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## Care Coordination (including CPA) within Children and Young Peoples Services

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1 INTRODUCTION

1.1 The Government has set out clear proposals to modernise the National Health Service (NHS) and Social Services (SS) and requires these agencies to work in partnership to provide integrated services.

1.2 The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and wellbeing of children and young people (CYP), and for providing high quality services that meet their needs.

1.3 And sets out that:

- That multi-agency services working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.

- All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.

2 PURPOSE

2.1 This policy sets out the principles and framework for assessment and care planning for children and young people receiving mental health or learning disability services within Cumbria Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/CNTW). This approach is underpinned by shared Values and Principles and is encompassed by the term care coordination.

2.2 The transition from children and young people’s services to adult services is facilitated through the care coordination process and relevant transitions protocols.

2.3 This policy includes the requirements of C(90)23/LASSL(90)11 “Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach (CPA) (1999)” and Department of Health (DOH) guidance Refocusing CPA(2008) recognising that CPA is not the only care planning method for children and young people and that its use needs to be coordinated with the other systems to ensure that young people are not overloaded with assessment and review meetings and to minimise duplication.

2.4 This policy applies to all professionals working in Children and Young Peoples Specialist Services (CYPS) in the Trust whether employed by health or social services.
2.5 For those areas of CYPS not currently using the choice and partnership approach the same principles and processes should be applied in their initial assessment process.

3 DEFINITIONS AND PRINCIPLES

3.1 The care coordination process is a system of joining together Health and Social Services Specialist Mental Health and Learning Disability care. It sets standards for the delivery of service that reflects good practice, and a model of delivering care where children and young people who are in touch with mental health and learning disability services can expect:

- To have access to information in a way they can understand
- Staff who understand their difficulties and listen to what is wrong
- To decide with staff about what could help and who to contact about the services
- To know who is doing what and when, and this to be written down in a care plan
- The care plan to be implemented and services provided
- To meet together with the contact person to see if the plan is working
- To have the care plan reviewed regularly and changed if necessary
- To have clear written crisis arrangements
- To have information on how risk will be assessed and managed

3.2 Underpinned by 6 key principles:

- Children and young people are at the centre of planning
- Children and young people will be able to have access to health and social care services via an integrated assessment process
- The role of families, parents and carers is recognised, and actively supported;
- No one treatment, service or agency can meet all the needs that a person has. Care coordination helps services combine when necessary to give children and young people access to the full range of community support they need in order to promote their recovery and social inclusion;
- This may require assistance with keeping safe, being healthy, achieving economic, wellbeing making a positive contribution, enjoying and achieving
- Care coordination is based on National and Professional standards, which seek to provide a quality service that is fair, open and easy to understand;

- The care and support of children and young people who are detained under the Mental Health Act 1983 will always take into consideration the five overarching principles set out in the Mental Health Act 1983 Code of Practice published 2015
  - Least restrictive option and maximising independence
  - Empowerment and involvement
  - Respect and dignity
  - Purpose and effectiveness
  - Efficiency and equity

3.3 Definitions of Terms used

- (CAF) Common Assessment Framework for Children
- Lead Professional. The lead professional is not a job title or a new role, but a set of functions to be carried out as part of the delivery of effective integrated support. These functions are to:
  - **Act as a single point of contact** for the child or family, who they can trust and who can engage them in making choices, navigating their way through the system and effecting change.
  - Co-ordinate the delivery of the actions agreed by the practitioners involved to ensure that children and families receive an effective service which is regularly reviewed. These actions will be based on the outcome of the assessment and recorded in a plan.
  - Reduce overlap and inconsistency in the services received
  - Co-ordinate the delivery of the actions agreed by the practitioners involved, to ensure that children and families receive an effective service which is regularly reviewed. These actions will be based on the outcome of the assessment and recorded in a plan.
  - Reduce overlap and inconsistency in the services received
- RiO The Trust electronic care record.
- UHR Unified Heath record
- CAMHS/CYPS Child and Adolescent Mental Health Services

3.4 Abbreviations used on CYPS section of electronic care record

- CAF Common Assessment Framework for Children
- TAF Team Around The Family
4 DUTIES AND RESPONSIBILITIES

4.1 The Chief Executive on behalf of the Trust retains ultimate accountability for the health, safety and welfare of all service users, carers, staff and visitors; however key tasks and responsibilities will be delegated to individuals in accordance with the content of this policy.

4.2 Directors and managers at all levels in the Trust and its partner agencies are responsible for ensuring the policy and relevant practice guidance is applied consistently and appropriately in their area of responsibility.

4.3 All staff are responsible for ensuring that they meet their professional standards of recording within all of their documentation when applying this policy.

4.4 All managers at all levels are responsible for ensuring the policy is applied consistently and appropriately in their area of responsibility.

5 CONSENT TO SHARE INFORMATION

5.1 It is part of the practice of care coordination that information is shared between the different agencies involved in the child’s care e.g. social services and health services. The Consent to share information screen on the electronic care record RiO is designed to guide the practitioner through the process of seeking the child’s or child/young person’s consent to this and the recording of this process. This document complies with the requirements of the DOH Confidentiality NHS Code of Practice 2003, the Data Protection Act 1998 and the Trust Policy of copying letters to patients.

5.2 Information sharing should be discussed with the child or child/young person and when appropriate, their parent or carer as part of the initial assessment whenever possible, or as soon as is practicable. If appropriate, this can be facilitated by sending the consent to share information at assessment form with an initial appointment letter. This provides the opportunity for the young person / parent / carer to be aware of the information sharing and if they wish to complete the form and bring it to their first appointment and / or prepare any questions they may have. It is important that individuals should not make any
promises of absolute confidentiality to any child/young person or family member.

5.3 If the child/young person does not have the capacity to understand the process and requirements of consent even with the support of parents or carers, then consent to share information should be discussed and agreed with parents or others with parental responsibility (see Section 5.10).

5.4 From 1st April 2013 information sharing also includes submission of data in line with the CAMHS secondary data set. Families have the right to opt out (withdraw consent for this specific issue). Appendix 3 sets out more detail including the associated recording requirements on the electronic patient record (RiO).

5.5 Once the consent form has been completed by/with the young person/parent / carer the outcomes should also be recorded on the consent screen. The consent to share information indicator on the young person’s case record screen should also be set to green if consent to share information is in place or to red if there are any limitations on information sharing.

5.6 The paper consent form can be filed in the young person’s RiO support (purple) file. However, if this would be the only content of the file it can be scanned onto the electronic care record. The image should be clearly named as a consent form. A copy of the completed and signed consent form should be offered to the young person / parent / carer.

5.7 Consent to share information should be revisited and the consent status screen updated:

- As part of the care planning process
- When indicated by the child/young person or by an appropriate parent or Carer
- Where information/circumstances demonstrate that the child or child/young person, and when appropriate parent or carer, has different wishes to those previously recorded
- When the child develops the capacity i.e. becomes competent under Fraser Guidelines to understand the process and requirements of consent

5.8 Usually information will be kept confidential in accordance with this agreement; however in certain circumstances there may be occasions where it is necessary to share information without consent in accordance with Trust Policy, common law and the Data Protection Act 1998 as appropriate. For example, in circumstances where disclosure is felt to be justified in the public interest, e.g. to protect the child or child/young person or someone else from harm. In these circumstances, the information shared will always be kept to the minimum necessary.
5.9 If it is not possible to comply with the child or child/young person’s wishes, or when appropriate their parent or carer, this must be explained, including what information must be shared and with whom, and an appropriate entry made in the child/young person’s record.

5.10 Under the Children Act 1989, any child of 16 or over is presumed to be mentally competent to give their own consent to medical treatment. This means that children of 16 or over should also be presumed competent to give their own consent to information sharing.

5.11 Under the Fraser Guidelines (formerly commonly known as Gillick Competence) children under the age of 16 may also be competent to give their own consent to the sharing of information about themselves between different agencies provided they are sufficiently mature to understand the implications of information sharing, including the implications of not doing so in terms of the possible impact on the quality of service provision. This is a judgment to be made by the professionals involved with the child.

