indicators.
- Who the service user is most responsive to.
- How to contact that person
- Previous strategies which have been successful in improving responses or getting agreement for changed care/treatment, e.g. leaving them alone, calling the police, asking a carer to leave the home for a while, etc.

7.7 This information will be clearly stated in a separate section of the Care Plan, which will be easily accessible out of normal hours. Appropriate personnel having access to a CPA IT system, which needs to be developed in each area can achieve this.

8. Support for Carers

8.1 The needs of the service user often relate not just to their own lives, but to the lives of their wider family. All individuals who provide 'regular and substantial' care for a person on the Care Programme Approach will be offered:

- An assessment of their caring, physical and mental health needs which will be repeated on an annual basis; or more often as needs dictate.
- A written Carers Plan, which is agreed with the carer and relates to their caring, physical and mental health needs. For younger carers this will also cover their educational and welfare needs. The Carers Plan will be reviewed on an annual basis.

8.2 Carers will receive information about help available to them, the services provided for the person for whom they are caring, (including medication, other treatments and interventions), and what to do and whom to contact in a crisis. The service user's consent will be sought before disclosure of this information to carers. If consent is refused then the guidance on confidentiality should be referred to (see section 13).

9. The Role of the Care Co-ordinator

Description:

9.1 The term care co-ordinator is specific to the person who designs and oversees the care plan. Those who deliver constituent parts of the care plan must not be called care co-ordinators.

9.2 The care co-ordinator will:

- Be a qualified health or social care professional, e.g. CMHN, Social Worker, Psychiatrist, Psychologist, Occupational Therapist.
- Normally be the qualified professional who has the highest level of involvement with the client.
- Maintain regular contact with the service user and any significant others in the life of the service user so that any changes in health and social circumstances are acknowledged and appropriate action is taken.
- Remain actively involved in the client's care and oversee the care process regardless of setting.
- Remain in regular contact if the service user is admitted to hospital and be actively involved in discharge planning. The care co-ordinator and named nurse must keep in regular contact during admission to plan and implement care.
- Assess service users need and complete the care plan as part of the ongoing review programme. This includes completion and review of risk assessment.
- Ensure appropriate dissemination of these assessments and the care plan in line with service policy around confidentiality.
- Organise and co-ordinate subsequent assessments by other disciplines.
- Inform carers of their right to a carers assessment / carers plan and to complete if agreed as necessary following negotiation with the carer.
- Co-ordinate and monitor the agreed package of care and record any unmet need.
- Regularly review and evaluate the progress of the care plan and adjust the plan accordingly.
- Call regular multidisciplinary review meetings to evaluate the care package and subsequently inform the referrer and all involved parties of any changes in the care of the client.
- Be a consistent point of contact for clients, carers and other professionals.

9.3 For service users on the Standard Care Programme Approach who have contact with only one professional, this person will take on the role of care co-ordinator.

9.4 It is critical that the care co-ordinator has the authority to co-ordinate the delivery of the Care Plan, regardless of agency or origin. It is also critical that the care co-ordinator can understand and respond to the specific needs of the service user that may relate to their cultural or ethnic background.

9.5 The decision about who should be care co-ordinator will be based on consideration of the service user's needs and wishes, balanced against staff availability and appropriateness.

10. Monitoring and Review

10.1 There is no requirement for nationally determined review periods. Frequency will be determined by service user needs, however a review will be required to be performed automatically if one has not taken place within any 12-month period.

10.2 By maintaining regular contact with the service user, the Care Co-ordinator will, in an informal manner, be reviewing and evaluating the Care Plan on an ongoing basis.

10.3 At each review the date of the next review should be set and recorded.

10.4 The review must be viewed as a process that may culminate in a meeting. In this manner the whole care team has an opportunity to contribute toward the review, including the General Practitioner. The care co-ordinator is the hub of this process.

10.5 There may be occasions between formal reviews when more urgent action is needed. This should trigger an emergency Care Programme Approach review and can be initiated by any member of the care team, service user, carer etc. by contacting the care co-ordinator.

10.6 After each review the agreed Care Programme Approach review form must be completed. (Appendix 6 is an example of a CPA review form)

10.7 If the service user is discharged from any member of the care team's provision of intervention this does not indicate discharge from the Care Programme Approach as long as care is still provided by Specialist Mental Health service personnel. A service user cannot be discharged from the Care Programme Approach if they are on the Enhanced Care Programme Approach, they must first be reviewed and placed on the Standard Care Programme Approach. Discharge from the Care Programme Approach can then be initiated.

10.8 Both Health and Social Services have joint responsibility to provide aftercare (Section 117 MHA 1983) to all service users who have previously been detained under Section 3, 37, 47, and 48 (MHA 1983). The review and monitoring process is exactly the same as for CPA other than where specific requirements need to be met under the Act, e.g. when granting Section 17 Leave.

11. Loss of Contact with Services – Enhanced Care Programme Approach

11.1 If it becomes clear that contact with a service user has been lost, a review meeting will be held to consider what action needs to be taken. The care team will make every reasonable effort to re-establish contact. Consideration will be given to contacting the following; carer/family, service user's GP, community teams in other areas (particularly if the service user is known to go to a specific area). The care co-ordinator will take lead responsibility to co-ordinate this activity.

