Cumbria Partnership NHS Foundation Trust

CARE CO-ORDINATION POLICY

Care Programme Approach & Care Management

Reference	POL/001/001
Version	2
Date Ratified	2 August 2018
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Accountable Director	Director of Quality & Nursing
Policy Author	Jo Johnston, Senior Network Manager

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Policy On A Page

SUMMARY & AIM

The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are:
Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
The formation of a care plan which identifies the health and social care required from a variety of providers;
The appointment of a care coordinator to keep in close touch with the service user and to monitor and coordinate care;
Regular review and where necessary, agreed changes to the care plan.

TARGET AUDIENCE:

- Mental Health Nurses
- Social Workers
- Occupational Therapists
- Assistant Practitioners
- Clinical Leads

TRAINING:

Induction will include details of local CPA practices and their responsibilities within the Care Coordination system. There will be an expectation that new employees familiarise themselves with the role/s they are likely to play in relation to care coordination, and will be supported in this.

KEY REQUIREMENTS

What do I need to follow?
CPA is a framework for delivering treatment and care to people in need of specialist mental health treatment.
High quality interventions must be received by the service user based on an individual assessment of their needs.
The approach to individuals care is person centred and needs the individual's involvement to promote recovery and treatment.
Referrals to mental health services are likely to originate from a variety of sources.
Assessment and planning must view the individual holistically.
Action is taken by care coordinators to encourage independence, self determination and promote self-directed support where possible.
Care planning is under pinned by engagement, requiring trust, commitment and team work.
Everyone referred to secondary mental health service will receive an assessment of their mental health needs in order to identify presenting needs and risk.
Risk assessment is an essential and on-going element of good mental health practice and a critical integral component of all assessment planning and review process.
Responsibility for the coordination of risk assessment and management lies with the care coordinator and will oversee the effectiveness and tolerability or prescribed medication regimes.
Care coordinator will formulate the care plan based on the assessment which will take place within 28 days of allocation.
Each service user subject to CPA will have their care plan reviewed at minimum 6 month intervals.

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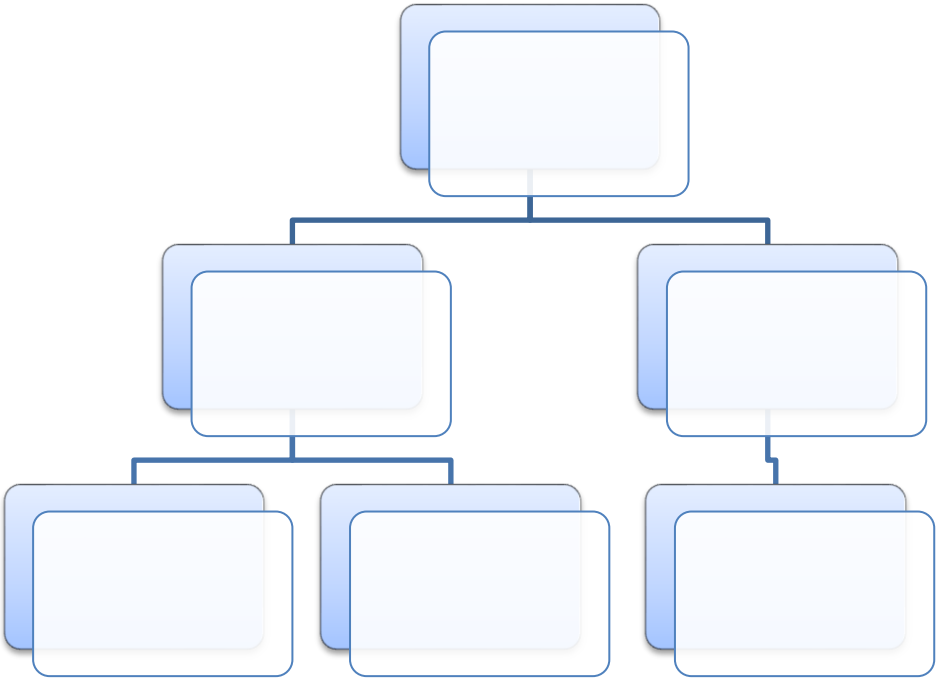

1. INTRODUCTION

1.1 The policy is the product of the ongoing partnership between Cumbria Partnership NHS Foundation Trust and Cumbia County Council. All agencies are committed to working together to improve the delivery of mental health services. Service users, Carer's and other organizations delivering Mental Health Services, have also participated in the development of this document through a process of dialogue and consultation. It supersedes all pre-existing Care Coordination Policies.