5.12 If a child is competent (either because they are 16 or over or because that are under 16 and competent under the Fraser guidelines) to give their own consent, that consent should be sought from them. If however they are assessed as not yet competent to give informed consent, the consent should be sought from a person who has parental responsibility for the child. Mothers automatically have parental responsibility. A married couple who have children together both automatically have parental responsibility. Parental responsibility continues after divorce.

5.13 Where the parents are not married, the unmarried father has parental responsibility if:
- His name is registered on the birth certificate - this is the case for births registered after 1 December 2003. Fathers can re-register if their names have not been placed on the birth certificate before this date
- He later marries the mother
- Both parents have signed an authorised parental responsibility agreement
- He obtains a parental responsibility order from the court
- He obtains a residence order from the court
- He becomes the child’s guardian

5.14 Others do not have parental responsibility. They can acquire it by:
- In the case of a local authority with a care order
- Being appointed as a guardian for care for a child if their parent dies
- Obtaining a residence order form the court for a child to live with then
- Adopting the child
5.15 Children in the Looked after system may have carers who do not have parental responsibility and it is very often inappropriate for information to be shared with parents. To ensure consideration specific to the issues involving children in the care of the Local Authority the Newcastle Looked after Children Team uses an additional consent recording tool on RiO.

6 ASSESSMENT

6.1 On receipt of the referral, the young person’s demographic information will be entered into the electronic care record (RiO) on the demographic by administration staff. Any missing demographic information will be entered as ascertained during the initial appointment.

6.2 Systematic assessment of Health and Social Care needs as they impact on a particular individual is the cornerstone of care coordination. The individual child or child/young person and his or her family or carers should be at the centre of the assessment, engaged in the process and its scope.

6.3 The core assessment screen on the electronic care record (RiO) provides the framework to support professional assessment practice of health and social care needs.

6.4 HONOSCA and GBO will be completed within 31 days of initial appointment and 31 days from discharge clinicians are to review this with and children/young people and families thought care and treatment

6.5 The aim of the initial appointment is to find out from the family whether the service has anything to offer, rather than try to ascertain this from the information provided by a referrer. This will also avoid families having an extended waiting period before an initial contact.

6.6 When their referral is accepted, the young person and their family are given the opportunity to book an appointment at a time (and ideally place) to suit them. For more vulnerable families the referrer may facilitate this appointment and that this may include the support from partner agencies to attend the agreed appointment.

6.7 Initial appointments aim to combine:

- Clinical Assessment
- Risk management
- Motivational enhancement
- Psycho-education
- Goal setting
- Things to try at home/ ‘homework’

○ The style is conversational, collaborative and strengths based
6.8 Recording of Initial Appointments

6.9 The approach to the recording of Initial / screening appointments ensures:

- Consistency
- Continuity for those young people who have continued involvement with CYPS
- Accountability and defensible decision making

6.10 Subsequent to the appointment recording, based on the information that may emerge from the appointment, will comprise of completion of relevant sections of the Core assessment on RiO. The specific components of the core assessment framework required are indicated in red text. However the option not to include these sections informed by clinical judgement remains. However the basis of this judgment must be recorded in the relevant section.

6.11 Based on referral / presentation clinical judgement will be used as to whether to seek information about all current medication and allergies at the initial appointment or to do so if / when the young person has a Treatment appointment.

6.12 The specific components of the core assessment framework required are shown in red text on RiO and are outlined below, with suggested matches to the previous CYPS assessment framework shown in brackets:

- Referral source and reason, including any advocacy needs and capacity concerns in relation to the assessment clinicians to consider Gillick competence within decision making (Concerns of referrers or others)
- Service user needs and expectations / presenting problem (including what the child / young person and family would like to change; How they would recognise when the change has happened – how it would look, how would it be different)
- Carers / relatives / views and information from third party sources (Parents/Carer’s Significant Relationships and Partnerships)
- Current medication should be recorded in the medication, sensitivities and allergies form in the core clinical documents
- History of mental health problems (Early Emotional and Behavioural Development; Later Emotional and Behavioural Development; Childhood Problems)
- Social circumstances (to include housing, employment and financial circumstance Family’s Social Integration and Supports; Family Structure; Social Presentation and Peer Relationships; Historical and Current Education/Training)
- Mental state (at interview) (Personality)
- Formulation/summary of assessment (Including Identified Strengths / Needs)
- Diagnosis/differential diagnosis
- Plan (i.e. The clinician and the young person/family have a discussion about whether or not the service can help, and if so, decide together what sort of help would be most useful, and whether or not any risk that comes up is managed within health or needs to be addressed by another agency. The action plan will also record information / advice given and outcome of initial / screening appointment e.g. Not appropriate for CYPS, referred on to (specify) appointment in CYPS (state who with and date)

6.13 Other sections of the assessment can be completed if appropriate due to the content of the initial contact. There is no requirement for all sections of the assessment to be completed.

6.14 Risk assessment

Risk assessment is a dynamic and ongoing process and is an integral part of any contact with young people and their families including at an initial appointment. This will be documented using the narrative/FACE risk assessment tools based on the information provided by the referrer, provided by the young person / family within the initial appointment and consideration of any previous case notes. At this early stage of engagement this is usually the level of reasonable and practical enquiry required.

6.15 However additional information gathering may be required in some instances, e.g. if the referrer indicates young person is subject to child protection.

6.16 If the Initial appointment is being undertaken by a less experienced clinician (band 5 and 6) who is not yet considered able to use the narrative risk assessment, then the risk assessment will be recorded using the appropriate FACE risk profile. In some instances risk will not be part of the presenting problem, and may not be a conspicuous part of the young person’s general presentation leading to many indicators within the FACE risk profile being marked as not known.

6.17 However the collated summary of previous risk factors, risk related behaviour, and of current ‘warning signs’ based on what is known may help indicate whether it would be useful to:

- Discuss the case with other practitioners
- Initiate or arrange more detailed risk assessment with a view to devising a risk management plan
- Initiate or arrange more immediate intervention (if, for example, ‘warning signs’ emerged at interview)
- Regardless of the risk assessment tool used
• For some young people and their families an initial appointment will be followed up by a treatment appointment.

• The treatment appointment aims to build on the initial appointment and risk assessment to enable clarification / confirmation of the goals of the young person and their family and agreement about how they can be helped to achieve them.

6.18 The specific components of the assessment framework required for consideration are indicated in red text. However clinical judgement should still be used as to whether any of these components are not relevant/ inappropriate to the young person’s assessment. The basis of this judgment must be record in the relevant section.

6.19 At both initial appointment and throughout ongoing assessment/treatment the core assessment should build on any previous assessment provided as part of the referral process e.g. Common Assessment Framework for Children (CAF) assessment, Child in need assessment, Safeguarding children assessment. This will be achieved by the practitioner, checking accuracy of factual information, cross referencing and recording appropriately on the core assessment document.

6.20 If a significant time has passed between the assessment provided and the referral, professional judgement, based on the child or child/young person’s situation, will be used as to the extent the assessment builds on the previous assessment. There may be circumstances where a complete reassessment is appropriate.

6.21 As the CAF process is implemented in each Local Authority it will become part of the expectation of services that where a CAF assessment should have been completed it will always be provided as part of the referral to CYPS.

6.22 Once a child or child/young person has received an assessment, or part of the assessment the service assumes some responsibility for them. In practice, this means that the assessing clinician (whether employed by health or social services) needs to put in place care arrangements that meet any urgent needs. This responsibility does not mean that the child or child/young person will necessarily be offered longer-term services by a team, but is designed to ensure that children and young people do not fall into gaps between services at transition points and is of particular importance when presenting as a substantial or high risk.

6.23 Accountability and responsibility for decisions following an assessment rests with the professional carrying out the assessment. They should seek support and advice from their supervisor if necessary but decisions following assessment cannot be made collectively by the team. However, team meetings / MDT case discussions are essential to good team practice in supporting colleagues and guiding and informing practice. Team members have a responsibility to give sound advice, particularly where there are risk issues.
6.24 The outcome of each stage of (i.e. choice and partnership) the assessment, including the initial plan (recorded on the plan section of the core assessment screen) should be communicated to the child/young person (in a way that they will understand), their parent/carer where appropriate, and the referrer, promptly. The completion of the electronic record of the assessment enables the automatic population of the editable assessment outcome letter, through the use GP assessment editable letter functionality on RiO.

