

## INTEGRATED CARE PLANNING APPROACH POLICY

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## DOCUMENT CONTROL

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Members	District Nursing
Members	Older Adult Mental Health
Members	Learning Disabilities
Members	Nursing and Patient Safety
Members	Children and Young Person's Division
Members	Countywide Services Division
Members	Clinical Policy Review Group
Members	Clinical Governance Group

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## 1. INTRODUCTION

- 1.1 This document sets out the policy governing the operation of the Integrated Care Programme Approach (ICPA) within Somerset Partnership NHS Foundation Trust (“the Trust”). This policy incorporates the key elements of national guidance and good practice, including the DH publication “Refocusing the Care Programme Approach – Policy and Positive Practice Guidance” published March 2008, The 2014 Five Year Forward View, No Health without Mental Health (2012) and National Voices (2014). This policy supersedes and is informed by previous policies; the Recovery Integrated Care Plan Approach Policy and the Personalised Care and Care Planning Policy.

## 2. PURPOSE & SCOPE

- 2.1 The Integrated Care Programme Approach provides a framework for effective health care with its principles of assessment, care plan, care coordination, review and putting the patient and where appropriate, the carer, at the centre of the process. In Somerset Partnership, to reflect the move towards integration of physical and mental health services, the process is known as the Integrated Care Programme Approach (ICPA).
- 2.2 This policy and procedure is applicable to all health and social care professionals and clinical support staff within the Trust, in order to fulfil their statutory, professional and contractual obligations with regard to the integrated care programme approach. This includes locum, bank or agency staff. Temporary staff should be advised about Trust requirements as part of their orientation on arrival. This is the duty of permanent staff handing over the care of patients to temporary staff.

## 3. DUTIES AND RESPONSIBILITIES

- 3.1 In accordance with national policy guidance, a lead officer at Executive Director level has been identified. The Chief Operating Officer is the Lead Officer for the ICPA in the Trust. As Lead Officer he/she is responsible to the Board for the implementation of national policy guidance and for ensuring that this policy and associated procedures and processes are implemented and monitored.
- 3.2 The **Chief Operating Officer** has responsibility for ensuring that the ICPA is embedded into clinical systems and processes.
- 3.3 The **Senior Managers Operational Group** has responsibility for monitoring Trust policies and performance items identified for monthly monitoring through the Balanced Score Card.
- 3.4 **Service/Team/Ward Managers** have responsibility for ensuring the quality of clinical interventions and record keeping by their staff, and monitoring compliance with this policy and procedure through the supervision process.
- 3.5 The **Integrated Care Plan Approach Best Practice Group** has responsibility for the dissemination of national and local policy/guideline, the

sharing of best practice, the circulation of audit findings and related action plans to relevant operational staff, and reporting to the Clinical Governance Group.

- 3.6 **All operational staff** (excluding Minor Injuries staff and Staff in Universal Services) whether health and social care practitioners or administrative staff who support them are responsible for ensuring they comply with this policy/procedure and draw to the attention of their line manager any issue where the failure to apply this policy/procedure and supporting record-keeping compromises patient safety and care.
- 3.7 The duties and responsibilities of Care Coordinators, Lead Professionals and Key Workers are described in Section 5 and **Appendix A**.

#### 4. EXPLANATIONS OF TERMS USED

- 4.1 **Integrated Care Programme Approach (ICPA):** the framework for effective health care with its principles of assessment, care plan, care coordination and review.
- 4.2 **Electronic Patient Record (EPR):** a computerised system to record demographic details, episodes of care and all clinical notes in a structured, systematic way.
- 4.3 **CGG:** the Clinical Governance Group which monitors best practice within the Trust.
- 4.4 **CPA Review (or Care Plan Review):** the periodic evaluation and review of a patient's care and treatment by all those involved (including the patient, family/carers, other agencies) to ensure that needs are being met in the best interests of the patient.
- 4.5 **MHA:** Mental Health Act
- 4.6 **Professionals Meeting:** a meeting of professionals from one or more organisation/agency to discuss a particularly complex case and/or where significant risk is identified, where it may not be appropriate for the patient to be present. However the care coordinator should arrange a CPA Review with the patient as soon as possible afterwards to agree the plan.
- 4.7 **Patient** in this policy means anyone in receipt of Trust services – service user, patient, client, child or adult.
- 4.8 **Handover:** the efficient transfer of high quality clinical information at times of transition of responsibility for patients in the absence of their clinical teams.
- 4.9 **Triangle of Care:** refers to collaborative working between patients, professionals and families/carers.
- 4.10 **Lead Professionals:** also referred to as key workers or named nurse

## **5. PRINCIPLES**

- 5.1 The Integrated Care Programme Approach personalises care and support and puts individual patients at the centre of their care and promotes social inclusion and recovery, supporting patients to feel optimistic that care will be effective. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient second.
- 5.2 The ICPA provides a framework for effective health and social care with its principles of assessment, care planning, care coordination and review. It recognises the whole person - supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationship; housing; employment; leisure; education; creative; spiritual; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.
- 5.3 The care plan is the principal document for each patient, supported by a series of assessments and the recording of progress notes. The information contained within it should ensure that safe and effective care is provided. This will be provided in an accessible format.
- 5.4 Self-care and self-management is promoted and supported wherever possible. Action is taken to encourage independence and self-determination, recognising what is important to each new patient and to help them maintain control over their own support and care.
- 5.5 Carers form a vital part of the support required to aid a patient's recovery and staff should encourage family/carer involvement with the consent of the patient. The carers' own needs should also be recognised. The ICPA is underpinned by the principles embedded within the "Triangle of Care", and wherever possible and appropriate, collaboration between Trust Staff, Patients and their Families and / or Carers.
- 5.6 The delivery of the Integrated Care Programme Approach by the Trust will fully take into account issues of age, race, religion/spirituality, disability, ethnicity, gender and sensory loss of patients and where appropriate their carers. The use of a professional interpreter may be necessary as part of the assessment and ongoing care planning process (please see the Professional Interpreting and Translation Service Policy accessible on the Trust Intranet).
- 5.7 Consideration needs to be given to a patient's capacity; and further information in relation to this can be found in the Consent and Capacity policy.