1.2 This policy is applicable to all service users presenting with complex needs and their Carer's, regardless of their age, in receipt of specialist mental health services. Primarily, this will be all those in receipt of secondary mental health services. It will apply to people with learning disability and drug and alcohol problems where they are in receipt of specialist mental health services.

1.3 Since the publication of the Mental Health National Service Framework in 1999 mental health policies have increasingly focused on personalization through an emphasis on meeting the wider needs of those with mental illness, addressing inequalities, tackling the problems of social inclusion, and promoting positive risk management. The Care Programme Approach (CPA) is at the centre of this personalization focus, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what are often complex systems of care.

2. PURPOSE

2.0 The Care Programme Approach (CPA) is a framework for delivering care and treatment to people in need of specialist mental health services. It has developed, from its introduction in 1991, into a whole systems approach, where it is recognized that the principles must be applied, regardless of setting whether community, in patient, residential or prison; people need to be able to access the required support, care and/or treatment in a personalized way at their time of need over 24 hour 7 days a week.

2.1 All individuals receiving treatment from secondary mental health services are entitled to receive high quality interventions based on an individual assessment of their needs. The needs and involvement of people receiving services (service users) and their carers are to be central to service delivery. An underpinning set of values and principles of person-centred care which apply to all is described below:-

- The approach to individuals' care and treatment puts the person at the centre and promotes recovery and treatment. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognizes the individual as a person first and a patient/service user second.

2.2 Assessment and planning views a person holistically, seeing and supporting them in their individual diverse roles and the needs they have for health, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimizing mental and physical health and well-being by Health, Social Care and non-statutory service.

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

- Carers form a vital part of the support required to aid a person's recovery. Their own needs will be recognized and directed for assessment through Adult Social Care in accordance with the Care Act 2014.

2.3 Care Planning is underpinned by engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, to ensure that the right service is available at the right time. Since October 2008 the criteria for a person to be subject to CPA coordinated care and support has been redefined and only those with complex mental health need(s) will be classified as subject to the Care Programme Approach (CPA). The presenting characteristics of this group will include;-

- Severe mental disorder (including personality disorder) with high degree of clinical complexity.
- Current or potential risk(s), including:
- Suicide, self-harm, harm to others (including history of offending as a result of a mental health problem)
- Relapse history requiring urgent response
- Self-neglect/non concordance with treatment plan
- Safeguarding adult/child protection issues e.g. they are at risk from harm/exploitation or present a risk to children/vulnerable adults.
- Exploitation e.g. financial/sexual
- Disinhibition
- Physical/emotional abuse
- Cognitive impairment
- Current or significant history of severe distress/instability or disengagement.
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability.
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team.
- Significant reliance on carer(s) or has own significant caring responsibilities.

The following client groups will automatically be subject to CPA;-

- All in-patients already in receipt of or who meet the criteria for secondary mental health services.
- All those service users who are discharged on Community Treatment Orders of the MHA.
- All prisoners with severe mental illness

The inclusion of service users with significant caring responsibilities will also need to be considered i.e. those;-

- Who have parenting responsibilities
- Who have significant caring responsibilities and/or have
- A dual diagnosis (substance misuse)
- A history of violence or severe self-harm
- Unsettled accommodation situation

2.4 Care Co-ordination is a whole system model of health and social care and the function of each component part of the mental health service has an important role to play in facilitating the achievement of this for those in need of support, treatment and care. To enable this, the following infrastructure will be established:-

- A single point of access for urgent referral - A clearly defined system for urgent referral to Mental Health Services, including self-referral, will be in place within each local area. When emergencies occur and there is a need for an immediate referral for example a Mental Health Act assessment or during out of hours, The ALIS/ Home Treatment Team will receive and respond to referrals from health/social care referrers.
- Coordination of the respective roles and responsibilities of each agency - Mental Health Services in Cumbria work in partnership and are coordinated in their approaches to meeting the mental health needs of the local communities they serve.

2.5 There will be a coordinated approach to assessing the individual needs and delivering care / treatment to service users by the routine use of:

- systematic arrangements for assessing peoples' health needs
- the appointment of a Care Coordinator
- developing of a care planning
- referral to ASC for an assessment of social care needs under the Care Act 2014
- regular and ongoing review

2.6 The Care Programme Approach (CPA) will be used as the framework for planning and coordinating support and treatment necessary for users with a dual diagnosis of learning disability and mental health problem.