6.25 Following an assessment if it is agreed that the child or child/young person’s needs are to be met by the service, the child/young person’s care coordination registration should be completed on the electronic care record using the CPA Management screen. All staff should ensure that the child/young person have a documented GP and next of kin. Next of kin is recorded in the contacts section of the electronic patient record (RiO) which is accessed from the demographics screen. Those who do not will be referred as a cause for concern to the Child Protection Until via the Trust Named Nurse.

6.27 Assessment is an ongoing process and children / young people should have their initial assessment developed to enable further formulation and support their ongoing care planning. The sections of the core assessment that comprise a comprehensive assessment for those young people with enhanced needs will be completed and informed by clinical judgement using the core assessment framework as a guide.

6.28 The post assessment plan should be developed into a comprehensive care plan in collaboration with the child / young person and (as appropriate) their parent / carer and appropriate others to address the needs identified at initial and treatment appointment.

7 CARE PLANNING

Care Planning Users who do not have enhanced needs

7.1 When a child or child/young person has more straightforward needs and does not meet the criteria of enhanced needs there still needs to be a shared understanding of how care and treatment will be carried out, by whom and when.

7.2. This care plan can be recorded via the lead professional care plan / review screen of the electronic care record the content of which should meet the directorate’s standards. This enables the automatic population of an editable letter using the GP review lead professional editable letter functionality. The community care coordination care plan screen of electronic care record of RiO can be used if this enables clarity for the child or child / young person their parent / Carer.

7.3 The care plan should be SMART and recorded via the lead professional care plan / review screen should be written using language / terms that the young
person /and their parent / carer (if appropriate) is able to understand as much as is practicable.

- The care plan should clearly contain:
  
  o The date of contact / clinic / visit
  o The current plan of intervention / care / treatment agreed with the young person / and their parent / carer (if appropriate) and who is providing this, and the goals of the intervention, including those determined by the young person
  o Indicate the circumstances in which the young person may need extra help and the associated crisis arrangements
  o The outcome of the assessment of risk and if appropriate the agreed plans to manage the identified risk
  o Date of next appointment / visit
  o If medication is part of the care plan the medication, dosage and prescriber should be specified including arrangements for future prescriptions.

7.4 Whatever format is used the child or child / young person and their parent /Carer, as appropriate must always be offered a copy of this care plan unless doing so would constitute a significant risk to the child or others. Copies should also be sent to the GP and all those people involved in the child/young person’s care who do not have access to the electronic care record (RiO) within 7 days of the care plan being discussed with the child/young person and/or their parent or carer as appropriate and potential benefits/risks explained.

7.5 Care Planning for children or young people with enhanced needs (incorporating CPA)

7.6 Where a child or child/young person has more complex needs and characteristics then enhanced care coordination incorporating the requirements of CPA will be the framework used to deliver a continuity of care for vulnerable children or young people who may require intensive intervention or long term support.

7.7 There is no substitute for sound professional judgement, dialogue and sound evidence-based practice underpinned by good, up to date research. This guidance does not seek to replace professional skills and knowledge but to offer the practitioner indicators and guidance on the particular level of care coordination.

7.8 Care planning should be a collaborative process with all children/young people as much as is possible. To help a child/young person be involved and make decisions appropriate to their age and understanding all possible and appropriate means of communication and providing relevant information should be tried.

7.9 If the child/young person (or their parents/carers on their behalf) and the professionals supporting them disagree over any element of the care plan the
approach should be one of discussion and compromise whenever possible. Where disagreement remains the care plan should record this.

7.10 Registration at enhanced level using the CPA / standard care management screen on RiO will be appropriate for children whose needs and care at the present time are likely to be very significantly compromised. In some situations, a single indicator that is so obviously significant will lead to registration at enhanced level even in the absence of any other indicator. Professional experience, training and judgement should always be used.

7.11 Enhanced Level Indicators

- Complex behaviour and emotional difficulties requiring more than one specialist intervention from Trust services with a higher degree of service coordination. This may take the form of more frequent interagency or interdisciplinary communication or review and shared decision making.
- Acute mental health problems with a high degree of clinical complexity
- In patient admission
- Current or potential risks including suicide, self-harm, harm to others, relapse history, self-neglect, non-concordance (non-compliance), child protection

7.12 The care coordination care plan must be coherent with and cognisant of other planning documents e.g. Child protection plan; Looked after children plan; Education plan.

7.13 Where such a plan is formulated the care coordination care plan will extrapolate from this and detail the Children and Young Peoples service contribution to meeting identified goals.

7.14 Through discussion and negotiation with the child/young person and where appropriate their parents / carers and others, a comprehensive, formal written care plan will be developed and agreed taking into account any advanced statement.

7.15 The care plan should clearly state the resources, actions and associated goals of such interventions and have been agreed with the child / young person, their family or carers. Young people’s goals should be integral to the care plan, which should also build on the young person’s strengths. This care plan will be recorded using the appropriate care plan on the electronic care record (Care Coordination care plan for community; core care plan for Inpatients).

7.16 If medication is part of the care plan the rationale for any prescribed medication, the dosage and prescriber should be specified including arrangements for future prescriptions and how and when it will be monitored.

7.17 If the child or child/young person disagrees with any part of the care plan, and this is not able to be resolved through discussion and negotiation in the
community, this will be recorded on the care plan agreement section of the care plan on the electronic care record (RiO).

7.18 All care plans will have a recorded crisis and contingency plan agreed with the child/young person, their family or carer and relevant others recorded RiO that clearly sets out:

- The circumstances in which the child/young person may need urgent extra help including, if relevant, warning signs which are indicators of worsening problems;
- The actions to be taken and by whom including the child/young person their family / carers and services;
- Where there is a risk management plan the crisis and contingency plan should not duplicate this but reflect a continuum of support arrangements

7.19 The child / young person and / or their parent or carer (based on consent) should be offered a copy of their care plan (including crisis and contingency plan and, if in place, risk management plan. However, if doing so would constitute a significant risk to the child or others, the reasons for not sharing the care plan should be recorded in progress notes. Clinical judgement will need to be used to decide if the reason for not offering a copy of the care plan to the young person is shared with them with the rationale for the decision recorded in progress notes.

7.20 A copy of the care plan should also be sent to the GP and all those people involved in the child or young person’s care who do not have access to the electronic care record (RiO) within 7 days of the care plan being discussed with the child / young person and / or their parent or carer as appropriate and potential benefits/risks explained.

7.21 Some young people admitted to inpatient services may not have a registered GP on admission. In such circumstances they will receive a GP service from the surgeries contracted by the Trust. In addition the need for registration with a local GP will be raised at the first inpatient review to ensure that this is in place prior to discharge to facilitate appropriate communication at discharge.

8 REGISTRATION ON CARE CO ORDINATION

8.1 Registration of the child/young person on care coordination requires the completion of the CPA/Standard care management screen on RiO.

8.2 Registration for non-enhanced level is completed choosing the option of not on CPA.

8.3 Registration for enhanced level is completed choosing the option enhanced care coordination.
8.4 Whatever the level of care coordination an appropriate professional to take on the role of Care Coordinator must be agreed and recorded.

8.5 If the appropriate professional to take on the role of Care Coordinator is not on the drop down list to choose form e.g. they are not an CNTW member of staff they can be added by contacting the IT help desk an providing the following information

Name
Professional role
Connect details – address and telephone number

Any requests regarding a change of Care Coordinator by a client or Care Coordinator should be made in writing and will be considered by the Team Manager

9 REVIEW

9.1 For all children and young people their care plan must be subject to ongoing monitoring, such as that stated by NICE or in shared care guidance, but should be reviewed formally in line with any risk management plan and planned review dates.

9.2 If a child or child/young person’s care had been reviewed through Safeguarding Children, Looked after Children, team around the child or child in need processes then a separate care coordination review should only be held if there is a clear need or if requested by the child/young person or their parent / carer.

9.3 Frequency of Reviews should be determined by the needs of the child / young person but should be at least every 6 months.