### **Assessment**

- 5.8 All patients will receive an initial assessment, to be recorded in accordance with the procedures and standards outlined in the Trust's Record Keeping and Records Management Policy. In determining patients who are likely to benefit from a coordinated approach to their treatment, the factors identified

in **Appendix B** should be considered. In addition, the following key points should be noted:

- the assessor is responsible for conducting a thorough clinical assessment and for ensuring that sufficient information is recorded to document both the assessment and to justify any decisions made and any interventions/treatments offered or recommended. Further assessment must be subsequently conducted and recorded if there is further involvement with the patient.
- assessment is a continuing process and information recorded at the initial assessment must be reviewed and updated.
- risk screening and assessment must be undertaken, where appropriate, and recorded in the appropriate place on EPR at regular intervals. The Trust “Clinical Assessment and Management of Risk of Harm to Self and Others”, “Safeguarding and Protection of Children”, Pressure Ulceration – Policy for Prevention and Management, Venous Thromboembolism Policy, Care Act 2014 and “Safeguarding Adults at Risk”, policies should be read in conjunction with this policy and the procedures applied and actions taken recorded appropriately;
- carer’s needs should be considered and recorded, but any actions/outcomes must always be in the patient’s best interests. Where there are conflicting needs and/or a lack of agreement between patients and carers, advice from a colleague or member of the Trust Safeguarding Team should be considered;
- support for carers can be accessed through the carer’s assessment service or signposted as appropriate.
- an assessment must be made of whether the patient has needs which are eligible for a personal budget from Somerset County Council under the national eligibility criteria;

They may be eligible for help if:

- Their identified need results from illness or disability, and
- There is a need for support to achieve outcomes in two or more areas of life, and
- Failure to achieve these outcomes would result in a significant impact on their wellbeing

5.9 Where it becomes apparent during the initial assessment that ICPA is not appropriate, Local requirements for record keeping and care planning will be followed.

5.10 Adult Mental Health Patients only: HONOS and Care Cluster rating should be assessed within one month of initial contact

### **CPA Level**

5.11 The level of care (CPA Level) is defined as follows based on patient factors – presentation/needs/risk/complexity:

- **Level One –:** Typically this refers to patients with more straightforward needs, lower risk, sole agency or no problems with access to other agencies/support. Patients on Level One are likely to be accessing one intervention/piece of treatment where coordination is not currently indicated, and therefore where a Lead Professional, Key Worker or Named Nurse would be allocated.
- **Level Two:** - Typically this refers to patients with complex needs, co-morbidity and current or imminent higher risk. Patients assigned as Level Two will be active; where there is frequent and ongoing treatment that requires coordination.
- **Care Managed – Somerset Partnership:-** Typically this refers to patients with complex needs, co-morbidity and higher risk. Where coordination of treatments is indicated but where this coordination is less active e.g. infrequent contact with the service and as review only.
- **Care Managed – Local Authority:-** where it has been agreed care management is best held by the Local Authority due to its more active involvement.
- **Care Managed – Other NHS Care:-** care management is best held by other NHS organisation (including GP practices) due to their more active involvement.

5.12 Following initial assessment, the appropriate level of care (CPA Level) must be allocated for all patients in accordance with the criteria outlined in **Appendix B**.

5.13 The level of care (CPA Level) for each patient must be reviewed regularly against the criteria set out in **Appendix B** and amended as appropriate.

5.14 Some external contracts for the provision of inpatient services will be excluded from CPA processes (e.g. MOD/mental health patients and patients whose treatment is being coordinated by Tertiary centres).

**Care Coordination (NB the following section applies to patients allocated as Level 2 and Care Managed – Somerset Partnership)**

5.15 A named Care Coordinator must be allocated to any patient who is subject to CPA Level 2 or Care Managed – Somerset Partnership (above). The patient may request a specific gender for their Care Coordinator and this will be honoured wherever possible. However, if this is not possible for staffing or clinical reasons this will be explained fully to the patient. (See Appendix A).

5.16 A Lead Professional is the named contact for patients receiving treatments where coordination is not indicated (e.g. Level One- See Appendix A).



5.17 The Care Coordinator is responsible for:

- monitoring/managing the care plan; including ensuring that other professionals have outlined their interventions/treatments.
- ensuring there is regular contact with the patient; particular focus may be appropriate during service changes;
- advising other members of the care team of changes in circumstance of the patient which might require a review or change of care plan;
- recording – including updating the Care Plan and risk management and relapse/escalation plans as necessary;
- the organisation of care reviews;

5.18 For further details on the role of the Care Coordinator, see **Appendix A**.

5.19 The Care Coordinator role can be allocated to another named person at any point during an episode of care, with the agreement of the new Care Coordinator and following discussion with the patient and Team Manager. Both Lead Professional and Care Coordinator can delegate tasks.

**Care Planning (NB the following section applies to patients allocated as Level 2 and Care Managed – Somerset Partnership)**

5.20 All patients (following the initial assessment phase) must be offered a single care plan in an accessible and understandable format in accordance with the procedures and standards outlined below. {See Appendix C for care planning guidance}

5.21 Care planning should be personalised, putting the patient at the centre of the assessment and planning process. A holistic approach will have a positive impact on their wellbeing and will help patients to make informed decisions regarding their care.

5.22 Care plans should reflect both immediate and long term goals and will identify how and when they are achieved, and should, where possible and relevant, consider contingency or emergency planning for those living with long term conditions.

5.23 The care plan must outline the way in which the patient, Care Coordinator (where indicated) and others will work together to reach and maintain the patient's best possible level of comfort, dignity and wellbeing. It should:

- recognise and use the strengths and resources of the individual;
- support the development of resilience;
- record outcomes, support and action that have been agreed;
- be written in a personalised manner; for example, **to** the patient (e.g. *"We will help you to.."*) avoiding jargon and using language accessible to the patient and their family/carer;
- exist for the benefit of the patient and be based upon needs and where possible, the patient's wishes; not upon the services the Trust can provide;
- respect and reflect the patient's age, culture, ethnicity, gender and sexuality, religion/spirituality, disability and sensory loss;

- be dynamic – at all times reflecting the current agreed plan to meet the changing needs and goals of the patient;
- as each goal is achieved or care needs cease, the care plan must be updated and the relevant section closed;
- include a telephone number for urgent help or advice (out of hours) and detail the needs and actions in the event of crisis;

5.24 Care Plans should be written in a manner that is ‘SMART’:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imely

5.25 The Care Plan Library facility is available when writing care plans; but should be adapted and personalised.

5.26 The care plan for all areas where electronic documentation is available on Level Two or Care Managed – Somerset Partnership can be created updated and printed using the RiO Care Plan module or agreed alternative. This must be the overarching plan, and must make reference to any other contemporaneous detailed plans.