11.2 If the service user is judged to pose a serious risk to themselves and/or others then the Trust's Missing Persons Procedure will be followed.

11.3 The care co-ordinator will document all action taken in trying to make contact and/or trace the service user. A brief entry on the "Special Information" section of the CPA IT system will also be made to reflect such action with the note 'Out of contact' added. The service user's GP will also be advised of the situation.

11.4 Service users may be discharged from the Enhanced Care Programme Approach in exceptional circumstances, for example if the service user has been out of contact for an extended period of time.

11.5 Consideration will be given to seeking the opinion of another doctor within the Mental Health Services, based upon all medical care records of that service user. The care co-ordinator will ensure that the GP and relevant carer/s are informed of any such decision.

12. Refusal to Maintain Contact – Enhanced Care Programme Approach

12.1 Every effort should be made to maintain contact with service users either directly or indirectly.

12.2 This procedure applies to service users on the Enhanced Care Programme Approach whose whereabouts and physical wellbeing are known and who have made it clear that they refuse to engage with services.

12.3 Refusal of engagement will promptly be discussed within the Community Mental Health Team and communicated to the GP. An assessment of the risks that the service user presents to them (including risk of self-neglect) and/or others will be undertaken and plans made accordingly.

12.4 In some circumstances consultation with the Forensic Psychiatric Services may be appropriate.

12.5 Consideration may be given to carrying out a mental health assessment with a view to compulsory admission to in patient services.

12.6 Where there are serious concerns regarding the safety of the public, liaison with the Police and the Probation service may also be appropriate in certain circumstances.

12.7 In all cases, an action plan will be formulated following discussion within the Community Mental Health Team and where appropriate family members and/or other carer/s, should be consulted/informed. The action plan will be clearly documented in the clinical notes and a brief outline of the plan will also be entered onto the Care Programme Register.

12.8 This action plan is likely to include the following elements;

- A formal review during the initial six months following attempts to engage the service user in services. (Prior to this there should be a wide-ranging consultation of people involved in the service user's care/support, which might include some or all of the following: team members, GP, carer/s and family members and other relevant agencies as appropriate, i.e. housing associations, housing officers and voluntary sector agencies).
- A team decision on the minimum type of contact with the service user, e.g. an attempt to visit, an offer of out-patient appointments every three months, contact with carers/relatives etc.
- A full risk assessment.

12.9 In exceptional circumstances a service user may be discharged from the Enhanced Care Programme Approach when there has been no contact for a significant period of time (twelve months for example). This step should be fully discussed by the Community Mental Health Team, documented in the clinical notes and recorded. The care co-ordinator should ensure that the GP and relevant formal and informal carer/s are made aware of any such decision.

12.10 A contingency/crisis plan for access to services should be agreed (see Section 7). Relevant service managers should be informed and involved in this process.

13. Confidentiality

13.1 Involving the service users and their carer/s as fully as possible in the Care Programme Approach means that there is an expectation that personal information will be shared with others in order to provide effective care.

13.2 Personal information is needed to deliver individual care and treatment. Members of the team need to obtain the consent of the service user **before** the information is shared.

13.3 As service users will be involved in negotiating the care they receive, the team has to be clear that, as part of the negotiation, they explain the need to share some personal information. This is to ensure that the service user receives appropriate support to safely meet his or her needs.

13.4 It is also important that the care co-ordinator negotiates with the service user the amount and type of information they are willing to be shared with their carer/s and/or relatives. NB. Team members should familiarise themselves with the policy on confidentiality relevant to their employing organisation, and, if in doubt, should seek advice from their managers and professional organisations as this document contains brief advice that should not be considered to be finite.

13.5 It is important to make a distinction between giving information to informal carers and giving information to the nearest relative who may not be an informal carer.

Building Bridges (1996) page 24, paragraph 2 states:

"Usually it is a good idea if the patient and his or her closest relatives are fully involved in his or her care. However if a patient specifically asks that his family and carers are not involved, his or her wishes must be respected unless they have been appointed by a Court to manage his or her affairs, or there is a public interest ground to give them information (e.g. if they are at risk of violence).

Under the Mental Health Act 1983, there are circumstances in which patients "nearest relative" is entitled to receive information even where the patient objects (e.g. an application for assessment in relation to the patient has been made, or that the patient's mental disorder has been reclassified)"

The Health Service Guidelines HSG (96) 11 gives further clarification:

"The (1995) Mental Health Act requires a patient's nearest relative to be consulted, (unless it is impractical to do so) about the initial application for supervised discharge and subsequently about its review, renewal or ending. A patient may however object to consultation with the nearest relative, ***unless he or she will be acting as the patient's informal carer.*** *The RMO may then consult the nearest relative only if the patient is known to have the propensity to violence or dangerous behaviour toward others and the RMO thinks such consultation is appropriate. The patient's objection should not lightly be set aside and it is for the RMO to judge whether the patient has a propensity to violent or dangerous behaviour (which must be directed towards other people) and if so whether consultation with the nearest relative is advisable in all circumstances."*

13.6 With regard to sharing information with fellow professionals, there is a well-established common law of confidence covering patient information. All information held is likely to be subject to the Data Protection Act 1984.