9.4 Each review should consider if the young person’s needs have changed and as such should the level of care coordination be changed and who, given the young person’s changing needs is best placed to be care coordinator. However, continuity of the role is to be encouraged unless the clinician is no longer to be involved in the young person’s care and treatment.

9.5 For young people who are inpatients they will have enhanced needs throughout their inpatient stay. However, the Discharge Review should consider and agree (with the involvement of community clinicians) the appropriate level of care coordination on discharge

9.6 In line with the principles (outlined in 3.2) every child and young person should have the opportunity to take part in the entire Care Coordination Review. This to ensure that the child or young person is at the centre of decision making about their own care and treatment

9.7 Support should be made available to the child or young person to attend which may include carer/relative, advocate or clinical staff support
9.8 Care Coordination Reviews should be structured in such a way as to make access by children and young people as easy as possible. This may include choice of venue, number of people attending, time of day etc.

9.9 If the child or young person chooses not to attend the review then support should be made available to the child or young person to take part in other ways e.g. through an advocate, through a member of the care team presenting their views, by writing their own report for the review

9.10 In certain cases it may not be appropriate (or assessed as in the child or young person’s best interest) to attend part or the whole of the CCR. Reasons for this may include:-

- Attendance at the CCR is assessed by the clinical team as detrimental to the health and wellbeing of the child or young person
- Information shared is of a confidential / third party nature
- Information shared involves aspects of safeguarding / public protection

9.11 If the child or young person is absent from part or the whole CCR then the Care Coordinator should clearly document this within the minutes of the meeting, outlining the reasons for this.

9.12 Care plan review for children and young people who do not have enhanced needs

9.13 The review will as a minimum be undertaken by the Care Coordinator involving the child or child / young person, and where appropriate their family and/or any identified carer and all members of the care team in a setting where the child or child / young person feels comfortable and will as a minimum be at least every six months.

9.14 Review progress of care plan against the agreed outcomes and agree any changes (if required).

9.15 Review current assessment of risk and agree any changes.

9.16 Review any relapse (crisis) and risk management plan and agree any changes (if required).

9.17 The review and the revised / new care plan should be recorded via the lead professional care plan / review screen of the electronic care record the content of which should meet the directorate’s standards. This enables the automatic population of an editable letter.

9.18 The review record on the lead professional care plan/review screen should be written using language and terms that the young person/and their parent/carer (if appropriate) is able to understand as much as is practicable. It should clearly indicate it is a review, e.g. when we met on date/date we reviewed your current plan of care and agreed that:
• Plan of intervention/care/treatment agreed with the young person/and their parent/carer (if appropriate) and who is providing this
• The circumstances in which the young person may need extra help and the associated crisis arrangements
• The outcome of the assessment of risk and if appropriate the agreed plans to manage the identified risk
• Date of next appointment / visit

9.19 The care coordination review section of the electronic care record (RiO) can be used if this enables clarity for the child or child/young person and their parents/carers. The CPA standard care management screen must also be updated to show the date the review occurred and the planned date for the next review.

9.20 Whatever format is used the service user must always be offered a copy of the review record unless doing so would constitute a significant risk to the child or others. A copy should be sent to the GP and any others who are part of the care team who do not have access to the electronic care record (RiO) within 7 days of the review.

9.21 Care plan review for children and young people with enhanced needs

9.22 The review will as a minimum be undertaken by the Care Coordinator involving the child or child/young person, and where appropriate their family and / or any identified carer and all members of the care team. This will usually involve a meeting of all concerned in a setting where the child or child / young person feels comfortable and will as a minimum:

• Agree a chair (this will usually be the Care Coordinator)

• Agree a scribe to complete the documentation and enter onto the care plan review section of the electronic care record (RiO). The scribe will check completed form with the child / child / young person, their parents / carers as appropriate and the Care Coordinator for accuracy.

• Review progress of care plan against the agreed outcomes

• Agree any changes to the care plan (if required)

• Agree who will record the new care plan with the child / child / young person and update on RiO

• Review current assessment of risk and agree any changes to risk assessment

• Review crisis / contingency plan and any risk management plan and agree any changes (if required)
• Agree who will undertake the recording of new risk assessment (if required) on electronic care record (RiO)

• Agree who will undertake to record new crisis / contingency plan and risk management plan (if required) with the child / child / young person and update the electronic care record (RiO) record

• If the child / child / young person has an Advance Statement review if this still reflects their wishes / views and ensures that any changes are updated on electronic care record (RiO)

9.23 The Care Coordinator will be responsible for ensuring that the record of the review is made in the electronic care record and that the CPA management screen is updated to show the date the review occurred and the planned date for the next review. A printed copy of the review record will be distributed by the care coordinator to the child or child / young person their parent / carer, where appropriate, GP and all those participating in the review process who do not have access to electronic care record (RiO) unless doing so would constitute a significant risk to the child or others.

9.24 If the review results in a new or revised care plan the child/young person and/or their parent or carer as appropriate must always be offered a copy of this care plan unless doing so would constitute a significant risk to the child or others. Copies should also be sent to the GP and all those people involved in the child or young person’s care who do not have access to the electronic care record (RiO) within 7 days of the review.

10 RISK ASSESSMENT AND RISK MANAGEMENT

10.1 Risk assessment is a multi-disciplinary responsibility and must be undertaken or reviewed and recorded using, as appropriate:

• Narrative risk tool
• FACE risk profile Children and Young People
• FACE risk profile Learning Disability (Child and Adolescent)

on the electronic care record (RiO). These are the minimum risk assessment tools approved for use in CYPS.

10.2 These minimum requirements can be supplemented by the use of other specific risk assessment tools as clinically indicated. Additional completed tools should be scanned onto RiO with an entry made in progress notes indicating outcome of risk assessment. The progress note entry should include who scanned the document if not the person making the progress note.

10.3 Less experienced clinicians (band 5 and 6) will complete FACE risk profile, until such time as they are considered by their manager, through supervision, to be
competent to use the narrative risk tool. This will be considered and recorded as part of the supervision process.

10.4 Where there is shared care between EIP and Children and Young people’s services the CYPS FACE risk profile is used for all young people with enhanced needs up to the age of 18.

10.5 For young people with enhanced needs who remain in service with CNTW post 18 at their next care co-ordination review (which would include a ward discharge review) the Adult FACE risk profile will be completed unless they are transitioning out of CNTW services when clinical judgement will be used to determine when (or indeed if) a different FACE risk profile should be used.

10.6 Appendix 4 sets out transition arrangements for young people in service at the time of this policy change.

10.7 Risk assessment is an ongoing, dynamic process and is required as a minimum at these stages of a young person’s pathway:

- As part of initial assessment when the narrative risk tool is used (see also Section 10.2)

- On admission to hospital. Any existing FACE risk profile should be updated if required. If the risk profile remains accurate this should be noted in a progress note entry which is marked as a significant event and the FACE risk profile re-dated on the electronic care record. All planned admissions of young people from CNTW services should be supported by the completion of a FACE risk profile by community clinicians. As part of planning and agreeing leave, the FACE risk profile and any inpatient risk management plan should be reconsidered and updated if required, using the create new facility on RiO, to reflect current risk and management plans. If there is no changes required this reconsideration should be recorded as part of the prescribing of leave record

- When young person is being discharged from an inpatient setting, the existing FACE risk profile should be updated if required. If the risk profile remains accurate this should be noted in a progress note entry which is marked as a significant event and the FACE risk profile re-dated on the electronic care record

- Significant changes to areas or levels of risk should lead to the creation of a new risk assessment using the narrative risk tool for young people who do not have enhanced needs and FACE for young people with enhanced needs. In both instances ‘the create’ new facility on RiO should be used. If appropriate a new risk management plan should be recorded

- As part of the review process the current assessment of risk and any risk management plan should be reconsidered. If the current assessment of risk and / or the risk management plan remains accurate and appropriate then this should be recorded on RiO in either the relevant section of the review
screen or on the lead professional care plan / review screen as appropriate to the young person’s level of need. Significant changes in areas or levels of risks should be recorded on the appropriate risk assessment on the electronic care record (RiO) using the create new facility and if appropriate a new risk management plan recorded on the electronic care record (RiO).

