MENTAL HEALTH & LEARNING DISABILITY SERVICES

CARE PROGRAMME APPROACH (CPA) & STANDARD CARE POLICY

Document Author	Authorised
Written By: Clinical Quality & Patient Safety Leads – Acute and Community Services **Date:** 12 April 2016	**Authorised By:** Chief Executive **Date:** 14th November 2017
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
	4	29 Mar 12	Andrew Hughes	Logo and wording updated for new Organisation	
31 May 12	4.1		Clinical Director, Community Health	Draft for consultation in line with NHSLA requirements	
31 Aug 12	4.2	31 Aug 12	Clinical Director, Community Health	Final Draft for approval	
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04 Dec 12	4.3		Clinical Director, Community Health	Transferred to new format	
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17 Dec 12	5	17 Dec 12	Clinical Director, Community Health	Approved at	Executive Board
15 Oct 13	5.1		Clinical Director, Community Health Directorate	Amended to inc clarity around 7 day follow up indicator	
04 Apr 14	5.1		Clinical Director, Community Health Directorate	Ratified at	Clinical Standards Group
15 Apr 14	6	15 Apr 14	Clinical Director, Community Health Directorate	Approved at	Policy Management Group
19 Jan 16	6.1		Head of Operations Mental Health Business Unit	Review and Update	Clinical Standards Group
12 Apr 16	7	12 Apr 16	Head of Operations Mental Health Business Unit	Approved at	Policy Management Group
18 Sept 17	7.1	18 Sept 17	Head of Operations Mental Health Business Unit	Updated to Reflect change of care process for non CPA Patients	
27 Oct 17	7.1		Head of Operations Mental Health Business Unit	Review and update for ratification	Clinical Standards Group
14/11/2017	8.0	14 Nov 17	Head of Operations Mental Health Business Unit	Approved at	Corporate Governance & Risk Sub-Committee
01/12/2020	8.0		Head of Operations Mental Health Business Unit	Extension to review date approved until 13/02/2021 by	Director of Mental Health & Learning Disabilities

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents **Page**

1 Executive Summary

Care Planning and the Care Programme Approach known as CPA throughout this document are the means by which a treatment plan is planned and delivered to patients in secondary care Mental Health Services.

For most patients, standard Care Planning will be adequate. For patients with high risk behaviours or problems, those with complex needs, or where multiple professionals are involved, CPA is the framework used to plan and deliver care and treatment.

2 Introduction

2.1 This CPA policy enables the Organisation to meet the requirements of the new guidance, 'Refocusing the CPA' 2008. The CPA and Standard Care remain central to the delivery of modern mental health services. The Organisation is committed to transforming the CPA & Standard Care into the starting point for a recovery based approach that supports people in living independent and valued lives. The 10 Essential Shared Capabilities should be actively incorporated throughout the Care Planning process. CPA & Standard Care will underpin an increasing focus on choice and control for people who use services and their carers. Their needs and preferences will be at its centre.

2.2 CPA is supported through simple, clear and relevant use of comprehensive evidenced based assessment tools and documentation.

2.3 CPA needs to be recognised as operating in all in-patient and community settings and by necessity will require good communication with all local Organisations, residential and nursing homes, supported housing, hospital, prison and where people reside in out of area placements.

2.4 CPA is the framework for care co-ordination and resource allocation from mental health services.

3 Definitions

Care Programme Approach
The approach used in secondary mental health care to assess, plan; review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics. It is called an "approach", rather than just a system, because the way that these elements are carried out is as important as the actual tasks themselves. Active service user involvement and engagement will continue to be at the heart of the approach, as will a focus on reducing distress and promoting social inclusion and recovery.

Standard Care
Where a service user has straightforward needs and has contact with only one agency.

Care Co-ordinator
A professionally qualified, registered and experienced Mental Health Practitioner with proven care co-ordination competencies that co-ordinates care for patients subject to CPA. The practitioner may be a nurse, OT or social worker.

Lead Clinician
A professionally qualified and registered Mental Health Practitioner competent in providing Care Planning/interventions for patients subject to standard care. This may be a nurse, OT, social worker, doctor, psychologist or psychological therapist.