As a general rule, information given for one purpose may not be disclosed to a third party or used for a different purpose without the consent of the patient. This is well covered in Building Bridges – Chapter 1 and Chapter 3.

13.7 Access to electronic database would enable 24-hour access to services user care plan information.

Referral and Registration

Date & Time of Referral:	**Is this a New Patient?** **Yes/No**

Personal Details Hospital No. _____ NHS No. _____

Surname:

Forenames:

DOB:

Address:

Postcode:

Tel No:

Gender ☐ Male ☐ Female

Ethnic Origin

☐ White UK (A) ☐ Irish (B)
☐ Caribbean (M) ☐ African (N)
☐ Pakistani (J) ☐ Mixed (D-G)
☐ Bangladeshi (K) ☐ Chinese (R)
☐ Other ..... ☐ Indian (H)

Language ☐ Interpreter?

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed

Religion:

Legal Status:

If an inpatient
Hospital Ward

Date & time of admission

Legal Status *(please state if 1st admission)* .....

Nearest Relative *(Legal)*

Name:

Address:

Postcode:

Tel No:

Relationship

Aware of Referral? ☐ Yes ☐ No

Consent to inform? ☐ Yes ☐ No

GP Details

Name:

Surgery Address:

Postcode:

Tel No:

Other Contacts Details: eg Next of Kin if different from Nearest Relative

Name:

Relationship:

Address:
Tel:

Is Contact aware of Referral? ☐ Yes ☐ No

Current Care Co-ordinator

Name:

Role:

Base
Tel:

Aware of Referral? ☐ Yes ☐ No

Sector:		Named Nurse:		Consultant:	

Referral Details

Referral Source: Name ☐ Tel No: Address:

Reason for Referral (*including brief history of, contact with Mental Health Services, physical difficulties and current medication*) ☐ ☐

Vulnerability Screening

Does this person have a history of self-harm?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of aggression to others?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of self-neglect?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of being exploited?	☐ Yes ☐ No ☐ Not Known
Does this person have a criminal record?	☐ Yes ☐ No ☐ Not Known
Does this person live alone?	☐ Yes ☐ No ☐ Not Known

If Yes, indicate access below

If yes, please detail the risk

CPA Level ☐ Standard ☐ Enhanced ☐ Section 117

Other Agencies Involved

Please specify below:

Action/Outcome: OFFICE USE

☐ No Further Action Reason

☐ Refer to Other Agency

☐ Further Information Required

☐ Assessment Required

Carer Details:

Name:

Relationship

Address

Tel No:

If identified complete **Carers Identification section** of Carers Assessment and Care Plan Form.

Referral Completed By

Name:

Role:

Signature:

Date:

Assessment

Name: Date of Birth: ID:

Arrival Time: Departure Time:

Assessed By:

Name	Role	Date	Time	Assessment Location

Presenting Problems: *Include person's own words, description of symptoms and their duration, circumstances leading to referral/admission and any recent stresses*

Mental State Examination	
Appearance	*Behaviour*
Speech	*Thoughts*
Mood	*Perceptions*
Cognitive Function	*Insight*
Sleep	*Appetite*

Previous Psychiatrict History: *Include any psychiatric admissions with legal status, diagnosis and treatment given (eg ECT, medication). Ask what has helped in the past*

Forensic History: *Include any past convictions, current court cases or probation orders*

Current Medication: *List all medication taken by the person, noting route, dose & frequency - Please record duration of treatment where relevant. Indicate compliance with medication / follow-up etc, as well as any side effects*

List all drugs allergies

Substance Use: *Indicate weekly use, what taken, when last used and triggers for abuse*

Alcohol: *Alcohol*	*Drugs:* *Drugs*

Smoker ? ☐ Yes ☐ No *Number per day .....*

Physical Factors: *Include past medical and surgical history with mobility, sight, hearing, speech, relevant family history. List any non-drug allergies*

Assessment

Name:	Date of Birth:	ID:

Personal History: *Include birth details, childhood experiences, schooling, relationships, including sexuality, spiritual/cultural history, personality and interests before illness, current activities*

Current Social Circumstances: *List areas including adequacy of accommodation, Education, Employment, Finance (including Benefits), Support Networks, Routines, Roles and any dependants or significant friends/neighbours.*

Family History: *Indicate if parents are still alive and their state of health, family composition and family psychiatric history*

Assessment Summary: Give top copy to patient and send copy to GP

Name:	Date of Birth:	ID:
Address:		
GP:		
Address		
Assessment Summary:		
Assessment Outcome:		
Service User Comments:		
Service User's Signature:		
Signature	Print Name:	Role: ..... Date:
Signature	Print Name:	Role: ..... Date:
Signature	Print Name:	Role: ..... Date:

Risk Assessment

Name:	
Address	
Tel No:	
Case / Hospital No.:	
NHS No:	

Persons involved in Risk Assessment:

Legal status:

Subject to s117 **YES/NO**

Nature of Risk(s)

a. Self Harm **YES/NO**

b. Violence **YES/NO**

c. Self Neglect **YES/NO**

d. Exploitation **YES/NO**

e. Criminal Activity **YES/NO**

The Enhanced CPA will manage the Patient/Client with a severe mental illness who is considered to be at risk of:

1. Serious Self Neglect or
2. Serious Risk of Suicide or
3. Serious Violence

If there is a substantial risk of the above or serious exploitation consider "After-care under supervision"

Date of HoNOS:

Degree of Risk indicated by:

1. Expressed intent by Patient:

2. Recent behaviour:

3. Current mental health status:

4. Social circumstances

5. Previous behaviour history:

6. Views of others involved:

7. Discrepancy in behaviour:

8. Any other relevant information:

SPECIFIC WARNING INDICATORS *(to be included in contingency / crisis plan)*

ACTION PLAN *(to be included in contingency / crisis plan)*

Form completed by:

Form ratified by:

Date:

Please use continuation sheets as required

Care Plan Standard

Please state if this is an **Amendment** *or* **Extension**

This care plan summarises care needs identified during assessment. You will given a copy to keep by your Care Co-ordinator

Name:			**NHS No:**
Address:			**Tel. No.:**
Assessed Strengths / Needs	**Outcome Expectation**	**How services/interventions will be delivered**	**Start Finish dates**
List of all care needs identified including; adequate housing, stable employment/occupational activity and financial entitlements	*Goals & Objectives*	*List Services/Providers for each need with an Action Plan*	

APPENDIX 4

Comments of Service User/Carer or others involved
Contingency / Crisis Plan *(List all contacts, points of action to be taken, including information for GP)*

Agreement Signatures (A Review date MUST be given)

Patient / Service User	RMO/CRMO	Care Co-ordinator	Date
Carer	GP	Named Nurse (*if different*)	Review Date

Please tell your Care Co-ordinator who you would like copies of this Care Plan to be sent to:

CARE PLAN
(Enhanced CPA)
Mental Health Care Episode

Date of Care Plan:	**HoNOS completed YES/NO**	**Date of HoNOS:**

This Care Plan summaries your care needs which have been identified during the assessment. It gives details about the services to be provided to help you. The Care Plan is about you and your needs, and you will be given a copy to keep. (Your Care Co-ordinator will explain this to you in more detail)

Service user/patient: .....

Address: .....

.....

.....

Tel: ..... DOB: .....

NHS No: ..... Hospital No: .....

G.P: ..... Tel: .....

Address: .....

Chosen Contact Person: .....

Address: .....

..... Tel: .....

OVERALL AIM OF CARE PLAN

REVIEW ARRANGEMENTS *(a date MUST be recorded)*
Review post discharge must be within a month

PLANNED DATE OF FIRST REVIEW OF CARE PLAN
(This should be within a month of start the of Care Plan)

Indicate METHOD OF REVIEW
Individual Contact/Review Meeting/Combination of both

A copy of this plan will be sent to the people involved in the assessment and, if appropriate, to people providing you with a service and to your GP

If you disagree, please tell who you do not want to receive a coy of this plan:

.....

.....

COMMENTS, COMPLIMENTS AND COMPLAINTS

IF THERE IS ANY ASPECT OF SERVICES PROVIDED THAT YOU ARE NOT SATISFIED WITH, YOU CAN DISCUSS IT WITH ANY OF THE PEOPLE NAMED ON THIS CARE PLAN.

DETAILS OF CARE PLAN

ASSESSED STRENGTHS / NEEDS *(including cultural, gender needs)*	**OUTCOME EXPECTATION**
List the care needs that have been identified including; adequate housing, suitable enmployment / occupational activity and financial entitlements	*List the goal and the objectives for each need/strength*

OTHER OPTIONS CONSIDERED - *for any of the needs being met in the Care Plan, give details of other options considered by the service user or assessor. If any of these is a preferred solution to that being provided, please state this clearly.*

HOW SERVICES/INTERVENTIONS WILL BE DELIVERED	START / FINISH DATE	COST TO USER
List action planned including details of who will be providing services		

OTHER COMMENTS - *of user, carer(s), assessor, other agency. Include any outstanding difference of view or unmet needs.*

PEOPLE INVOLVED IN THE CARE PLAN			
PLEASE SIGN IN AGREEMENT WITH CARE PLAN			
Name	**Signature**	**Role**	**Location / Tel. No.**
		Service User/Patient	
		Carer	
		Care Co-ordinator	
		Named Nurse	
		RMO	
		G.P	

GP Specific Information	GP Specific Role

CONTINGENCY PLAN	Name	Tel No.
For general information contact		
Urgent service need contact		
Interim support available from		
Emergency Accommodation at		

WHAT TO DO IN A CRISIS	
Warning Indicators/Signs of Relapse	**Action Plan** *(include strategy and what has worked previously)*

CARE PLAN REVIEW

Mental Health Care Episode

Please refer to the Current Care Plan and amendments when carrying out this review

1. Service user/patient:

Address

Tel No:

DOB: NHS No:

Hospital No:

2. Review completed on:

HoNOS completed on:

3. Review / HoNOS conducted between (dates)

and

4. **Current level of CPA** *(please tick and delete as appropriate)*

Standard ☐ Is the person in receipt of care management provision? YES/NO

Enhanced ☐ Is funding an issue? YES/NO

Has a funding review been undertaken? YES/NO

s. 117 applied YES/NO Legal Status:

5. Method of Review

- Individual Interview with user/carer(s)/advocate/provider ☐
- Review meeting involving the above ☐
- Combination of both ☐

6. Who was involved as part of the review? *Please tick and name.*

☐ Users

☐ Carers/Family

☐ Psychiatrist

☐ General Practitioners

☐ Social Services 'field' workers

☐ Social Services Residential workers

☐ Other NHS Clinical Officers

☐ Voluntary sector workers

☐ Mental Health Nurse

☐ Advocate

7. Date of the latest full Care Plan:

Date of latest amendment to Care Plan *(if any)*:

Date of last review completed:

Date of last Risk Assessment

Date of last HoNOS:

8. Does the user/patient have regular support from carer/advocate? *(Please delete as appropriate)*

YES/NO

If YES, please name

REVIEW

8. SERVICE USER/PATIENT'S VIEW - *eg about needs identified or about relevance of services received*

10. CARERS VIEWS - *eg those identified in section 6 as carers, advocates etc.*

11. DESCRIBE ANY CHANGES IN THE USER'S/PATIENT'S CIRCUMSTANCES SINCE THE LAST REVIEW
- eg physical health, mental health, personal care, accommodation, finances, social situation

12. HoNOS Score Sheet

1.	Overactive, aggressive, disruptive behaviour	
2.	Non-accidental self-injury	
3.	Problem drinking or drug taking	
4.	Cognitive problems	
5.	Physical illness or disability problems	
6.	Problems with hallucinations & delusions	
7.	Problems with depressed mood	
8.	Other mental & behavioural problems	*(Specify disorder A, B, C, D, E, F, G, H, I or J)*
9.	Problems with relationship	
10.	Problems with activities of daily living	
11.	Problems with living conditions	
12.	Problems with occupation & activities	

CARE PLAN REVIEW

13. OVERALL AIM OF CARE PLAN

Does the overall aim of the Plan remain appropriate? *Please delete* YES/NO
(If 'No' a re-assessment of user needs should be undertaken and a new Care Plan completed)

If no Contingency/Crisis Plan exists then a new Care Plan must be completed

14. ASSESSED STRENGTHS / NEEDS /

Are the needs of the user still as detailed in the original Care Plan? *Please delete* YES/NO
Please comment as appropriate

(For minor changes in need, amend the Care Plan. For fundamental changes, consideration should be given to reassessing the user's/patient's situation and fomulating a new Care Plan)

15. SERVICES PROVIDED

Are the services provided as indicated on the Care Plan? *Please delete* YES/NO

Do they remain appropriate? *Please delete* YES/NO
Please comment as appropriate

(If service provision is different or if minor changes are required, amend the Care Plan)

16. UNMET NEEDS/PROPOSAL FOR SERVICE DEVELOPMENT *(complete if required)*

17. CARE CO-ORDINATORS' COMMENTS.

eg reasons for recommendation overleaf. Where amendment to the Care Plan is recommended, describe the specific services to be amended. Remember to amend the latest Care Plan.

18. CARERS

Has a carer been identified? YES/NO
Have they been offered an assessment? YES/NO
Has they Carers Assessment been reviewed (annually)? YES/NO

19. CO-ORDINATORS' RECOMMENDATION

☐	A	Continue service at existing level
	B	Amend Care Plan by;
☐		continuing service at a changed level
☐		adding extra services
☐		withdrawing some services
☐	C	Re-assess user's/patient's needs - complete a new Care Plan
☐	D	Major reduction of services - cease Care Plan and transfer to direct Service Provider to minotor
☐	E	End service provision/Care Plan

RECOMMEND FUTURE LEVEL OF CPA ☐ Standard ☐ Enhanced

Care Co-ordinator's Signature ..... Date

20. SERVICE USER'S/PATIENT'S SIGNATURE

I accept this review ..... Date

21. DATE OF NEXT REVIEW *(mandatory)*

If the Care Co-ordinator responsibility is to transfer to a different worker/team please state:

Name: Location: Date:

22. TEAM MANAGER'S APPROVAL *(essential if financial implications)*

Are the recommendations of the review approved? *Please delete* YES/NO

Comments

Name Team

Signature ..... Date .....

23. Care Co-ordinator responsible for undertaking the review

Name: Location: Tel. No:

Proposal for Service Development

(CPA Recording of Unmet Need)

Report to *(tick as appropriate)*	Health		Social Services	
	Education		Community Services	
	Housing		Hospital Services	
	For Implementation		For Action	

FOR THE ATTENTION OF THE CPA LEAD OFFICER

From:

Name:

Designation:

Workplace:

Tel. No.