5.27 If a patient does not attend planned appointments or unavailable for a scheduled visit, the Care Coordinator may need to be informed and guided by clinical judgement in relation to safe and effective care. The Care Coordinator should try to maintain contact and negotiate, if possible, acceptance of some elements of the care plan. Decisions about an appropriate course of action must be made, based on the knowledge of the individual involved. If the Care Coordinator is in any doubt about the correct course of action then it must be discussed with the relevant Team Manager.

**Care Reviews (NB the following section applies to patients allocated as Level 2 and Care Managed – Somerset Partnership)**

5.28 The Care Coordinator is responsible for ensuring that the plan of care is reviewed with the patient and other professional and informal carers at intervals determined by the particular circumstances of the case/patient’s condition, but in accordance with the following standards:

- the maximum interval between reviews is twelve months;
- the patient may request that a review be brought forward to the earliest convenient date;
- a review must be undertaken at any significant change in the patient’s clinical presentation or treatment/care;
- a review must take place before discharge from inpatient services and where indicated again within 28 days of discharge. For mental health patients this is a requirement (see Suicide Prevention Strategic Plan);

5.29 The format of a care review is determined by the Care Coordinator/Lead Professional, under the supervision of their manager, and in consultation

with the patient. The review should always involve discussion between care coordinator and patient. Others involved in the care of the patient may contribute to the review in a variety of ways:

- by informal discussion or correspondence with the Care Coordinator
- one or more brief meetings between the Care Coordinator and other professionals or informal carers;
- through meeting together in a “Professionals Meeting” arranged with or without the patient present (but with his/her knowledge) to discuss a particularly complex case and/or where significant risk is identified (if the patient is not present, the Care Coordinator should arrange to meet with the patient as soon as possible afterwards to agree the plan);
- through a formal “Case Conference or Multi-Disciplinary Meeting.”

5.30 Whatever format is chosen, it should include consideration of:

- the patient’s view of the care plan including the acceptability of the interventions offered;
- progress towards identified goals;
- any new/altered needs;
- any significant risk issues and any newly identified risks (reassess using the risk screening);
- a review of physical and mental health and health promotion (including annual health checks and screening programmes);
- diagnosis and associated risk;
- relapse/escalation plans;
- medication;
- the views and needs of relevant family members, carers or significant others;
- changes required to the plan as a result of all the above;
- services from which the patient would significantly benefit but which are unavailable (Service Managers should be made aware of these);
- the need for continued Section 117 aftercare services (where relevant);
- the need for or review of existing advance decisions;
- the date by which the care plan will next be reviewed;
- the CPA level;
- the means by which the user may re-access services if a decision is taken to discharge the patient;
- equality and diversity;

5.31 The patient has a right to request a review of their care (including medication).

5.32 Care reviews for patients subject to CPA Level One may be conducted over the telephone at the discretion of the Lead Professional in consultation with the patient, where only the lead professional and patient are going to be involved in the meeting.

- 5.33 For mental health patients subject to CPA Level 2 or Care Managed – Somerset Partnership, additional guidance and the national requirements in relation to care plan reviews are outlined in **Appendix D**.
- 5.34 Within all teams, the Team Manager is responsible for ensuring that there is a robust mechanism to prompt and supervise Care Coordinators and Lead Professionals in arranging and conducting reviews. Where psychiatrists are the only health professionals involved in a case, the lead physician is responsible for ensuring that the care plan is reviewed in accordance with this policy. The relevant manager should be aware of any cases managed in this way.

### **Patient and Carer Involvement**

- 5.35 Given the principles of ICPA (see 5.1 above), the Integrated Care Programme Approach must be explained verbally and an ICPA leaflet given to both the patient and where appropriate, the carer. The “Confidentiality of Service User Information” must also be given to patients (and where appropriate carers).
- 5.36 With the patient’s agreement (or in their best interest), families and carers must be consulted on their personal experience and knowledge of recognising and coping with the patient’s difficulties. Carers often make a significant contribution to the support identified on the care plan and as such, they should be clear about the proposed plan and the support available to them, especially in times of crisis.
- 5.37 Where a carer is providing regular and substantial support, they should be made aware of their right to an individual assessment of their own needs. This offer must be recorded within the patient’s record (community health) and in the initial carer’s assessment within the patient’s record (mental health). If the carer declines a formal assessment, this should be recorded in the same way and every attempt should still be made to assess needs and record them informally. The offer of a formal assessment should be repeated no less than annually.
- 5.38 Where a carer wishes to have a formal assessment, this must be recorded within the patient’s record (community health) and within carer’s own record (mental health). Further communication about the carer’s needs should be recorded in the same way. The needs of any young people providing carer support must also be considered. The diversity needs of carers must be taken fully into account when assessing their needs.

### **Transfer of Care**

- 5.39 Care Coordinators/Lead professionals are responsible for the safe and prompt transfer of care between Somerset Partnership teams and services, and where necessary the transfer of care to other agencies and providers within and outside Somerset.
- 5.40 If a Care Coordinator/Lead professional is not available and a patient need is identified, local arrangements for cover will be set up.

- 5.41 Individual care plans should include detailed plans of the transfer of care with individual actions of staff highlighted.
- 5.42 The principles outlined above should be followed when transferring cases or transferring the coordination of care to other agencies/organisations within Somerset or other secondary care mental health providers.
- 5.43 When patients are transferred to Acute/District Hospitals, please refer to “Transfer of Patients from the Trust to General Hospital Care” policy.