Assessment
A process of gathering and discussing information with the patient and/or carer in order to develop an understanding of what the person's needs are. The assessment is focused on the whole person; their entire well-being is discussed – physical, emotional, spiritual, mental, social, and environmental. The process culminates when the assessment results are used to inform a Care Plan."

Care Plan/Risk Plan
A statement of plans and an allocation of individual responsibilities for translating collective decisions into actions. This process should name all the relevant people involved in the treatment and support, including the individual service user and appropriate informal carers. It should also clearly identify the dates for reviewing the assessment and management plans.

4 Scope

This Policy applies to all staff working within Adult Mental Health and Learning Disability Services and all patients being cared for within the Adult Mental Health Services

5 Purpose

This CPA policy enables the Organisation to meet the requirements of new guidance, 'Refocusing the CPA' 2008.

6 Roles and Responsibilities

6.1 Executive Lead

The Chief Operating Officer is the executive lead for the Trust Board for CPA.

6.2 Clinical Director, Head of Operations and Operations Managers for the MH & LD Business Unit

The Clinical Director, Head of Operations and Operation Managers are responsible for ensuring that all teams operate the CPA in a way that delivers optimum care for patients.

6.3 All Clinicians

All clinicians working in Mental Health services for the Organisation must use the process of CPA as a basic underpinning for all care delivered by the Organisation. Therefore all referred patients should be assessed to ascertain whether they fall within the criteria for CPA. Patients who are taken onto caseload but not within the scope for CPA should be cared for under the process for Standard Care. Those within Standard Care should still be subject to written (electronic) Care Plans and regular review.

6.4 Care Co-ordinators

Good care co-ordination should reflect the following principles and values (see "Refocusing the Care Programme Approach" DoH (March 2008)):

6.4.1 The approach to individual's care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and service user/service user second.

6.4.2 Care assessment and planning views a person "in the round" seeing and supporting them in their individual diverse roles and the needs they may have, including; family; parenting; relationships; substance misuse; housing; employment; leisure; education; creativity; spirituality; self management and self-nurture; with the aim of optimising mental and physical health and well being.

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

6.4.4 Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

6.4.5 Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.

6.4.6 Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

6.4.7 Patients subject to CPA will have a Care Co-ordinator who is responsible for ensuring that all the appropriate assessments are completed and updated in line with Trust policy and entering them onto the relevant electronic system. They are also responsible for developing care plans and contingency plans with patients, co-ordinating the care, monitoring and evaluating progress against the plans and timely transfer back to primary care. They will liaise with carers or significant others to ensure they are fully aware of the care-plans where appropriate and if the patient agrees.

Lead Clinicians

Lead Clinicians work with patients who are not subject CPA and will take responsibility for organising care, recording appropriate information and clinical notes, liaising with the referrer and others as appropriate to do so, and organising care reviews.

Team Leaders

Team Leaders' main responsibility is to manage Care Co-ordinators and Lead Clinicians through Caseload management. Team Leaders in community teams and in-patient settings have responsibility to ensure that all patients receiving care through their service are assessed to see if they fall within the criteria for CPA. Team Leaders are responsible for ensuring that all patients requiring CPA are allocated an appropriate Care Co-ordinator. Team Leaders are responsible for ensuring that patients under the care of their team are appropriately reviewed by clinicians in their team. Team Leaders are responsible for monitoring the quality of Care Plans and the CPA process in their teams.

Consultant Psychiatrists

All patients under CPA will have a Consultant Psychiatrist involved in their care. Some patients on Standard Care may have a Consultant Psychiatrist as their Lead Clinician. Under the principles of New Ways of Working, a Consultant Psychiatrist may be consulted by a Care Co-ordinator or Lead Clinician in relation to the care delivered to the patient. The Consultant Psychiatrist is not clinically responsible for all decisions taken solely by the Care Co-ordinator.
There will be some patients who may not need a named Consultant Psychiatrist involved in their care. The medical care of such patients should be undertaken by their GP. Consultant Psychiatrists should be involved in decision making of risk sharing for complex patients.

7 Policy detail/Course of Action

7.1 Referrals

7.1.1 All referrals to Adult Mental Health Services are subject to initial screening and assessment using the initial assessment tool.