2.7 Care Coordinators are required to recognise the positive role that advocacy can play in enabling effective service user involvement in the development and management of their care. Section 30 of the Mental Health Act 2007 gives certain individuals access to independent advocacy services to be delivered by Independent Mental Health Advocates (IMHAs) and/or IMCAs in cases for individuals under Mental Capacity Act.

3. POLICY DETAILS – INFORMATION FOR USERS & CARERS

It is the responsibility of all practitioners and clinicians to ensure that information e.g. leaflets about mental health services and the CPA process are provided in an appropriate format/language to users and Carers of the service. Information sharing ensures users and Carers have an understanding of all aspects of care, treatment and support proposed by the specialist services and that they are advised about resources they can access from within their local community.

3.1 Equality & Diversity

Cumbria Partnership NHS Foundation Trust (CPFT) is committed to providing equal and fair environments that work to eliminate victimization, discrimination and harassment for all Service Users. CPFT is committed to the advancement of equality for the nine protected characteristics; Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sex, Sexual Orientation, Marriage and Civil Partnership; as set out in the wider Equality Act 2010 and Equality & Diversity Policy.

3.2 Referral

Referrals to the mental health service are likely to originate from a variety of sources. Once a referral has been received, it will be screened and or triaged in accordance with the eligibility criteria for specialist service. Urgent referrals will be responded to by the ALIS / Home treatment team, unless response by local community mental health service is considered more appropriate.

All referrals will be managed in line with the operational policies and protocols of the appropriate team, to ensure timely access, assessment and treatment as appropriate.

3.3 The Role of the Care Coordinator

3.4 The role of Care Coordinator is pivotal to the success of CPA. To strengthen the role, Care Coordinator principles of practice, core functions and competences (linked to associated National Occupational Standards and the Knowledge and Skills Framework) have been nationally agreed.

3.5 The care coordinator does not necessarily have to be the person who delivers the majority of care. There will be cases where the therapeutic input will be delivered by other more specialist members of the team. This approach aims to use the skills available in the most appropriate, effective and efficient manner. Every effort will be made to accommodate a service user's choice of gender of the Care Coordinator as this will be a crucial factor in establishing trust within the therapeutic relationship. Services users will be afforded a choice of care coordinator which takes account of any cultural or religious needs whenever practicable and this may also be a key factor for people who have had damaging experiences of sexual abuse or violence.

3.6 The assessment will commence as soon as possible once the referral has been accepted, this will be in line with the established targets as appropriate. The allocation of the Care Coordinator will be made at the earliest possible time after the service user's assessment is completed or the need agreed.

3.7 In hospital, the named nurse may act as the Care Coordinator if appropriate until one is allocated. Similar arrangements will operate for service users receiving services from ALIS/ home treatment team.

3.8 Where a service user requests a change of Care Coordinator, this should be fully discussed and considered, and the request accommodated, as appropriate.

3.9 Responsibilities of the Care Coordinator are:

- To continue the holistic assessment of a user's needs, including risk
- To ensure the prompt and appropriate circulation of risk information, care plans etc to those who need to know.
- To identify strengths of service users, and those of their Carers, where appropriate.
- To collaborate with service users, Carers and others as appropriate, in developing and implementing a Risk Management plan for the service user.
- To collaborate with service users, Carers and others as appropriate, in developing a care plan for the service user in line with the Care and treatment Pathways.
- Ensure high quality care is delivered in accordance with care pathways relevant for the service user, his or her condition and adapted in such ways that they provide consistent personalized high quality care.
- To facilitate timely access to help, advice and support of other agencies including adult social care (ASC) ,Housing and educational/training institutions
- To schedule and convene timely reviews of care plans, and urgent reviews as required.
- To complete relevant CPA/care management documentation as required
- To provide reports to MHA Mangers Appeals and MHRT as appropriate in line with agreement with Adult Social Care.

- To access training appropriate to the role.
- Ensure that the service users' care reviewed in line with the care pathway, and advise other members of the care team, including Carers where appropriate, of any changes in the circumstances / care requirements of the service user that might require review of the care plan.