### **Discharge of Care**

- 5.44 For Adult Mental Health patients only: HONOS should be recorded at the time of discharge from any inpatient
- 5.45 Discharge goals and the likely duration of intervention should be negotiated during the assessment, allocation and care planning process, and should meet the agreed outcome/goals of the patient and be clear and achievable (see **Policies : Admission, Transfer and Discharge (Community Hospital Inpatient) Policy**).
- 5.46 For secondary care mental health patients additional guidance and the national monitoring requirements in relation to the discharge of patients are outlined in the **Transfer of Patients to Acute Hospital Care Policy (April 2013)**.

## **6. TRAINING REQUIREMENTS**

- 6.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- 6.2 All health and social care practitioners involved in care planning should ensure they are familiar and competent in the theory and practice of care planning.
- 6.3 In addition, the record keeping processes supporting ICPA are included in EPR training programmes.

## **7. EQUALITY IMPACT ASSESSMENT**

- 7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

## **8. MONITORING COMPLIANCE AND EFFECTIVENESS**

- 8.1 The Clinical Governance Group (CGG) is responsible for monitoring overall compliance with this policy, receiving assurance from the ICPA Best Practice Group (which reports to the CGG) in the form of audit results and monitoring reports of compliance with the ICPA policy and procedures.
- 8.2 This policy will be regularly reviewed and maintained by the ICPA Best Practice Group. Review of the policy will occur at least once every three years or sooner if required due to local or national guidance.

### **Methodology to be used for monitoring**

- 8.3 The quality of clinical records will be monitored in three ways:
- 8.3.1 Audit of this policy is incorporated into the Trust's three year Clinical Audit Plan, and will be appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking the audit and signing off key recommendations is held by the ICPA Best Practice Group. Progress with any recommendations is included within the ICPA Best Practice Group six-monthly report to Clinical Governance Group.
- 8.3.2 Some ICPA standards will also be audited as part of other clinical audits.
- 8.3.3 Key Trust performance or risk-related standards are audited via continuous monitoring through the Trust Balanced Score Card, which is presented to the Senior Managers Operational Group monthly.

### **Dissemination of Audit Findings**

- 8.4 Clinical audits are presented to relevant Best Practice and Audit Groups.
- 8.5 All clinical audits are published on the Trust Intranet and highlighted through the Trust newsletter.

## **9. COUNTER FRAUD**

- 9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

## **10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS**

- 10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the **fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment

Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

## 11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

### 11.1 References

Health and Social Care Act 2012 (DoH)

Still Building Bridges: The Report of a National Inspection of Arrangements for the Inspection of Care Programme Approach with Care Management (DoH March 1999)

Carers' (Recognition and Services) Act 1995 (DoH)

Effective Care Coordination in Mental Health Services, 1999 (DOH)

National Service Framework for Mental Health: modern standards and service models (DoH February 2007)

Making Recovery a Reality, 2008 (Sainsbury Centre for Mental Health)

10 Essential Shared Capabilities – a framework for the whole of the mental health workforce, 2004 (DoH, NIMHE)

New Ways of Working for Everyone, 2007 (DoH)

Our Choices in Mental Health, 2006 (CSIP/NIMHE)

Independence, Choice and Risk: a guide to best practice in supported decision-making, May 2007 (DoH)

Refocusing the Care Programme Approach, 2008 (DoH)

Children Act, 1989

NICE Clinical Guideline 136 Service User Experience in Mental Health

NICE Public Health Guideline 48 Smoking cessation - acute, maternity and mental health services

Care Act 2014

## 11.2 **Cross reference to other procedural documents**

Admission, Transfer and Discharge (Community Hospital Inpatient) Policy  
Advance Decisions / Statement of Treatment Preferences (please refer to the Resuscitation Policy and the Do Not Attempt Resuscitation (DNAR) Policy  
Clinical Assessment and Management of Risk of Harm to Self and Others Policy  
Consent and Capacity to Consent to Examination and/or Treatment Policy  
Medicines Policy  
Medicines Reconciliation Policy  
Physical Assessment and Examination of Service Users Guidelines  
Pressure Ulceration – Policy for Prevention and Management  
Professional Interpreting and Translation Service Policy  
Record Keeping and Records Management Policy  
Safeguarding Adults at Risk Policy  
Safeguarding Children Policy  
Section 117 Aftercare Policy  
Single Equality Strategy  
Spiritual Care Policy  
Venous Thromboembolism

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

## 12. **APPENDICES**

12.1 For the avoidance of any doubt, the appendices in this policy constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	The Role of the Care Coordinator, Lead Professional and Key Worker
Appendix B	Checklist of Criteria to Determine what integrated Care Planning Approach Level (ICPA) applies
Appendix C	Care planning guidelines
Appendix D	CPA requirements for secondary care mental health services
Appendix E	Audit Standards





Somerset Partnership NHS Foundation Trust

## **THE ROLE OF THE CARE COORDINATOR, LEAD PROFESSIONAL, NAMED NURSE AND KEY WORKER**

### **1. A Care Coordinator may undertake the following tasks:-**

#### **Clinical**

- Develop, review and implement programmes of care for individual patients, ensuring preventative actions within the programme, ensuring appropriate use of hospital beds.
- Empower patients and facilitate a “self-management” approach for patients and carers.
- Assessing and interpreting patient conditions and taking appropriate action e.g. responding to the patient need for specific clinical interventions, within the scope of practice that will ensure appropriate hospital bed use.
- Coordinate timely and effective multi-disciplinary and multi-agency services, appropriate for patient’s needs. Work in partnership with hospital and primary care staff in the planning of appropriate care.
- Provide leadership in complex care coordination.

#### **Communication**

- Establish and maintain excellent communication with individuals and groups, exploring complex issues relating to care options and decisions.
- Provide written communication in the form of care management plans and reports, ensuring high quality of care and appropriate resources to meet individual patient needs.
- Chair meetings related to service delivery or case management for individuals or groups of patients.
- Effectively managing patient information and analysing data from a clinical perspective.
- During an inpatient stay, the named Care Coordinator will maintain an active interest including:
  - Close liaison about reasons for admission;
  - Visiting the patient on the inpatient ward;
  - Early identification of and action on community issues that will need addressing before discharge.