7.1.2 All referrals that are accepted will be assessed to determine whether CPA or Standard Care is appropriate.

7.1.3 Regardless of whether the Patient is accepted for a service or not, they will be made aware that they can have access to the completed assessment if requested and the referrer made aware of any outcome of assessment.

7.2 Assessment for CPA or Standard Care

7.2.1 The initial assessment and the risk profile will provide the basis for determining whether CPA or Standard Care is the most appropriate service response.

7.2.2 All those receiving mental health services should be considered for CPA.

The characteristics to consider when deciding if CPA is needed are quoted as follows from "Refocusing the Care Programme Approach" DoH (March 2008):
Severe Mental Disorder (including personality disorder) with a high degree of clinical complexity

- Current or potential risk(s), including:
  - Suicide, self harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
  - Self neglect/non concordance with treatment plan
  - Vulnerable adult; adult/child protection e.g.

- Exploitation e.g. financial/sexual
- Financial difficulties related to mental illness
- Disinhibition
- Physical/emotional abuse
- Cognitive impairment
- Child protection issues

- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse, learning disability.
- Multiple service provision from different agencies, including; housing, physical care, employment, criminal justice, voluntary agencies.
- Currently / recently detained under Mental Health Act or referred to crisis/home treatment team.
- Significant reliance on carer(s) or has own significant caring responsibilities.
- Experiencing disadvantage or difficulty as a result of:-
  - Parenting responsibilities (including pregnancy)
  - Physical health problems (including disabilities)
  - Unsettled accommodation /housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Any other issues relating to being from a particular protected group (e.g. ethnicity, religion, sexual orientation etc.).

7.2.3 The following points should be noted:
There are not a minimum or critical number of items on the list that should indicate the need for CPA

- All inpatients will be subject to CPA

- All Dual Diagnosis service users (serious mental illness and substance misuse) will be on CPA. It is very important that there is clarity about the care co-ordination responsibilities for those with dual diagnosis, defined as those with severe mental illness and drug and/or alcohol problems. Whilst these individuals should receive treatment for their substance misuse problems from the appropriate agency (HDARS), they should receive care co-ordination under CPA from mental health services.

- All those subject to Supervised Community Treatment or to guardianship under the Mental Health Act will be on CPA

- Those to whom section 117 (Mental Health Act 1983) applies will not be on CPA for this reason alone

- These criteria place greater emphasis on service users who have parenting responsibilities or significant caring responsibilities, who have dual diagnosis, who have a history of violence or self-harm, and who are in unsettled accommodation

7.2.4 Where Standard Care is agreed, the principles and values underpinning CPA should still apply.

7.2.5 Where the assessment highlights significant risks, a full risk assessment and risk profile will be completed, and action to address those issues need to be written in the Care/Risk plan.

7.2.6 Assessments need to fully acknowledge both the possible, and any current effects on the family due to any mental health problems identified. This is particularly relevant where there are children in the family, or where there may be a significant impact on other caring responsibilities the person may have. A Consultant Psychiatrist will be involved in clinical decision making for Patients who may pose a risk to children.

7.2.7 Where more specialist assessments are required, the appropriate referrals will be requested and this will be recorded on the Care/Risk plan. All assessments must adhere to the principles of social inclusion, and equality of opportunity and diversity, consideration being given to potential discrimination due to age, disability, gender, sexual orientation, race, ethnicity and religious beliefs.

7.3 Patients assessed as needing Standard Care

7.3.1 All those receiving services under Standard Care will have an identified Lead Clinician who will take responsibility for organising care, recording appropriate information and clinical notes, liaising with the referrer and others as appropriate to do so, and organising care reviews.

7.3.2 The patient and referrer will receive a summary of the assessment and this will include the Standard Care care-plan.

7.4 Patients assessed as needing CPA

7.4.1 Those patients assessed, and needing the CPA will have a named Care Co-ordinator who will take responsibility for all the functions of CPA. This including any further assessments, liaison with professionals and carers and organising reviews.

7.4.2 Any breakdown in the relationship between the care co-ordinator and the Patient must be discussed with the team leader and a decision agreed as to what action should be taken.