- When there are major changes/incidents, including any that are communicated by other professionals / agencies, the risk assessment and any risk management plan needs to be reconsidered. If the risk assessment remains accurate then the concerns and the reconsideration of risk should be recorded in progress notes and the significant event box checked so that this is added to the time line. Significant changes in areas or levels of risks should be recorded on the risk assessment on the electronic care record (RiO) using the create new facility and if appropriate a new risk management plan recorded on the electronic care record (RiO).

- When alerted by parents/carers due to concerns, the risk assessment profile needs to be reconsidered. If the risk assessment remains accurate then the concerns and the reconsideration of risk should be recorded in progress notes and the significant event box checked so that this is added to the time line. Significant changes in areas or levels of risks should be recorded on the risk profile on the electronic care record (RiO) using the create new facility and if appropriate a new risk management plan recorded on the electronic care record (RiO).

- When transferring children and young people to other teams / service providers a current risk assessment must be completed and a copy sent to the new team/service provider if they are not RiO users.

10.8 Risk management plans are an integral part of a young persons care plan regardless of their level of need and will be developed when the level of risk is significant, serious or serious and imminent {FACE risk profile ratings scale 2, 3, or 4}. The management of risk issues that are rated 1; should be covered by the crisis and contingency plan.

10.9 For young people with enhanced needs a risk management plan should be recorded on the care coordination care / risk management plan.

10.10 For young people who do not have enhanced needs the plan arising from the narrative risk assessment should be integrated into their care plan.

10.11 Risk related incidents should be recorded in the progress notes section of the electronic care record and the risk history box checked to enable a record to be made on the Risk and Significant events Chronology and time line.

11 THE CLINICAL RISK AND SIGNIFICANT EVENTS CHRONOLOGY TIME LINE

11.1 The Clinical Risk and Significant events Chronology pre the use of RiO will be available in the patient’s unified health record The Time line on RiO is used to document significant events including those relating to risk throughout the
child/young person’s pathway of care.

11.2 It can be added to by any member of the care team through the use of the significant event and/or add to risk history check boxes in progress notes.

12 INPATIENT OR DAY UNIT ADMISSION AND DISCHARGE ARRANGEMENTS (INCLUDING SECTION 117)

12.1 All children or young people admitted to an inpatient facility will be registered on enhanced care coordination using the CPA management screen on RiO.

12.2 Where there has been previous involvement from Trust services the child or child/young person’s RiO support file should move with the child/young person to the inpatient setting. The admitting team should also be aware of any historic records and the following care coordination documentation will be updated on RiO on admission:-

- Core assessment including a record of all medications used by the child including over the counter and herbal remedies recorded in the medication, sensitivities and allergies form in the core clinical documents.
- On admission service users should have their medicines checked for accuracy and appropriateness – Please refer to the Trust’s CNTW(C)17 – Medicine Management Policy, practice guidance note: _UHM-PGN-02 - Prescribing Medicines_ - Section 4
- Presence or absence of Allergies should be recorded
- Risk assessment (FACE risk profile) and Risk Management Plan agreed as part of planned admission process;
- Initial Care plan agreed as part of planned admission process this will document the involvement of the Care Coordinator during the period of inpatient care

12.3 Admission of young people in CNTW services does not and should not require a change of Care Coordinator. Where admission is for a young person not in CNTW services, a member of the IP team will take on the role of Care Coordinator for the period of the inpatient stay.

12.4 Where Admission relates to a child/young person not already in CNTW Service the lead professional will be expected to supply the admitting professional with the following documentation, which will be scanned onto RiO and saved as the relevant image type with an entry made in progress notes. The progress note entry should include who scanned the document if not the person making the progress note

- Current Assessment

- The risk assessment and risk management plan agreed as part of planned admission process
• The initial care plan agreed as part of planned admission process; this will document the involvement of the lead professional during the period of inpatient care

12.5 These will inform the updating on admission of:
• Core assessment
• FACE risk profile
• Inpatient care plan, including crisis and contingency plan and risk management plan
• Observation levels
• Leave arrangements, on the electronic care record (RiO)

12.6 Where the admission to an inpatient ward is due to a crisis, the appropriate professionals e.g. admitting nurse and doctor, and referrer, in conjunction with the child or child/young person and parent/carer (where appropriate), will collectively complete/update the risk profile on RiO as appropriate and use this as a basis to develop the initial in patient Risk Management Plan, which will incorporate the following:
• Planned or agreed leave
• Observation levels
• Action to be taken in the event of increased clinical risk e.g. absconson risk
• Any medication the child or child/young person requires
• Details of risk history

12.7 A record should be made of all prescribed medications used by the child including required monitoring and over the counter and herbal remedies. Presence or absence of allergies should be recorded.

12.8 Children admitted to the Trust or to CYPS will be seen by the admitting clinician within six hours. The admitting clinician will assess whether urgent physical examination is required or whether it would be more clinically appropriate to await routine examination by the contracted GP service at the next available opportunity. The outcome of this assessment will be clearly recorded. On those rare occasions where young people are admitted to adult mental health facilities they will be offered a physical examination as per the Trust standards.

12.9 If the child or child/young person is competent under Fraser Guidelines and refuses assessment of their physical condition, a limited interim assessment should be offered e.g. temperature, pulse and blood pressure. A more detailed assessment should be offered as soon as is practicable.

12.10 Children and young people who stay in hospital for six months or more should have their physical needs and condition fully assessed by a medical
practitioner, every six months for the first year and annually thereafter unless changes in the young person’s condition prompt re-assessment.

12.11 However if the young person is prescribed stimulants for ADHD they will need physical health parameters measured 6 monthly. If commenced on antipsychotic medication the young person may need physical health checks repeated after medication started and if high dosage antipsychotic therapy is used physical checks will be 3 monthly.

12.12 Each inpatient admission, regardless of time elapsed, is a separate episode and will have a full assessment including a risk assessment and physical examination completed at all times.

12.13 At the first inpatient Multi-disciplinary Team Meeting the team will hold a formal care coordination review and with the Care Coordinator, will complete a full review of the patient’s care needs for the duration of their inpatient admission.

12.14 In addition to the clinical record of the review it should be logged via the CPA/Standard care management screen.

12.15 The review will be informed by the care coordination assessment, the risk profile and other appropriate clinical assessments (health and social care) and documented on the care plan review section of the electronic care record (RiO).

12.16 This outcome of the review will formulate a care coordination care plan recorded on electronic care record (RiO) which will include the agreed interventions by all members of the care team. This will include any interventions to be delivered by/the involvement of the Care Coordinator during the inpatient admission. The arrangements for subsequent reviews prior to discharge will also be agreed.

12.17 Any prescribed medication will be reviewed in line with trust formulary requirements.

12.18 If the child or child/young person is from out of area then the care plan will document agreed interventions to be delivered by and the involvement of, the local lead professional during the inpatient admission. The arrangements for subsequent reviews prior to discharge will also be agreed. An agreed appropriate member of the inpatient team will undertake the role of Care Coordinator for the period of admission, as outlined in this policy and the CPA management screen completed.

12.19 The child or child/young person and/or their parent or carer as appropriate must always be offered a copy of the care plan unless doing so would constitute a significant risk to the child or others.

12.20 The Clinical Risk and Significant events Chronology pre the use of RiO will be available in the patient’s unified health record. The Time line on RiO is used to document significant events including those relating to risk throughout the child/young persons pathway of care.
12.21 Any member of the multi-disciplinary team will add information to Time line as and when incidents occur through the use of the significant event and / or add to risk history check boxes in progress notes.

13 THE PRE-DISCHARGE MEETING OR FINAL PATIENT REVIEW (Multi-disciplinary team meeting)

13.1 Prior to the patient's actual discharge, the team would hold a formal care coordination Review. With the Care Coordinator, or out of area lead professional, a discharge care plan, identifying the patient’s care needs for their immediate discharge and successful reintegration into the community will be completed and recorded on the electronic care record (RiO) with particular reference to immediate needs, support in the first week of discharge and the subsequent 3 months including:

- Medication changes, the arrangements for prescribing and dispensing of medication post discharge and any associated monitoring requirements. This could include when appropriate whether the young person will be responsible for their own medication based on an assessment of concordance and ability to self-administer
- Out-patient appointments
- Social requirements
- A Risk Management Plan (if applicable)
- Crisis plan
- Formal transfer of care (for regional / national patients)
- Agreement for any Section 117 services if applicable

13.2 The Care Coordinator/out of area lead professional will be responsible for ensuring copies of the Care plan are sent to all relevant parties who do not have access to the electronic care record (RIO). The child or child/young person and/or their parent or carer as appropriate must always be offered a copy of this care plan unless doing so would constitute a significant risk to the child or others.