- Providing input into multidisciplinary meetings;
  - Attending discharge reviews.
2. The role of Care Coordinator/Lead Professional can be undertaken by any professionally qualified member of staff (Band 5 or above).
  3. Health and Social Care Practitioners who are identified as Care coordinators (including Lead Professionals) must ensure that their details on RiO have been configured correctly - flagged as a Care Coordinator, the correct Care Coordinator Occupation Code, with full details of work address, telephone number and email address (email: [ITServices@sompar.nhs.uk](mailto:ITServices@sompar.nhs.uk))
  4. The procedure for nominating Care Coordinators should be agreed by each team with the aim of ensuring:
    - They have the relevant experience and skills to address the needs of the patient;
    - They have a good knowledge of service provision, community resources, roles of various agencies and can access resources;
    - They have an understanding and awareness of any particular race, culture and gender issues relevant to the patient;
    - They have access to appropriate levels of supervision and caseload management information;
    - They are best placed to offer continuity so that changes are kept to a minimum;
  5. Wherever possible, the wishes of an individual to choose the gender of their Care Coordinator should be considered. If this is not possible, reasons will be given.
  6. There will be circumstances when a patient is admitted to a ward from the community. If this person already has an allocated Care Coordinator, then the day-to-day responsibility for updating assessments, the care plan and reviews will transfer to the Ward Key Worker/Named Nurse.
  7. When a patient is admitted to a Mental Health inpatient ward without an allocated care coordinator, the appropriate team manager must arrange for one to be allocated within two weeks to facilitate discharge planning. The Ward Manager may be recorded as the Care Coordinator as an interim measure.
  8. It is the responsibility of the Care Coordinator to involve, or take advice from, senior medical colleagues and/or specialist services where appropriate.

**A Lead Professional / Key Worker / Named Nurse may undertake the following tasks:-**

Be the key contact person for patients and their families/carers where it has been assessed that coordination is not indicated.

A Lead Professional / Key Worker or Named Nurse will typically be allocated to patients receiving 'single' interventions or 'single' course of treatment.

The Lead Professional will be the identified clinician responsible for:-

- Ongoing recording
- Liaison with patients/carers/family members and where indicated other agencies.
- Providing ongoing review for the need for coordination.

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### Checklist of Criteria to Determine what integrated Care Planning Approach Level (ICPA) Applies

- Consider ICPA level **after** a thorough initial assessment of the patient’s symptoms, distress, degree of functioning and risk, and reassess/review periodically.
- No CPA Level is a permanent classification. Holistic assessment and review processes will guide the correct allocation of CPA level.
- Changes to ICPA level may result in a change of professional, however for most clients moving through the ICPA levels the professional will remain the same.
- When allocating ICPA level, consider; ethnicity, employment, gender, sexuality, sensory, accommodation, carers responsibility, reliance of carers and impact these issues have on health and risk.
- When allocating ICPA level consider clients and carers view and views of any agencies/services providing care.

<b>CPA Level One - Lead Professional / Key Worker or Named Nurse</b>	
1	Single specific need which is more straight forward and not complex.
2	Care is provided by a single service but client can independently access other relevant support if required.
3	Simple care plan/plan of care (one professional).
4	Lead professional can delegate task to other services/support staff, if task is related to the work they are doing.
<b>CPA Level Two - Care Co-ordination</b>	
1	Patient has single complex need or complex multiple needs.
2	Patient has a dual diagnosis (complex, physical, mental health need and or substance misuse).
3	Patient has a care plan that requires regular review due to severe physical or mental illness or social needs.
4	Patient has known clinical risks which are either acute or long term or both.  Risks would include: Self-neglect, self-harm, harm to others, non-compliance with essential medical treatment, suicide, environmental risk/accidental self harm, deterioration in physical or mental health, risk to children, risk of exploitation, change in prognosis, risk of severe disablement or death, multiple comorbidities, complex physical health needs.
5	Current safeguarding concerns.
6	The patient is an inpatient, or being seen in other intensive community treatment and/or support.
7	The patient is subject to the Mental Health Act (including Community Treatment Orders but excluding Section 117 after care).
8	The patient is receiving active interventions from a number of different Trust services and/or agencies including housing, physical care,

	employment, criminal justice and voluntary agencies which require <i>active</i> care coordination by Somerset Partnership.
9	There is a current and historical complex family/parental situation that impacts upon the “recovery” potential of a young person and there are emotional and psychological disturbances that could precipitate a severe mental disorder.
10	The patient has a significant reliance on carer(s) or has his/her own significant caring responsibilities and Somerset Partnership is the sole/lead agency.
<b>Care Managed Somerset Partnership</b>	
1	Patient has a severe physical and/or mental health or complex social care needs that are stable or managed by a care plan which is purchased solely from other agencies which requires statutory review by Somerset Partnership staff. (Purchased care can be self-funded and/or funded by Social Services (personal care budgets) and/or Continuing Health Care or Funded Nursing Care.
2	Patient does not require regular treatments/interventions provided by Somerset Partnership.
<b>Care Managed – Local Authority</b>	
1	The Local Authority (e.g. Adult Social Care, Children’s Services, Adult Learning Disabilities) is best placed to coordinate care due to its more active involvement.
2	Any other agencies involved are supporting the care plan and are in agreement with care being coordinated by the Local Authority.
<b>Care Managed – Other NHS</b>	
1	Primary care (e.g. GP, Practice nurse) is best placed to coordinate care due to its more active involvement.
2	Any other agencies involved are supporting the care plan and are in agreement with care being coordinated by primary care.

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## Care Planning Guidelines

The following guidelines are designed to assist staff working with patients to develop effective collaborative care plans. There are many factors that need to be considered when developing care plans for clients, such as consent, capacity, choice and whether the patient is detained under the Mental Health Act and these guidelines do not address all these issues but are designed to provide basic principles for care planning.

The principles of the ICPA policy are that the care plan will be coordinated by the Care Coordinator in the community or the Named Nurse/Key Worker/Inpatient Coordinator within the hospital setting. In addition to this, specialist or other services can add sections to the care plan specific to the interventions they are providing for the patient.