7.4.3 Practitioners need to be aware that systems other than CPA may apply to particular patient groups such as: CAMHS, Learning Disabilities, Offenders and Substance misuse. Older people should have CPA

7.4.4 All people receiving care under the CPA will have a comprehensive care-plan developed with and signed by them and the Care Coordinator. A copy of the Care/ Risk plan will be given to the patient and carer/significant other where appropriate.

7.4.5 Care/ Risk plans will clearly set out the type of intervention required, the responsibilities of those involved, and the desired outcome.

7.4.6 The Care/Risk plan is structured to record those needs that the person can address for themselves and those where support is necessary from mental health services, other Organisations or family carers.

7.4.7 The Care/Risk plan should identify and build on a strength based approach consistent with the recovery approach.

7.4.8 Potential risks and any action/s to be taken should be included in the plan. Positive risk management should underpin any plan of care.

7.4.9 Wherever possible the care/risk plan will be formed with the patient and carer/significant other where appropriate, contain a review date and are signed by the patient and carer/significant other. In any instance where this is not possible a reason for this needs to be recorded in the notes

7.4.10 those people named on the Care/risk plan (including carers) will be offered a copy of the Care/ risk plan unless specific objections are made by the patient.

7.4.11 All Care/ risk plans will include crisis /contingency plans, and any advanced wishes (or decisions). The plan must include action to be taken with regard to any disengagement or non-attendance for appointments.

7.4.12 Disengagement or non attendance should always be discussed with the Team Leader, action agreed and then recorded in the notes. Please see Managing Patients who disengage from Service Policy (2014).

7.4.13 Patients will be informed that in certain circumstances, practitioners have a duty to breach confidentially regarding information recorded.

7.4.14 Care/risk plans should reflect the aim of personalised care and social inclusion, and be based on the recovery model, identifying the strengths of the patient.

7.5 Reviewing care in the community

7.5.1 Each review needs to consider the issue of whether CPA, Standard Care or discharge is appropriate, and the appropriate risk assessment undertaken to support any changes made. If the patient no longer meets the criteria for CPA but needs to stay in secondary services longer, then the core assessment will be updated and closed down to reflect this and the care plan will become the Out Patient Clinic letter.

7.5.2 Reviews of care should take place with the patient (and others involved) at periods set out in the Cluster, or no less than every six months, or whenever it is agreed necessary to do so.

7.5.3 Where face to face reviews - are to be held the patient should identify who they wish to be present.

7.5.4 An updated assessment will be used to provide the basis for determining change in mental heath state and social circumstances and thereby guide further decisions and actions to be taken.

7.5.5 If discharge is being considered then a full risk assessment will be undertaken.

7.5.6 On discharge, all relevant information must be communicated to the GP (and the referrer if different). The GP, the patient and any carers should be made aware of circumstances where re-referral may be appropriate, and how to re-refer. The electronic patient record (PARIS) will be updated to reflect what follow up care the patient will have on transfer back to primary care. The core assessment will be updated to reflect what follow up care the patient will have on transfer back to primary care. The discharge summary letter will be the care plan for the person on discharge from secondary MH Services.

7.5.7 Wherever possible family, carers and significant others will be consulted, and involved in all stages of developing Care/ risk plans and reviewing the ongoing care of the Patient.

7.6 Reviewing care in hospital

7.6.1 Patients discharged from hospital will have a CPA review at the earliest opportunity before discharge takes place. It may be that the patient no longer requires follow up care under CPA and only requires standard care.

7.6.2 The Care/ Risk plan must reflect the particular vulnerability of service users leaving hospital and clearly document actions to be taken to provide the requisite level of care in the post discharge period.

7.6.3 Patients deemed no longer subject to CPA will no longer require a Core Assessment and this will be closed at the point of discharge. The discharge summary letter will provide the patient, Carers/family and GP with the care plan for the person when they leave hospital.