- To act as a consistent point of contact for everyone concerned, including primary care.
- To maintain a lead on the Organisational processes of care, when a service user is admitted to hospital, and work with the named nurse to monitor the person's progress and facilitate development of plans for them leaving hospital at earliest time.
- To retain contact with the service user if they are on any form of out of County placement. Liaison with the staff providing care should be at least 6 monthly (Ref: Out of Area Protocol).
- To ensure that when a person leaves the area, direct communication takes place with the receiving service, and relevant recorded information accompanies the service user to their new home. This will also apply to those who relocate on temporary basis to attend University.
- Ensure a full assessment of an individual is undertaken to ensure provision of the correct care package is in place before they return from out of County Placements
- To ensure the service user is aware of advocacy arrangements.
- Ensure the service user does not fall out of contact with services. At the time of discharge follow the discharge policy which stipulates effective discharge procedures and handovers referring to any relevant policies or protocols such as safe exit protocols.
- Manage any disengagement by the service user as per the agreed protocol/ policy

4. ASSESSMENT

4.1 Everyone referred to secondary mental health services will receive an assessment of their mental health needs. The initial assessment will identify the presenting needs and risks of the service user. The outcome from this enables immediate decisions relating to level of vulnerability/ risk and facilitates prioritization of service response. If it is agreed that the person's needs are best met by a secondary mental health service, a care plan will be devised and agreed with the service user, whenever practicable, and, also their carer where appropriate. They will then be allocated to a care pathway which is considered likely to provide them with optimal care for their needs.

Risk assessment is an essential and on-going element of good mental health practice and a critical, integral component of all assessment, planning and review processes. The philosophy underpinning effective care co-ordination is one that balances care needs against risk needs, and that emphasizes: positive risk management; collaboration with the service user and others involved in care; the importance of recognizing and building on the service user's strengths; and the organization's role in risk management alongside the individual practitioner. This approach stresses the importance of the assessment of dynamic (changing) risk factors and the care team adjusting interventions accordingly. Clinical Risk Policy POL/001/017

4.2 Specialist mental health services will complete a single, holistic assessment of each individual's health needs within four weeks (28 days) of allocation to a named practitioner. This will be supplemented by additional functional or profession specific assessment where indicated. Exceptions to this timescale will be made on case by case basis with support of line manager – (this may be applicable where local targets or contractual arrangements

specify a timescale for services).

4.3 As well as focusing on holistic needs, the assessment process will always include a clinical risk assessment, using the agreed format, as appropriate. Identified risks and how these are to be managed must be detailed within the care plan / risk management plan and or staying well plan.

4.4 All assessments will be person-centred, and result in an understanding of the presenting needs including "health beliefs" and how these can best be treated through a process of two-way dialogue. The holistic assessment will make reference to psychiatric, psychological and social functioning, the impact of medication including benefits and side-effects; risk to the individual and others, including contingency and crisis planning; needs arising from co-morbidity; personal circumstances including family and care of children; housing needs; financial circumstances and capability; employment, education and training needs; physical health needs; equality and diversity issues; and social inclusion and social contact and independence.

4.5 Drug and alcohol misuse will be considered in all assessments undertaken by mental health services. Reference to current and past substance use will routinely be made by assessors asking service users about recent legal and illicit drug use. These enquires will facilitate an understanding of any drug and alcohol problems and any need for referral to specialist drug and alcohol services.

4.6 The links between mental ill health and physical ill health are well researched and have shown that people with mental health problems have higher rates of physical illness, resulting in increased rates of morbidity and mortality. Assessing and addressing the physical health needs of a mental health service user are to be given a higher priority. Service users will be encouraged and supported to access support for their physical health needs through local arrangements.
This may be provided by secondary or primary care in order that they receive a relevant physical health check. Certain medication may compound physical health risks, i.e. causing weight gain or increasing the risk of diabetes – The prescribing doctor, non-medical prescriber or responsible clinician will provide full explanation of side effects from the outset of treatment to the service user and when indicated their carer.

4.7 The assessment and planning process will aim to meet the service user's needs and choices and not just focus on what professionals and services can offer. It will reflect a person's aspirations and strengths as well as their needs and difficulties. It is vital for trust and honesty to underpin the engagement process to allow for an equitable partnership between services users, Carers and providers of services. Care coordinators will aim to improve the quality of life and the health of service users under their care. Assessments and care plans are to be cognizant of and tackle the impact that mental illness symptoms and treatment options have on physical health and the impact that physical symptoms can have on an individual's mental well-being

4.8 Clinicians are required to ensure the implications of the Mental Capacity Act with regard to an individual's capacity to consent care/treatment. The care coordinator has a pivotal role in establishing capacity in relation to care planning, how this is recorded and best

interest process to enable informed consent is not compromised.