*In these guidelines, Care Coordinator will be used to refer to the following, Care Coordinator, Key Worker/Named Nurse/Inpatient Coordinator.*

- Be clear about your role, Care Coordinator or a service adding in to the care plan as this will determine your responsibilities. The Care Coordinator will have responsibility for the whole care plan but a service providing specific interventions for the patient will only be looking at a specific intervention on the care plan.
- The Care Coordinator should discuss with the patient the involvement of carers, relatives and friends in the care planning process. If the patient chooses to involve carers and relatives they should be involved throughout the care planning process. If the patient chooses not to involve carers in the care planning process the Care Coordinator should consider the level of support the carer provides or would be expected to provide in the future and this should be discussed with the carer.
- There needs to be a comprehensive assessment of the patient's needs which has been discussed with the patient.
- A face to face meeting then needs to be held with the patient to discuss which needs identified in the initial assessment are going to be addressed and together agree realistic goals.
- The Care Coordinator will discuss with the patient a range of intervention options to meet the identified needs.
- Once the patient has chosen which interventions they prefer then the patient and Care Coordinator will work together to develop the care plan based on the already identified needs, intervention choices and goals.
- Each identified need will have its own section in the care plan which identifies the need, the chosen intervention, who will do this and when it will be achieved by and the review date. The Care Coordinator and patient will work together to determine SMART outcomes S=Specific, M=measureable A=achievable, R= realistic and T= time frame.

- Once the care plan is completed a copy is given to the patient for their reference. Additional copies can be sent to carers and/or other agencies/professionals.
- Future work with the patient will be based on the care plan and working with the patient to achieve their agreed goals.
- The interventions should be reviewed regularly against the goals and the identified time frame to ensure that the chosen intervention is effective.
- Regular formal reviews of the care plan should be carried out with the patient and any other services providing care to ensure the goals remain SMART, effective and the patient remains clear about the interventions. At a formal review, the care plan can be changed;
  - if the patient is not happy/not engaging with the current intervention
  - the intervention is not achieving the desired outcome and there is an alternative intervention.
  - if the patient's condition has changed and further assessments have indicated different needs/interventions.
  - if the goals need to be changed.
- Once a patient has achieved an identified goal, the relevant section in the care plan should be closed and the outcome recorded.
- When all the goals are achieved or discontinued the Care Coordinator should review the care plan with the patient and consider discharge from the service or transfer to other services for further treatment.



## 12 Principles for Care Planning

No.	
1	The care plan is the principal document for each patient and is supported by a series of assessments and the progress/continuation records. The information contained within it should ensure that safe effective care is provided.
2	Each patient should have only one active care plan in place (multi-disciplinary where applicable).
3	The care plan should record what is important to the patient, and the key care needs and specific goals to be achieved.
4	The patient should be an equal partner in the care planning discussion and carer/relative where appropriate. Where the patient lacks capacity the views of others who know the patient should be taken into account.
5	The care plan should use language that the patient understands with no abbreviations or use of jargon.
6	A current copy of the care plan should be offered or made available to each patient.
7	We encourage the involvement of all members of the team in care planning but the qualified professionals remain accountable for the care plan
8	The progress notes /continuation records must reflect the care needs in the care plan and <b>not replace them.</b>
9	As each goal is achieved or care needs cease, the care plan must be updated with the patient and the relevant section closed.
10	The care planning process starts at the first appointment or on admission, and for inpatients an interim care plan should be in place within 4 hours of admission. It should identify key risks, priorities, individual goals and timeframes.
11	The working care plan should be in place within 24 hours in Community Hospitals and 72 hours within mental health inpatient units, and in the community once the initial assessments have been completed.
12	The care plan remains a live document and should be reviewed regularly with the patient and updated at any time the care needs change.

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## CARE PLAN REVIEW PROTOCOL

### (Secondary Mental Health Services only)

1. The Mental Health and Learning Disability Minimum Dataset (MHLDMDS) requires a formal recording of care plan reviews at least annually for all patients subject to 'CPA Level Two' or 'Care Managed – Somerset Partnership' using the RiO CPA Review section.
2. Patients subject to 'CPA Level One' may be reviewed in a less formal way by means of updating and circulating a RiO care plan or plan of care letter to the patient (copying in the GP). Plan of care letters shall be uploaded to documents using plan of care letter document code PCL.
3. One meeting can fulfil many review of care requirements; for example in the hospital environment one meeting can cover CPA, Section 117 aftercare arrangements and discharge planning and similarly an individual's status under the Mental Health Act can be reviewed at a CPA review meeting when in the community.

#### 4. Pre CPA Review

- 4.1. Consider what style of review would be appropriate for the patient concerned. CPA Level One reviews (not 'CPA Level Two' or 'Care Managed – Somerset Partnership' reviews) may be conducted over the telephone at the discretion of the lead professional in consultation with the patient, where only the lead professional and patient are going to be involved in the review. If any other professional or family carer is involved in the review, then a face-to-face meeting is indicated.
- 4.2. Consider who needs to be invited, and if unable to attend, invite them to submit a written report.
- 4.3. Identify the consultation/meeting as a Care Plan Review.
- 4.4. Provide information to the patient/carer about the purpose of a Care Plan Review, including who will be present.
- 4.5. Allocate sufficient time for the review

#### 5. At CPA Review

- 5.1. The care co-ordinator should normally chair the meeting (but see section 7 below regarding complex/risky cases).
- 5.2. Ensure that everyone involved is aware that it is a Care Plan Review.
- 5.3. Ensure everyone is introduced.

- 5.4. Provide copies of the current care plan in a format that can be easily understood by the patient, carer, care co-ordinator and medical staff / others.
- 5.5. The care co-ordinator should provide a brief overview of the mental health, physical health (including cardio-metabolic monitoring), psychological and social care needs, including risks and current treatments / interventions. Significant changes since the last CPA review should be highlighted.
- 5.6. There should be a detailed review of the current care plan including medication
- 5.7. Agree changes to the care plan, and any further action to be taken, if required. Record this at the meeting or within 72 hours.
- 5.8. Set the date and proposed format of the next Care Plan Review.