13.3 The In patient consultant is responsible for ensuring that notification of discharge and a discharge summary is sent to GP within one week of discharge which includes details of physical health

13.4 At discharge a sufficient supply of any medication should be provided to avoid medications running out before the arrangements for the service user’s next prescription are in place.
14 INPATIENT - TRANSFER BETWEEN WARDS

14.1 Prior to transfer the young person’s current ward must ensure that all records are up to date (electronic and paper) including the medication screen.

14.2 On transfer the admitting ward will record the admission on electronic care record (RiO) including (if required) any changes to demographics, personal contacts, care coordination registration (via CPA management screen).

14.3 The admitting Doctor and Nurse update the assessment, risk assessment and care plan on electronic care record (RiO) as appropriate to reflect the child/young person’s current presentation/circumstances.

14.4 If the risk assessment and care plan continue to be current despite the change of ward this must be agreed at first MDT recorded on Children and Young Peoples care plan review section of RiO and each section of the electronic care record (RiO) re-dated.

14.5 If the young person is competent (either because they are 16 or over or because that are under 16 and competent under the Fraser guidelines) then the admitting Doctor and nurse should ascertain if the consent to share information record in RiO contuse to reflect their wishes. If the young person is not competent this should be checked with parents or others with parental responsibility whoever has parental responsibility.

14.6 The Young Persons RiO support file and any previous UHRs should always transfer with the young person.

15 YOUNG PEOPLE WHO MOVE WITHIN CUMBRIA NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

15.1 Where young people move from one area/service to another within Cumbria Northumberland, Tyne and Wear NHS Foundation Trust, there is the potential for interruption in the continuity of care and treatment.

15.2 Planned Moves

15.3 The decision to transfer responsibility for the care of a child/young person should take place within the care coordination review process involving the child/young person and their family/carer (if appropriate), unless exceptional circumstances prevent this. An inpatient admission should not automatically lead to a change of Care Coordinator

15.3 Appropriate representatives of the receiving service should be invited to contribute to the review by attending a review meeting or by other means if that is not possible, e.g. the proposed Care Coordinator, consultant.

15.4 This must be supported by effective communication, and detailed information must be made available to the appropriate professionals in the receiving
team/service prior to the review. As a minimum this information must comprise of copies (for those participating without access to RiO) of the most recent

- Assessment
- Risk assessment
- Care plan including relapse (crisis) plan, prescribed medication and ongoing monitoring and where appropriate risk management plan

15.5 The review should consider the impact of the child/young person’s transfer on risk issues and jointly complete a new risk assessment if appropriate and also agree any changes needed to the child/young person’s care plan.

15.6 An agreed timescale for implementing the transfer should be drawn up between the current and receiving service to enable:

- The receiving team/service to identify the new Care Coordinator who then accepts responsibilities for the child/child/young person at the agreed time and updates the CPA Management screen to record the transfer of responsibility
- Appropriate services to be set up by the receiving team/service, in consultation with the child/young person their family and other service providers, to meet needs identified in the current care plan before the transfer takes place
- The transfer of the child/young person’s records

15.7 Unplanned Moves

15.8 Some young people will move in an unplanned way, where this is very local, and the original Care Coordinator is aware of this they should continue working with that child/child/young person until formal hand over arrangements, described in Section 15.2, can take place.

15.9 Where the move is at some distance and it would be impracticable for the Care Coordinator to do this, then discussion should take place between the teams at the earliest opportunity to enable formal hand over including the child/young persons record(s).

16 CHILDREN / YOUNG PEOPLE WHO MOVE OUTSIDE OR INTO CUMBRIA NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

16.1 Where a child/young person moves out of area any Section 117 responsibility remains with the Local Authority where they were ordinarily residing, however, legal advice may be needed in particularly complex cases around issues such as ordinary residence, funding responsibility and Section 117 responsibility.
16.2 If a the child/young person user is moving outside of the geographic area covered by CYPS, Care Coordination Lead can support Care Coordinators to establish the appropriate team/service that covers the area the service user is to/has moved to.

16.3 The Care Coordinator should make contact with team/service that covers the area the young person is to/has moved to and arrange a formal hand over. If practicable this should be undertaken, though review meeting attended by a representative of the receiving team. Where the move is at some distance or has been unplanned discussion should take place between the teams at the earliest opportunity to enable formal hand over.

16.4 Whatever methodology is used the handover must be supported by effective communication and detailed information must be made available to the appropriate professionals in the receiving team/service. As a minimum this information must comprise the new address and copies of the most recent:

- Assessment
- Risk assessment
- Care plan including crisis plan and where appropriate risk management plan
- Summary of most recent contacts with the service user
- Prescribing information and ongoing monitoring as shared care requirements may vary

16.5 If young person is moving into the area covered by CYPS the expectations are that the out of area Lead professional/Care Coordinator should make contact with the Trust team/service that covers the area the service user is to/has moved to and arrange a formal hand over.

17 DE-REGISTRATION

17.1 De-registration occurs and is recorded on the electronic care record (RiO) system using the CPA/Standard Care Management screen when the child or child/young person ceases contact with mental health and learning disability services provided by this Trust e.g.

- Discharged to Primary Care Team
- Care continued by the Local Authority (LA) but no involvement from Trust services

17.2 In both instance appropriate information should be provided to the young person/their family (as appropriate) and relevant others at discharge from CYPS to enable safe transitions including, where needed, continuity of care. Whilst there may have been a care coordination review or other meeting e.g. LAC review, Child protection case conference prior to the young person’s discharge it is important that at the point of discharge a discharge
letter/summary is sent to the GP and any others who remain involved with the child/young person and the young person and when appropriate, their parent or carer.

17.3 The discharge letter/summary will recorded in letter format and uploaded onto the electronic care record via images and logged as document type discharge letter. Appendix 5 sets out the range of information that should be considered for inclusion as clinically relevant to the young and their ongoing needs.

17.4 Discharge from an individual clinicians caseload on electronic care record (RiO) does not equate to or result in de-registration from care coordination.

18 CARE COORDINATOR ROLE

18.1 All Care Coordinators will be employed by the statutory health or social services, usually in a specialist role.

18.2 The appropriate Children and Young Peoples Service worker to take the role of Care Coordinator will be decided on a case by case basis and should be the most appropriate person given the child or child/young person’s needs. It should usually be taken by the person who is best placed to oversee case management and can be of any discipline depending on capability and capacity.

18.3 The Care Coordinator will have the authority to coordinate the delivery of the care coordination care plan and ensure that this is respected by all those involved in delivering interventions.

18.4 It is not the intention that the care coordinator necessarily is the person that delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required.

18.5 For children or young people who have had damaging experiences of sexual abuse or violence, choice of gender of the Care Coordinator may be a crucial factor in establishing trust and a therapeutic relationship.

18.6 Where a child or child/young person does not have enhanced needs and has contact with only one professional then that person will be the Care Coordinator and will be the person responsible for facilitating their care.

18.7 Where a child or child/young person does not have enhanced needs and has contact with more one professional within Trust services a Care Coordinator will be agreed from within the care team.