4.9 Where the service user lives in a household with young children or has dependent children or comes into contact with children or other caring responsibilities, the assessment will explore the impact of the illness on those involved with the person's life. Similarly, where the service user is supported by someone acting in a caring capacity, young or old, the assessor will need to be alert to any potential risk factors and advise them of these.

4.9.0 If the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children, including delusional belief involving them, and drawing on as many sources of information as possible, including compliance with treatment.

4.9.1 Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met. A referral must be made:

If service users express delusional beliefs involving their child *and/or*
If service users might harm their child as part of a suicide plan

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4.9.6 Reference will be made to NICE Guidelines Quick Reference Guide CG89 "When to suspect Child maltreatment" when making decisions and judgements in respect of safeguarding children's concerns.

4.9.7 The assessment should also comply with recommendation 12 from the Climbie Inquiry Report which states that: “front line staff in each of the agencies which regularly come into contact with families with children must ensure that in each new contact, basic information about the child is recorded. This must include the child’s name, address, age, the name of the child’s primary carer, the child’s GP and the name of the child’s school if the child is at school age”. Keeping Children Safe: The Government’s Response to the Victoria Climbie Inquiry Report and Joint Chief Inspectors Report Safeguarding Children, September 03. Safeguarding Policy POL/001/006

4.9.8 When there is a perceived risk of dangerousness identified, the management of which could be of public interest, the Care Coordinator will share this information with their supervisor/line manager with a view to making a referral to the Multi Agency Risk Evaluation (MARE) & if appropriate Multi Agency Public Protection Arrangements (MAPPA). [See policy pol/001/005/020 and policy for Provision of Forensic Outpatient clinics pol/001/035]

4.9.9 The complex presentation of needs of individuals meeting criteria for inclusion within CPA have previously been described in 2.4 above but in order to differentiate those who meet criteria from those who no longer do, the chart below has been developed.

Service users needing CPA	**Other service users**
An individual’s characteristics	
Complex needs; multi-agency input; higher What the service users should expect Support from CPA Care Coordinator (trained, part of job description, co-ordination support recognised as significant part of caseload)	More straightforward needs; one agency or no problems with access to other lower risk Support from professional(s) as part of clinical/ Practitioner role. Lead professional identified. Service user self-directed care, with support.
A comprehensive multi-disciplinary, multi-	A full assessment of need for clinical care and
Assessment covering the full range of needs and risks	Treatment, including risk assessment
An assessment of social care needs against eligibility criteria for community (plus Direct Payments)	An assessment of social care needs against eligibility criteria for community (plus Direct Payments)
Comprehensive formal written care plan:	Clear understanding of how care and treatment
Including risk and safety/contingency/crisis	Will be carried out, by whom, and when (can be a clinician’s letter)
On-going review, formal multi-disciplinary, multi-agency review at least once a year but	On-going review as required

likely to be needed more regularly	
At review, consideration of on-going need for CPA support	On-going consideration of need for move to CPA if risk or circumstances change
Increased need for advocacy support	Self-directed care, with some support if necessary
Carers identified and informed of rights to	Carers identified and informed of rights of
Own assessment and offered the sanmassessment	Own assessment

4.9.10 The default position for individuals presenting with these needs as listed will normally be under CPA however there will be individuals, who through a thorough assessment of need and risk show otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records.

4.9.11 It is vital to recognise that some service user will not be subject to CPA but will still require input from secondary mental health services for their presenting needs to be effectively managed etc. The care cycle will apply to all accepted into service however they will not be recorded under CPA as their needs do not meet the threshold for CPA as described above.

5. Training and support

Induction will include details of local CPA practices and their responsibilities within the Care Coordination system. There will be an expectation that new employees familiarise themselves with the role/s they are likely to play in relation to Care Co-ordination, and will be supported in this.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
Compliance with CPA reviews	performance monitoring dashboard	Information systems	Governance structure. performance meeting	monthly

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Data quality of CPA reviews	Data quality audit	Data quality dept.	CMHART operational meeting	Monthly

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the *name of relevant committee* minutes
- Risks will be considered for inclusion in the appropriate risk registers

7. REFERENCES:

Keeping Children Safe: The Governments Response to the Victoria Climbie Inquiry Report and Joint Chief Inspectors Report Safeguarding Children, September 03.Safeguarding Policy POL/001/006