Patient / Service User:

Address:

Postcode:

DOB:

NHS No:

Please forward to CPA Lead Officer

1. Resulting from a CPA Meeting on _____ the following Need / service development has been identified

2. The following attempts have been made to meet this need / service deficit

3. The following requirements are highlighted to meet this need / service deficit

4. Action Taken (CPA Lead Officer Use Only)

Referral and Registration

Date & Time of Referral:	**Is this a New Patient?** **Yes/No**

Personal Details | Hospital No. _____ NHS No. _____

Surname:

Forenames:

DOB:

Address:

Postcode:

Tel No:

Gender ☐ Male ☐ Female

Ethnic Origin

☐ White UK (A) ☐ Irish (B)
☐ Caribbean (M) ☐ African (N)
☐ Pakistani (J) ☐ Mixed (D-G)
☐ Bangladeshi (K) ☐ Chinese (R)
☐ Other ..... ☐ Indian (H)

Language ☐ Interpreter?

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed

Religion:

Legal Status:

If an inpatient
Hospital Ward

Date & time of admission

Legal Status *(please state if 1st admission)* .....

Nearest Relative ***(Legal)***

Name:

Address:

Postcode:

Tel No:

Relationship

Aware of Referral? ☐ Yes ☐ No

Consent to inform? ☐ Yes ☐ No

GP Details

Name:

Surgery Address:

Postcode:

Tel No:

Other Contacts Details: eg Next of Kin if different from Nearest Relative

Name:

Relationship:

Address:
Tel:

Is Contact aware of Referral? ☐ Yes ☐ No

Current Care Co-ordinator

Name:

Role:

Base
Tel:

Aware of Referral? ☐ Yes ☐ No

Sector:		Named Nurse:		Consultant:	

Referral Details

Referral Source: Name ☐ Tel No: Address:

Reason for Referral (*including brief history of, contact with Mental Health Services, physical difficulties and current medication*) ☐ ☐

Vulnerability Screening

Does this person have a history of self-harm?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of aggression to others?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of self-neglect?	☐ Yes ☐ No ☐ Not Known
Does this person have a history of being exploited?	☐ Yes ☐ No ☐ Not Known
Does this person have a criminal record?	☐ Yes ☐ No ☐ Not Known
Does this person live alone?	☐ Yes ☐ No ☐ Not Known

If Yes, indicate access below

If yes, please detail the risk

CPA Level ☐ Standard ☐ Enhanced ☐ Section 117

Other Agencies Involved

Please specify below:

Action/Outcome: OFFICE USE

☐ No Further Action Reason

☐ Refer to Other Agency

☐ Further Information Required

☐ Assessment Required

Carer Details:

Name:

Relationship

Address

Tel No:

If identified complete **Carers Identification section** of Carers Assessment and Care Plan Form.

Referral Completed By

Name:

Role:

Signature:

Date:

Assessment

Name: Date of Birth: ID:

Arrival Time: Departure Time:

Assessed By:

Name	Role	Date	Time	Assessment Location

Presenting Problems: *Include person's own words, description of symptoms and their duration, circumstances leading to referral/admission and any recent stresses*

Mental State Examination	
Appearance	*Behaviour*
Speech	*Thoughts*
Mood	*Perceptions*
Cognitive Function	*Insight*
Sleep	*Appetite*

Previous Psychiatrict History: *Include any psychiatric admissions with legal status, diagnosis and treatment given (eg ECT, medication). Ask what has helped in the past*

Forensic History: *Include any past convictions, current court cases or probation orders*

Current Medication: *List all medication taken by the person, noting route, dose & frequency - Please record duration of treatment where relevant. Indicate compliance with medication / follow-up etc, as well as any side effects*

List all drugs allergies

Substance Use: *Indicate weekly use, what taken, when last used and triggers for abuse*

Alcohol: *Alcohol*	*Drugs:* *Drugs*

Smoker ? ☐ Yes ☐ No *Number per day .....*

Physical Factors: *Include past medical and surgical history with mobility, sight, hearing, speech, relevant family history. List any non-drug allergies*

Assessment

Name:	Date of Birth:	ID:

Personal History: *Include birth details, childhood experiences, schooling, relationships, including sexuality, spiritual/cultural history, personality and interests before illness, current activities*

Current Social Circumstances: *List areas including adequacy of accommodation, Education, Employment, Finance (including Benefits), Support Networks, Routines, Roles and any dependants or significant friends/neighbours.*

Family History: *Indicate if parents are still alive and their state of health, family composition and family psychiatric history*

Assessment Summary: Give top copy to patient and send copy to GP

Name:	Date of Birth:	ID:
Address:		
GP:		
Address		
Assessment Summary:		
Assessment Outcome:		
Service User Comments:		
Service User's Signature:		
Signature	Print Name:	Role: ..... Date:
Signature	Print Name:	Role: ..... Date:
Signature	Print Name:	Role: ..... Date:

Risk Assessment

Name:	
Address	
Tel No:	
Case / Hospital No.:	
NHS No:	

Persons involved in Risk Assessment:

Legal status:

Subject to s117 **YES/NO**

Nature of Risk(s)

a. Self Harm **YES/NO**

b. Violence **YES/NO**

c. Self Neglect **YES/NO**

d. Exploitation **YES/NO**

e. Criminal Activity **YES/NO**

The Enhanced CPA will manage the Patient/Client with a severe mental illness who is considered to be at risk of:

1. Serious Self Neglect or
2. Serious Risk of Suicide or
3. Serious Violence

If there is a substantial risk of the above or serious exploitation consider "After-care under supervision"

Date of HoNOS:

Degree of Risk indicated by:

1. Expressed intent by Patient:

2. Recent behaviour:

3. Current mental health status:

4. Social circumstances

5. Previous behaviour history:

6. Views of others involved:

7. Discrepancy in behaviour:

8. Any other relevant information:

SPECIFIC WARNING INDICATORS *(to be included in contingency / crisis plan)*

ACTION PLAN *(to be included in contingency / crisis plan)*

Form completed by:	
Form ratified by:	
Date:	

Please use continuation sheets as required

Care Plan Standard

Please state if this is an **Amendment** *or* **Extension**

This care plan summarises care needs identified during assessment. You will given a copy to keep by your Care Co-ordinator

Name:			**NHS No:**
Address:			**Tel. No.:**
Assessed Strengths / Needs	**Outcome Expectation**	**How services/interventions will be delivered**	**Start Finish dates**
List of all care needs identified including; adequate housing, stable employment/occupational activity and financial entitlements	*Goals & Objectives*	*List Services/Providers for each need with an Action Plan*	

Comments of Service User/Carer or others involved
Contingency / Crisis Plan *(List all contacts, points of action to be taken, including information for GP)*

Agreement Signatures (A Review date MUST be given)

Patient / Service User	RMO/CRMO	Care Co-ordinator	Date
Carer	GP	Named Nurse (*if different*)	Review Date

Please tell your Care Co-ordinator who you would like copies of this Care Plan to be sent to:

CARE PLAN
(Enhanced CPA)
Mental Health Care Episode

Date of Care Plan:	**HoNOS completed YES/NO**	**Date of HoNOS:**

This Care Plan summaries your care needs which have been identified during the assessment. It gives details about the services to be provided to help you. The Care Plan is about you and your needs, and you will be given a copy to keep. (Your Care Co-ordinator will explain this to you in more detail)

Service user/patient: .....

Address: .....

.....

.....

Tel: ..... DOB: .....

NHS No: ..... Hospital No: .....

G.P: ..... Tel: .....

Address: .....

Chosen Contact Person: .....

Address: .....

..... Tel: .....

OVERALL AIM OF CARE PLAN

REVIEW ARRANGEMENTS *(a date MUST be recorded)*
Review post discharge must be within a month

PLANNED DATE OF FIRST REVIEW OF CARE PLAN
(This should be within a month of start the of Care Plan)

Indicate METHOD OF REVIEW
Individual Contact/Review Meeting/Combination of both

A copy of this plan will be sent to the people involved in the assessment and, if appropriate, to people providing you with a service and to your GP

If you disagree, please tell who you do not want to receive a coy of this plan:

.....

.....

COMMENTS, COMPLIMENTS AND COMPLAINTS

IF THERE IS ANY ASPECT OF SERVICES PROVIDED THAT YOU ARE NOT SATISFIED WITH, YOU CAN DISCUSS IT WITH ANY OF THE PEOPLE NAMED ON THIS CARE PLAN.

DETAILS OF CARE PLAN

ASSESSED STRENGTHS / NEEDS *(including cultural, gender needs)*	**OUTCOME EXPECTATION**
List the care needs that have been identified including; adequate housing, suitable enmployment / occupational activity and financial entitlements	*List the goal and the objectives for each need/strength*

OTHER OPTIONS CONSIDERED - *for any of the needs being met in the Care Plan, give details of other options considered by the service user or assessor. If any of these is a preferred solution to that being provided, please state this clearly.*

HOW SERVICES/INTERVENTIONS WILL BE DELIVERED	START / FINISH DATE	COST TO USER
List action planned including details of who will be providing services		

OTHER COMMENTS - *of user, carer(s), assessor, other agency. Include any outstanding difference of view or unmet needs.*

PEOPLE INVOLVED IN THE CARE PLAN			
PLEASE SIGN IN AGREEMENT WITH CARE PLAN			
Name	**Signature**	**Role**	**Location / Tel. No.**
		Service User/Patient	
		Carer	
		Care Co-ordinator	
		Named Nurse	
		RMO	
		G.P	

GP Specific Information	GP Specific Role

CONTINGENCY PLAN	Name	Tel No.
For general information contact		
Urgent service need contact		
Interim support available from		
Emergency Accommodation at		

WHAT TO DO IN A CRISIS	
Warning Indicators/Signs of Relapse	**Action Plan** *(include strategy and what has worked previously)*

CARE PLAN REVIEW

Mental Health Care Episode

Please refer to the Current Care Plan and amendments when carrying out this review

1. Service user/patient:

Address

Tel No:

DOB: NHS No:

Hospital No:

2. Review completed on:

HoNOS completed on:

3. Review / HoNOS conducted between (dates)

and

4. **Current level of CPA** *(please tick and delete as appropriate)*

Standard ☐ Is the person in receipt of care management provision? YES/NO

Enhanced ☐ Is funding an issue? YES/NO

Has a funding review been undertaken? YES/NO

s. 117 applied YES/NO Legal Status:

5. Method of Review

- Individual Interview with user/carer(s)/advocate/provider ☐
- Review meeting involving the above ☐
- Combination of both ☐

6. Who was involved as part of the review? *Please tick and name.*

☐ Users

☐ Carers/Family

☐ Psychiatrist

☐ General Practitioners

☐ Social Services 'field' workers

☐ Social Services Residential workers

☐ Other NHS Clinical Officers

☐ Voluntary sector workers

☐ Mental Health Nurse

☐ Advocate

7. Date of the latest full Care Plan:

Date of latest amendment to Care Plan *(if any)*:

Date of last review completed:

Date of last Risk Assessment

Date of last HoNOS:

8. Does the user/patient have regular support from carer/advocate? *(Please delete as appropriate)*

YES/NO

If YES, please name

REVIEW

8. SERVICE USER/PATIENT'S VIEW - *eg about needs identified or about relevance of services received*

10. CARERS VIEWS - *eg those identified in section 6 as carers, advocates etc.*

11. DESCRIBE ANY CHANGES IN THE USER'S/PATIENT'S CIRCUMSTANCES SINCE THE LAST REVIEW
- eg physical health, mental health, personal care, accommodation, finances, social situation

12. HoNOS Score Sheet

1.	Overactive, aggressive, disruptive behaviour	
2.	Non-accidental self-injury	
3.	Problem drinking or drug taking	
4.	Cognitive problems	
5.	Physical illness or disability problems	
6.	Problems with hallucinations & delusions	
7.	Problems with depressed mood	
8.	Other mental & behavioural problems	*(Specify disorder A, B, C, D, E, F, G, H, I or J)*
9.	Problems with relationship	
10.	Problems with activities of daily living	
11.	Problems with living conditions	
12.	Problems with occupation & activities	

CARE PLAN REVIEW

13. OVERALL AIM OF CARE PLAN

Does the overall aim of the Plan remain appropriate? *Please delete* YES/NO
(If 'No' a re-assessment of user needs should be undertaken and a new Care Plan completed)

If no Contingency/Crisis Plan exists then a new Care Plan must be completed

14. ASSESSED STRENGTHS / NEEDS /

Are the needs of the user still as detailed in the original Care Plan? *Please delete* YES/NO
Please comment as appropriate

(For minor changes in need, amend the Care Plan. For fundamental changes, consideration should be given to reassessing the user's/patient's situation and fomulating a new Care Plan)

15. SERVICES PROVIDED

Are the services provided as indicated on the Care Plan? *Please delete* YES/NO

Do they remain appropriate? *Please delete* YES/NO
Please comment as appropriate

(If service provision is different or if minor changes are required, amend the Care Plan)

16. UNMET NEEDS/PROPOSAL FOR SERVICE DEVELOPMENT *(complete if required)*

17. CARE CO-ORDINATORS' COMMENTS.

eg reasons for recommendation overleaf. Where amendment to the Care Plan is recommended, describe the specific services to be amended. Remember to amend the latest Care Plan.

18. CARERS

Has a carer been identified? YES/NO
Have they been offered an assessment? YES/NO
Has they Carers Assessment been reviewed (annually)? YES/NO

19. CO-ORDINATORS' RECOMMENDATION

☐	A	Continue service at existing level
	B	Amend Care Plan by;
☐		continuing service at a changed level
☐		adding extra services
☐		withdrawing some services
☐	C	Re-assess user's/patient's needs - complete a new Care Plan
☐	D	Major reduction of services - cease Care Plan and transfer to direct Service Provider to minotor
☐	E	End service provision/Care Plan

RECOMMEND FUTURE LEVEL OF CPA ☐ Standard ☐ Enhanced

Care Co-ordinator's Signature ..... Date

20. SERVICE USER'S/PATIENT'S SIGNATURE

I accept this review ..... Date

21. DATE OF NEXT REVIEW *(mandatory)*

If the Care Co-ordinator responsibility is to transfer to a different worker/team please state:

Name: Location: Date:

22. TEAM MANAGER'S APPROVAL *(essential if financial implications)*

Are the recommendations of the review approved? *Please delete* YES/NO

Comments

Name Team

Signature ..... Date .....

23. Care Co-ordinator responsible for undertaking the review

Name: Location: Tel. No:

Proposal for Service Development

(CPA Recording of Unmet Need)

Report to *(tick as appropriate)*	Health		Social Services	
	Education		Community Services	
	Housing		Hospital Services	
	For Implementation		For Action	

FOR THE ATTENTION OF THE CPA LEAD OFFICER

From:

Name:

Designation:

Workplace:

Tel. No.

Patient / Service User:

Address:

Postcode:

DOB:

NHS No:

Please forward to CPA Lead Officer

1. Resulting from a CPA Meeting on _____ the following Need / service development has been identified

2. The following attempts have been made to meet this need / service deficit

3. The following requirements are highlighted to meet this need / service deficit

4. Action Taken (CPA Lead Officer Use Only)