18.8 Where there is multi agency involvement and a multi-agency care plan the Coordinator is responsible for co-ordinating the care planning process of Children and Young Peoples Services only and being the Trust lead in multi-agency working.
18.9 The Care Coordinator role does not automatically equate to the lead professional role under Safeguarding Children or CAF

18.10 The responsibility for the coordination of the overall multi agency Safeguarding Children care plan will remain that of the safeguarding lead professional

18.11 Where a CAF care plan is developed and Children and Young Peoples Services are part of the team around the child the CAF lead professional will ensure that support and services for a particular child is coordinated and provided in an integrated, effective way. On a case by case basis it may be agreed that the Care Coordinator will also undertake that role

19 CARE COORDINATOR RESPONSIBILITIES

- Ensuring full details of a new child or child/young person are entered into the electronic care record (RiO), or ensuring entry of the change of Care Coordinator via the CPA management screen when receiving a transfer. Where the patient resides outside Cumbria Northumberland Tyne and Wear NHS Foundation Trust’s services and has a local Care Coordinator/Lead Professional this responsibility will be undertaken by the allocated worker/Children and young peoples case manager

- Making contact with the child or child/young person at agreed intervals and if they cease contact, informing others as necessary

- Providing care planning and review arrangements with the child or child/young person and his or her family or carers in accordance with the standards set out in this policy. Communicating effectively with all those involved with the child or child/young person’s care; including where there are multi-agency plans participating in multi-agency meetings

- Ensuring the completion of the appropriate FACE risk assessment(s)

- Identifying when a child or child/young person needs advocacy to enable them to participate in the planning of care and ensuring they have access to the care identified

- Making arrangements for their inclusion in the care planning and review arrangements and supporting their role

- Receiving information from others providing a service to the child or child/young person and using as appropriate in the care arrangements

- Ensuring the completion of clinical outcome measures e.g. HONOSCA

- Informing the person responsible for the care coordination system where difficulties arise, either because the system is not being adhered to or because the system itself is not meeting the best interests of the child or child/young person
• The Care Coordinator may fulfil these responsibilities through effective, agreed and appropriate delegation to other members of the care team. Such delegation will be recorded in progress notes or on the care plan or review screens on RiO as appropriate to when delegation occurs.

19.1 RESPONSIBILITIES OF ALL MEMBERS OF THE CARE TEAM

19.2 All professionals whether employed in the statutory or voluntary sector, and any carers, have a responsibility to:

• deliver agreed interventions recording appropriately
• undertake their own dynamic and ongoing risk assessment recording appropriately
• contribute to the overall assessment of risk through sharing of their professional assessment
• communicate with the Care Coordinator regarding their assessment of risk their role in the care plan and progress of associated service delivery

19.3 This is particularly important following any major change in the circumstances of the child/child/young person or should service delivery cease or no longer seems appropriate.

19.4 The Time line on the electronic care record (RiO) is used to document significant events including those relating to risk throughout the child/young persons pathway of care. It can be added to by any member of the care team through the use of the significant event and/or add to risk history check boxes in progress notes.

20 INFORMATION LEAFLETS

20.1 Information leaflets for Young People and their families about care coordination are available from the Patient information centre of via the following links:


21 GOOD PRACTICE IN JOINT WORKING AND RECORD KEEPING

21.1 Regardless of who is the Care Coordinator for a young person this role does not equate to responsibility for completing all aspects of the electronic patient record. Their responsibility is to ensure the record is completed. Where there is joint assessment the clinicians involved in that joint assessment should ensure that the record of the assessment includes and reflects their joint input. This may be through each clinician adding to the appropriate sections of the core assessment and saving. It would be validated once it is agreed it is complete, i.e. there is an agreed formulation and initial plan.
21.2 Similarly where there is joint assessment of risk the clinicians involved in that joint assessment should ensure that the record of the assessment includes and reflects their joint input. This may be through each clinician adding to the risk assessment screen on the electronic record, or one clinician undertaking the initial recording and validating the document once it is agreed it is complete, i.e. reflects the current assessment of risk.

21.3 Each member of the care team having involved the young person should record on the care plan their intervention, i.e. the need(s) the intervention is to address, the goals to be achieved (these may be short term), the intervention planned and when this will be reviewed. Goals should include those determined by the young person. Once the care plan has been completed it should be validated.

21.4 In preparation for a review each member of the care team can record progress in relation to the care plan interventions and goals in the section progress/presentation since last review.

21.5 Record progress against any actions that they were allocated at a previous review in the update of actions section. It is also good practice for an agreed member of the care team prior to the review to discuss and record the young person’s thoughts, views and wishes, and where appropriate their parent/carers thoughts, views and wishes.

22 IDENTIFICATION OF STAKEHOLDERS

22.1 This is an existing policy which has been reviewed in line with the Trust’s CNTW(O)01 – Development and Management of Procedural Documents, having a two week consultation to the following:

- North Locality Care Group
- Central Locality Care Group
- South Locality Care Group
- North Cumbria Locality Care Group
- Corporate Decision Team
- Business Delivery Group
- Safer Care Group
- Communications, Finance, IM&T
- Commissioning and Quality Assurance
- Workforce and Organisational Development
- NTW Solutions
- Local Negotiating Committee
- Medical Directorate
- Staff Side
- Internal Audit
- Health Safety Security and Resilience
23 EQUALITY AND DIVERSITY ASSESSMENT

23.1 In conjunction with the Trust’s Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

24 TRAINING

24.1 The Trust will ensure that all staff have access to appropriate levels of training, it is the responsibility of each operational director to ensure staff attend. Whilst attendance can be monitored at a team / ward or individual level via the Trust dashboards it is also formally monitored through the Group governance arrangements. (Appendix C)

24.2 Levels of training are identified in the training needs analysis and are included within the Essential Training Guide

24.3 Training on the principles and process of care coordination within Children and Young Peoples services incorporating risk assessment and recording using the narrative and risk assessment appropriate FACE Profile will be provided for all those involved in the system and will be built into local induction training for all disciplines.

24.4 This training will be overseen by the Specialist Group Quality and Performance Group and is Essential Clinical Training and a priority for all clinical staff as reflected in the Training Needs Analysis. i.e. Those staff who take on the role of Care Coordinators, specifically Consultant Psychiatrists, Specialist Registrars (SpR's), Staff Grade Psychiatrists, Social workers, Psychologists, Qualified Nurses suitably experienced and skilled under appropriate supervision, Occupational therapists, Clinical Staff from Department of Psychological therapies, Psychotherapists. Course attendance will only be required when identified through the competence framework being introduced in 2014

24.5 Training is also offered to those who participate in the process i.e. support workers, unqualified nurses, and Psychiatry trainees (formerly known as SHOs)

25 IMPLEMENTATION

25.1 Taking into consideration all the implications associated with this policy, it is considered that an immediate implementation of this policy is achievable for the contents to be embedded within the organisation.
26 MONITORING COMPLIANCE - Appendix C

26.1 An annual audit of the policy implementation will be undertaken thought the Trust Quality and Monitoring audit process to establish the level of embedding of the policy as shown in Appendix C, Monitoring Tool.

26.2 Action planning to address any remedial action needed, will be overseen by the Specialist Services Safety group which is a sub group of Group Quality and Performance Group including, if required, delegating actions to task and finish groups.

26.3 Attendance figures for Clinical Risk and care coordination training will be reported monthly as part of the Workforce report to Trust wide Quality and Performance Group.

27 FAIR BLAME

27.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

28 FRAUD, BRIBERY AND CORRUPTION

28.1 In accordance with the Trust’s policy CNTW(O)23 – Fraud, Bribery and Corruption, all suspected cases of fraud and corruption should be reported immediately to the Trust’s Local Counter Fraud Specialist or to the Executive Director of Finance.