## 6. Post CPA Review

- 6.1. The Care co-ordinator (or delegated person) should review and update any relevant assessments.
- 6.2. The Care co-ordinator (or delegated person) must update the risk screen to demonstrate the risk has been considered (even if the risks have not changed).
- 6.3. The Care co-ordinator (or delegated person) must update the Care Plan and send a copy to the patient and GP and record the date the care plan has been sent in the 'Other information for Care plan' on RiO
- 6.4. The Care co-ordinator (or delegated person) must record a RiO CPA Review and validate it (this will then automatically appear in progress notes)
- 6.5. See section 9 below for further details on recording a CPA Review.

## 7. Formal Review Meetings

- 7.1. A "case conference" style review should normally take place in circumstances where there are complex interagency and risk-related issues to consider, specifically where:
  - 7.1.1. Two or more patients have a close relationship and significant risk issues are currently identified (a joint review should be considered in such cases), **and/or**
  - 7.1.2. The patient is on CPA Level Two or 'Care Managed – Somerset Partnership' and significant risk issues are currently identified, **and/or**
  - 7.1.3. The Care Plan is complex as a result of the involvement of a range of professional and/or informal carers.
- 7.2. In addition, a formal review should be convened at least annually for long-term patients on CPA Level Two who have a significant risk history.

- 7.3. The care coordinator is responsible for arranging the review; collating relevant background information and ensuring that the patient's rights and interests are properly represented (the involvement of an advocate should be considered).
- 7.4. In particularly complex or risky cases, the care coordinator should consider requesting, via the Team Manager, that the review be chaired by another professional.

## **8. Inpatient CPA Review/Discharge Planning (in addition to sections above)**

- 8.1. The Care Coordinator and ward Named Nurse will discuss and agreed who will be responsible for arranging the meeting at a convenient time and place for the patient and/or carer and relevant staff.
- 8.2. The Community staff should meet with the patient prior to the meeting and, through liaison with other staff, be aware of identified needs.
- 8.3. Attendance at CPA Review meetings, especially pre-discharge, is a priority for all staff involved.
- 8.4. The patient and, where appropriate, carer should be informed of the purpose and format of the meeting and their views obtained prior to the meeting.
- 8.5. Only appropriate personnel may attend the meeting; students can be present with the agreement of the patient.
- 8.6. Patients should always be present at the meetings unless they have clearly stated they do not want, or they are unable to participate. Should the patient choose not to attend, the ward Named Nurse should seek the patient's views and present them at the meeting.
- 8.7. Patients should always be asked if they agree to their carer attending. If they refuse then it must be explained that the carer's views will be sought and presented at the meeting.
- 8.8. Patients must be offered the support of an advocate in attendance at a CPA Review if there is no carer, or the patient does not wish the carer to attend.
- 8.9. Before the review meeting takes place, the ward Named Nurse should ensure that any reasonable adjustments, such as the provision of a hearing loop or a professional interpreter are arranged and in place.
- 8.10. The date, time and location of the next CPA Review must be agreed at the meeting and be undertaken within 28 days of discharge.

## **9. CPA Review Checklist: Other review**

- 8.11. Schedule review 3-4 weeks in advance
- 8.12. Check demographic details, including contacts
- 8.13. Update the core assessments editing or adding new as necessary
- 8.14. Record Risk Screening and update Risk Information, risk incidents in Risk History and Alerts as appropriate
- 8.15. Complete/update the Employment Status assessment
- 8.16. Complete/update the Accommodation assessment
- 8.17. Complete final HoNOS rating, dated and timed on or before CPA Review
- 8.18. Record Care cluster and HoNOS (CAMHS: record HoNOS as not known/not applicable '99999999 9999' (8 x '9', space, 4 x '9'))
- 8.19. Update the plan of care (ideally using the RiO Recovery Care Plan, but a plan of care letter uploaded onto RiO is acceptable where patient has been allocated to Level One) in collaboration with the patient
- 8.20. Review "Other Information for Care Plan", including out of hours contact number, details on agreed actions if patient is beginning to struggle and any other supporting information, including any Advance Decisions/Statement of preferences
- 8.21. Review Alerts
- 8.22. Review CPA Level
- 8.23. Set provisional next review date
- 8.24. Outcome and validate "Other Review" via CPA Management screen (review notes will automatically be added to progress notes)
- 8.25. Schedule next CPA review if definite date/time agreed
- 8.26. Update diagnosis/presentation if appropriate; link new (or unchanged) diagnosis to the CPA review event
- 8.27. Provide a copy of the revised care plan to the patient in a format which they can easily understand
- 8.28. If using RiO Care Plan, record "Care Plan given/sent to patient/carer on:" date within "Other Information for Care Plan"
- 8.29. Distribute revised care plan to GP and any other relevant parties even if minimal or no changes, as it includes provisional next review date
- 8.30. If using RiO Care Plan, record "Care Plan shared with the GP" date within "Other Information for Care Plan"

## **9. CPA Review Checklist: Discharge**

- 9.1. Check demographic details, especially (correspondence) address
- 9.2. Update the core assessment, editing as necessary
- 9.3. Record Risk Screening and update Risk Information, risk incidents in Risk History and Alerts as appropriate
- 9.4. Complete/update the Employment Status assessment
- 9.5. Complete/update the Accommodation assessment
- 9.6. Record HoNOS (CAMHS: record HoNOS as not known/not applicable '99999999 9999' (8 x '9', space, 4 x '9'))
- 9.7. Review and update the RiO Care Plan, closing outstanding problems/ interventions as appropriate, or construct a letter to reflect a discharge plan involving the patient where possible
- 9.8. If using the RiO Care Plan, review and update "Other Information for Care Plan", including out of hours contact number, details on agreed actions if patient is beginning to struggle and any other supporting information
- 9.9. Schedule (if not already scheduled), outcome and validate "Discharge Review" details via CPA Review screen, selecting a "finished" or "transferred" outcome (review notes will automatically be added to progress notes)
- 9.10. Update diagnosis/presentation if appropriate; link new (or unchanged) diagnosis to the CPA review event
- 9.11. Discharge all open referrals
- 9.12. Provide a copy of the revised care plan to the patient in a format which they can easily understand
- 9.13. If using RiO Care Plan, record "Care Plan given/sent to patient/carer on:" date within "Other Information for Care Plan"
- 9.14. Distribute revised care plan to GP and any other relevant parties even if minimal or no changes, as it includes provisional next review date
- 9.15. If using RiO Care Plan, record "Care Plan shared with the GP" date within "Other Information for Care Plan".