8. ASSOCIATED DOCUMENTATION:

Equality Act 2010 and Equality & Diversity Policy
Clinical Risk Policy POL/001/017
Confidentiality Policy POL/002/038
Information Sharing Policy POL/002/065
Safeguarding Policy POL/001/006
Multi Agency Public Protection Arrangements (MAPPA) POL 001/005/020
Provision of Forensic Outpatients Clinics POL/001/035
Advanced Statements Policy and Procedure POL/001/036
Section 117 Aftercare POL/001/005/011
Section 17 Leave of Absence POL/001/005/006
Section 17 (A-G) Supervised Community Treatment (SCT)POL/001/00/010
Community Treatment Order Policy POL/001/00/010
Missing Persons POL/001/009
Non-Attendance (Did Not Attend) Policy POL/001045

https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural conditions/mental-health-and-behavioural-conditions--general-and-other#panel-pathways
https://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-serviceshttps://www.nice.org.uk/guidance/qs14

9. DUTIES (ROLES & RESPONSIBILITIES)

1. 9.1 Chief Executive / Trust Board Responsibilities

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

1. 9.2 Executive Director Responsibilities:

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

1. 9.3 Nominated Director

The Executive Director of Operations for this Policy and will be responsible for providing assurance reports to the appropriate committee. The Trust Board will require assurance from the Localities that appropriate structures are in place and that staff are provided with appropriate training and resources to undertake their delegated duties.

1. 9.4 Trust Board

The Trust Board will ensure there are appropriate structures in place for the management of newly appointed/qualified staff as outlined within the eligibility criteria across the trust.

1. 9.5 Governance Quality and Risk Committee

The Governance Quality and Risk Committee is a sub group to the Board of Directors. It will receive assurance reports regarding the application of this policy via the mental health care group governance structure.

1. 9.6 ADNS/Professional Leads

Associate directors of nursing (ADN's) and Professional Heads have the responsibility for advising on the scope of professional skills and competencies that are required in accordance with the policy, and ensure the implementation and monitoring of the policy.

1. 10. MANAGERS RESPONSIBILITIES

1. 10.1 ADO's and Network Managers

Associate director of operations and network managers are responsible for ensuring this policy is implemented and complied with across their Localities. This includes compliance with training and record keeping. This activity may be delegated to others as appropriate.

1. 10.2 Team leaders and Ward Managers

Ward managers and Team Leaders are responsible for ensuring all staff within their sphere of responsibility, attend training on this policy where appropriate; that this policy is implemented and documentation is completed. They will ensure this is monitored through supervision and audit. They will take action with individual staff where necessary where the policy is not being adhered to.

1. 11. STAFF RESPONSIBILITIES

1. 11.1 Registered Staff

All professionally qualified clinical staff are responsible for ensuring that they comply with the Trust policies and their Professional Regulatory Body's Registration requirements to practice and identify their own training needs.

1. 11.2 Assistant Practitioners and other Health Professionals

Have an ongoing responsibility to identify their own training needs in conjunction with their manager, job description and service specification. This must be acknowledged within the appraisal system. The registered practitioner has a responsibility to support this process in line with their professional accountability.

1. 12. Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

13. ABBREVIATIONS / DEFINITION OF TERMS USED

Keep lists in alphabetical order

ABBREVIATION	DEFINITION
CPA	Care Programme Approach
ADO	Associate Director of Operations
ALIS	Access and Liaison Integrated Service
AND	Associate Director of Nursing
ASC	Adult Social Care
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CPFT	Cumbria Partnership Foundation Trust
CTO	Community Treatment Order
LAC	Looked After Child
MCA	Mental Capacity Act
MHA	Mental Health Act

MHRT	Mental Health Recovery Team
NTA	National Treatment Agency
RC	Responsible Clinician
SAP	Supported Assessment Process
SCT	Supervised Community Treatment
SOAD	Second Opinion Approved Doctor

DOCUMENT CONTROL

Equality Impact Assessment Date	Not required for this review
Sub-Committee & Approval Date	CPMG 2/8/18

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
2	2/8/18	31/8/2021	6/8/18	6/8/2038

Statement of changes made from version

Version		Section & Description
2		Removed duplication/repetition throughout document Revised the focus of policy to CPFT – with reference to partnership working with ASC / CCC Clarified re inpatients – to ensure only those meeting threshold for secondary / specialist mental health services included. Clarified roles and responsibilities of care coordinator Clarified work re inpatients / care coordination processes

List of Stakeholders who have reviewed the document

Name	Job Title	
M/H and Acute and Urgent Care reviewed		