29 ASSOCIATED DOCUMENTATION

- CNTW(C)03 - Leave, Absence without Leave, and Missing Patient Policy
- CNTW(C)06 - Non Attendance Policy
- CNTW(C)19 - Observation Policy
- CNTW(O)01 - Development and Management of Procedural Documents
- CNTW(O)09 – Management of Records Policy
  - MR-PGN-02 - Record Keeping Standards
- CNTW(O)22 - Sharing Letters with Patients Policy
- CNTW(O)23 – Fraud, Bribery and Corruption Policy
• CNTW(O)33 - Risk Management Policy
• CNTW(HR)09 – Staff Appraisal Policy and practice guidance notes

• RiO User Guides
• Relevant Local Authority Common Assessment Framework Guidance
• DOH Guidance 2008 Refocusing CPA
• NSF Children, Young People and Maternity 2005
# Equality Analysis Screening Toolkit

<table>
<thead>
<tr>
<th>Names of Individuals involved in Review</th>
<th>Date of Initial Screening</th>
<th>Review Date</th>
<th>Service Area / Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Long</td>
<td>October 2020</td>
<td>October 2023</td>
<td>Trust wide</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy to be analysed</th>
<th>Is this policy new or existing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNTW(C)48 – Care Coordination, Care Programme Approach – Children and Young People V05</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What are the intended outcomes of this work?</th>
<th>Include outline of objectives and function aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy sets out the principles and framework for assessment and care planning for children and young people receiving mental health or learning disability services within Cumbria Northumberland, Tyne and Wear NHS Foundation Trust. This approach is underpinned by shared Values and Principles. This policy includes the requirements of C(90)23 /LASSL (90)11 “Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach (CPA) (1999)” and Department of Health (DOH) guidance Refocusing CPA(2008) recognising that CPA is not the only care planning method for children and young people and that its use needs to be coordinated with the other systems to ensure that young people are not overloaded with assessment and review meetings and to minimise duplication.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who will be affected?</th>
<th>e.g. staff, service users, carers, wider public etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>This policy applies to all professionals working in Children and Young Peoples Specialist Services (CYPS) in the Trust whether employed by health or social services.</td>
<td></td>
</tr>
</tbody>
</table>

- CNTW(C)03 - Leave of Absence Policy
- CNTW(C)06 - Non Attendance Policy
- CNTW(C)19 - Observation Policy
- CNTW(O)09 - Policy and Procedure for the Management of Records
- CNTW(O)22 - Sharing Letters with Patients Policy
- CNTW(O)33 - Risk Management Policy
- Relevant Local Authority Common Assessment Framework Guidance
- Refocusing CPA 2008
- NSF Children, Young People and Maternity 2005

### Protected Characteristics under the Equality Act 2010.

The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them:

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Sex</td>
<td>Choice of the Care Coordinator will take account of any situation where the choice of a particular gender would not be advised</td>
</tr>
<tr>
<td>Race</td>
<td>Information will be provided in an accessible way for children</td>
</tr>
<tr>
<td>Age</td>
<td>CC/CPA for children, which provides an extremely comprehensive approach towards care coordination (Not applicable for older people)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Gender reassignment (including transgender)</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>Needs will be addressed as part of care plan</td>
</tr>
<tr>
<td>Carers</td>
<td>Provides an extremely comprehensive approach towards care coordination</td>
</tr>
<tr>
<td>Other identified groups</td>
<td>Staff – clear effective guidelines for staff have been provided</td>
</tr>
</tbody>
</table>

**How have you engaged stakeholders in gathering evidence or testing the evidence available?**

Through standard policy process procedures

**How have you engaged stakeholders in testing the policy or programme proposals?**

Through standard policy process procedures

**For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:**

Appropriate policy review with author/team

**Summary of Analysis** Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Provides clear guidelines for ensuring effective, high quality care Coordination for children and young people. Monitor effectiveness of impact one year after the formal introduction of the policy.

**Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic**

<table>
<thead>
<tr>
<th>Eliminate discrimination, harassment and victimisation</th>
<th>All noted areas are positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance equality of opportunity</td>
<td>Yes</td>
</tr>
<tr>
<td>Promote good relations between groups</td>
<td>Designed to promote good relations between professionals and children and young people-/.</td>
</tr>
<tr>
<td>What is the overall impact?</td>
<td>All noted areas are positive</td>
</tr>
<tr>
<td>Addressing the impact on equalities</td>
<td>This policy does not unlawfully discriminate against equality target groups</td>
</tr>
</tbody>
</table>

**From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?**

No

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager’s signature: Lisa Long        Date: October 2020
# Communication and Training Check List

**Key Questions for the accountable committee designing, reviewing or agreeing a new Trust policy**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this a new policy with new training requirements or a change to an existing policy?</td>
<td>Review of existing policy.</td>
</tr>
<tr>
<td>If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.</td>
<td>No</td>
</tr>
<tr>
<td>Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice?</td>
<td>National policy, local standards and best practice</td>
</tr>
<tr>
<td>Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHS Solutions etc.</td>
<td>DOH Refocusing CPA;</td>
</tr>
<tr>
<td>Please identify the risks if training does not occur.</td>
<td>Staff not policy compliant, not trained in minimum requirements of risk assessment.</td>
</tr>
<tr>
<td>Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.</td>
<td>All Registered staff require training if identified through Competency framework</td>
</tr>
<tr>
<td>Is there a staff group that should be prioritised for this training / awareness?</td>
<td>Staff who act as Care Coordinators. Newly appointed registered staff</td>
</tr>
<tr>
<td>Please outline how the training will be delivered. Include who will deliver it and by what method.</td>
<td>I day course delivered by clinical trainer through book in courses. Updates delivered by book in courses delivered by clinical trainer / team based sessions delivered by clinical trainer or Care Coordination Development / Training Lead / other appropriate Clinical risk training as identified in appendix B Competence framework to be developed Care Coordination process and recording for administrative staff team / service based sessions Flow charts in policy for easy reference</td>
</tr>
<tr>
<td>The following may be useful to consider: Team brief/e bulletin of summary Management cascade Newsletter/leaflets/payslip attachment Focus groups for those concerned Local Induction Training Awareness sessions for those affected by the new policy Local demonstrations of techniques/equipment with reference documentation Staff Handbook Summary for easy reference Taught Session E Learning</td>
<td></td>
</tr>
<tr>
<td>Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.</td>
<td>Care Coordination Development / Training Lead</td>
</tr>
</tbody>
</table>
## Training Needs Analysis

**This is Essential Clinical specialist training relevant to registered staff groups identified**

<table>
<thead>
<tr>
<th>Staff/Professional Groups</th>
<th>Type Of Training</th>
<th>Duration of Training</th>
<th>Frequency of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>All registered staff</td>
<td>Care Coordination</td>
<td>1 day</td>
<td>Once</td>
</tr>
<tr>
<td></td>
<td>Suicide prevention / Clinical Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All registered staff who have completed the initial one day Care Coordination and Clinical Risk Course.</td>
<td>Care Coordination</td>
<td>1 day</td>
<td>Completion of one of these options every 3 years if required.</td>
</tr>
<tr>
<td></td>
<td>Suicide prevention / Clinical risk</td>
<td>1 day</td>
<td></td>
</tr>
<tr>
<td>All non registered staff who participate in the care co ordination process as a member of the care team</td>
<td>Care Coordination and Clinical Risk</td>
<td>½ day</td>
<td>Once</td>
</tr>
<tr>
<td>All non registered staff who participate in the care co ordination process as a member of the care team</td>
<td>Care Coordination and Suicide prevention /Clinical Risk update</td>
<td>2 hours</td>
<td>Completion of one of these options every 3 years if required.</td>
</tr>
<tr>
<td></td>
<td>OR Care Coordination update</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ Suicide prevention Foundation</td>
<td>½ day</td>
<td></td>
</tr>
</tbody>
</table>

**Copy of completed form to be sent to:**
Training and Development Department,
St. Nicholas Hospital

**Should any advice be required, please contact:**- 0191 223 2216 (internal 32216)
Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

<table>
<thead>
<tr>
<th>CNTW(C)48 - Care Coordination (including CPA) within Children and Young Peoples Services - Monitoring Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auditable Standard/Key Performance Indicators</strong></td>
</tr>
<tr>
<td>Registered Staff attend Clinical Risk and care coordination training in accordance with policy requirements</td>
</tr>
<tr>
<td>Current assessment and risk assessment available to the ward upon admission</td>
</tr>
<tr>
<td>Risk assessment has been reviewed and reflects current needs</td>
</tr>
<tr>
<td>Assessment and risk assessment updated appropriately prior to the first in patient MDT to reflect the service user’s needs and risk.</td>
</tr>
<tr>
<td>A care plan has been developed with the involvement of the child/young person and their parents / carers (if appropriate)</td>
</tr>
<tr>
<td>Joint review of the care plan and risk profile involving inpatient and community staff prior to discharge from hospital</td>
</tr>
<tr>
<td>Appropriate information provided to service user and relevant others at discharge from CYPS</td>
</tr>
</tbody>
</table>

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Quality and Performance Governance Group in line with the frequency set out.