## ICPA CLINICAL AUDIT STANDARDS

MARCH 2016

**Service area(s) to which standards apply  
(All Operational Services excluding MIU and Universal Services)**

X	MH Inpatient (CAMHS)	X	Community CAMHS	X	CH Specialist Services
X	MH Inpatient (Adult)	X	C & YP Integrated Therapy	X	MH Specialist Services
X	MH Inpatient (Older)		School Nursing	X	MH Community Adult
X	MH Rehab & Recovery		Health Visitors	X	MH Community Older
X	Community Hospital	X	CH Rehab	X	Learning Disabilities
	MIU	X	Musculo-Skeletal		District Nurses

ICPA CLINICAL AUDIT STANDARDS					
Ref No	Standard	Policy Reference	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
<b>ASSESSMENT</b>					
1	All patients referred or admitted to services should receive a needs led assessment	5.8	100%		A needs led assessment will be determined by specific service areas.
2	All patients accepted into services after an initial assessment should be allocated a CPA level.	5.11 Appendix B	100%	External contracts for the provision of inpatient services (e.g. MOD, detox.)	The default level for all patients is CPA Level One. See Appendix B of the ICPA policy for when to apply CPA Level Two, Care Managed by Somerset Partnership or Care Managed by another agency. <b>To be recorded in CPA Management on RiO</b>
3	All inpatients should be allocated to CPA Level 2 on admission.	Appendix B, point 6	100%	External contracts for the provision of inpatient services (e.g. MOD, detox.)	<b>See Appendix B</b>
4	<b>Mental Health only</b> All inpatients should be allocated a Care Coordinator within 14 days of admission.	Appendix A, point 7	100%	External contracts for the provision of inpatient services (e.g. MOD, detox.)	If a community care coordinator is not yet allocated, the Ward Manager may be recorded as the care coordinator as an interim measure. A community care coordinator/care manager must be allocated before discharge. <b>To be recorded in CPA Management on RiO</b>



## ICPA CLINICAL AUDIT STANDARDS

Ref No	Standard	Policy Reference	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
<b>CARE PLANS</b>					
5	All patients should have a RiO Care plan or plan of care letter or equivalent	5.20	100%	Those patients still undergoing the assessment phase	To be determined on a service specific basis
6	All patients subject to CPA Level 2 should have a RiO Care plan.	Appendix D, point 9.9	100%	None	To be recorded within the Care planning module on RiO.
7	All patients should be offered a copy of their care plan	Appendix C	100%	None	A copy should be offered at each CPA review, as a minimum
8	Care Plans should focus on strengths and needs, seek to promote recovery and be drawn up in consultation with the patient (and carer if there is one)	5.23	100%	Where patients lack capacity, consultation will be proportionate to their capacity (para 5.7)	Particular effort should be made to consult with family/carers where the patient lacks capacity and such a consultation is in the patient's best interests.
9	Care plans should be written in a personalised manner, avoiding jargon and using Plain English which can be easily understood by the patient and their family/carer.	5.23	100%	None	This could include care plans written to the patient, by the patient or with explicit patient involvement

<b>ICPA CLINICAL AUDIT STANDARDS</b>					
<b>Ref No</b>	<b>Standard</b>	<b>Policy Reference</b>	<b>Compliance</b>	<b>Exceptions</b>	<b>Definitions</b> <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
10	Care Plans should be written in a manner that is: Specific, Measurable, Achievable, Realistic and Timely	5.24	100%	None	
<b>CPA REVIEWS</b>					
11	CPA reviews should: <ul style="list-style-type: none"> <li>Summarise progress made since the last review</li> <li>Include a detailed review of the care plan</li> <li>Include a re-assessment of risk</li> <li>Involve patients/carers wherever possible</li> </ul>	5.30	100%	None	CPA Reviews must be recorded by scheduling and outcoming a CPA Review on RiO.
12	An updated care plan should be distributed to all relevant parties, including patient, carer and GP as a result of the review.	Appendix D, point 6.3	100%	None	
13	A date should be agreed at the CPA review for the next review, the maximum interval between reviews being 12 months	5.28	100%	None	A “provisional date” should be recorded in the CPA Management section of RiO (which will then automatically appear on the RiO care plan).
14	Any Advance Decisions should be reviewed at the same time as the Care Plan	5.30	100%	None	

## ICPA CLINICAL AUDIT STANDARDS

Ref No	Standard	Policy Reference	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
<b>CPA REVIEWS – MENTAL HEALTH ONLY</b>					
15	There should be a CPA Review to plan the discharge of all patients being discharged from inpatient care	5.28	100%	Patients who have discharged themselves against professional advice. Patients who are discharged from service when being discharged from inpatient care (e.g. MOD contract, detoxification etc.).	
16	A CPA review should take place for all patients discharged from an inpatient ward within 28 days of discharge.	5.28	100%	None	

## ICPA CLINICAL AUDIT STANDARDS

Ref No	Standard	Policy Reference	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
<b>HONOS and CARE Clusters (Secondary Care Mental Health only)</b>					
17	HONOS and care cluster ratings should be recorded for all adult patients (≥18) assessed by our service within one month of initial contact	5.10	100%	Patients who did not attend initial assessment, or disengage from assessment before it has been completed	HONOS ratings should be recorded by the patient's care coordinator. For inpatients they should be recorded by the ward named nurse.
18	HONOS and care cluster ratings should be recorded at each CPA review	Appendix D, point 9.7	100%	None	HONOS ratings should be recorded by the patient's care coordinator. Formal RCPA reviews should occur at least once a year, and the HONOS updated within 1 month of the review.
19	HONOS should be recorded at the time of discharge from any inpatient unit	Appendix D, point 10.6	100%	None	Discharge HONOS ratings should be recorded by the ward discharging nurse.