7.6.4 The National Confidential Inquiry into Suicide and Homicide by people with mental illness – October 2016 highlights "The first three months after hospital discharge continue to be a period of high suicide risk. In England the number of deaths rose to 200 in 2014 after a fall in the previous year. Risk is highest in the first two weeks post- discharge: in a previous study we have shown that these deaths are associated with preceding admissions lasting less than 7 days and lack of care planning." Locally it has been agreed that good practice indicates that the majority of patients being discharged from in-patient wards should be followed up by the Home Treatment Team and it must be clearly documented the rationale for anyone not being followed up by them.

7.6.5 Robust discharge planning between the Home Treatment Team and the Community Teams needs to take place bearing in mind the risks identified in The National Confidential Inquiry (October 2016). There must be a minimum of weekly visits by the Community Team for a minimum of 3 months post discharge from the Home Treatment Team.

7.6.6 Individual care plans must clearly document and reflect any risks prior to stepping down to the Community Mental Health Service (CMHS) and how these risks will be addressed and the level of contact must be recorded in the care plan.

7.7 Confidentiality

7.7.1 Patients have a right to understand their rights to confidentiality and also when practitioners have a duty to share otherwise confidential information with others.

7.7.2 Whenever possible, it is good practice to share relevant information both within the clinical team and with family, carers and significant others.

7.7.3 The limits of confidentiality must be discussed and agreed with the patient, family carers, and significant others in order to develop the most positive therapeutic relationships between all those involved with the person.

7.8 7 Day Follow Up

7.8.1 This indicator is important because reductions in the overall rate of death, by suicide, can be supported by provision of appropriate care for all those with mental ill health.

7.8.2 Following up someone on who has been discharged from inpatient care within seven days of discharge reduces risk and social exclusion and improves care pathways.

7.8.3 **Best practice** states that the follow up contact should be **face to face** and all efforts must be made to ensure that this is followed.

7.8.4 Phone follow ups should only be used as a rare exception once all avenues to arrange a face to face contact have been exhausted.

7.8.5 It is the responsibility of the Trust to follow up patient treatment. Links will need to be established with the receiving institution if a patient is discharged to, for example, a care home, to enable follow up to take place.

7.8.6 This indicator features in Monitor's 'Risk Assessment Framework', and as such is a national priority target which Foundation Trusts are expected to achieve. **Failure to meet this target is a breach of the Trust's terms of authorisation.**

7.8.7 This indicator is reported to Monitor on a quarterly basis and as such affects the overall governance risk rating of the Trust.

7.8.8 The indicator is also reported to our commissioners monthly and non-compliance can result in monetary penalties to the Mental Health and Learning Disability Business Unit and so may affect the funding available for patient care.

Summary of responsibilities for 7 Day Follow Up's

All staff

Every person who has contact with either:
a) A service user (either face to face or telephone contact) or
b) any individual (either face to face or telephone contact) with regards to the service user's care, must record this contact in the patient notes (with the date, time, signature and counter-signature, if required).

Team Leaders

- Oversee and ensure discharge planning process is carried out on the ward and that every patient has a discharge review
- Notify the relevant Care Coordinator/community team of the patient being discharged and discharge date
- Ward staff must ensure that 7 day follow up occurs for patients who are discharged/transferred to any service other than CMHS or CRHT
- Validate reports and any figures showing as breaches/non compliant, correct the record if necessary, including updating patient records on the clinical system and provide feedback
- Provide exception report to Operation Managers for any breach of 7 day follow up
- Monitor daily bed state report to identify potential breaches.

Community Team Leaders/CRHT

- Ensure that the follow up is carried out within 7 days of discharge, and ideally within 4 days, to account for any DNAs and recording them on the system within 24 hours.
- Validate reports and any figures showing as breaches/non compliant, correct the record if necessary, including updating patient records on the clinical system and provide feedback
- Provide exception report to Operations Managers for any breach of 7 day follow up
- Monitor daily bed state report to identify potential breaches.

Operations Managers

- Oversee the completion of actions to address under-performance which may require developing action plans
- Provide evidence of service improvements established to address performance.

8 Consultation

This document was disseminated for consultation throughout Mental Health and Learning Disability Business Unit Quality Group.

9 Training

9.1 A national learning and development package to support the workforce was launched in February 2010. Materials from this package will be used to support the Organisations training programme.

9.2 Staff will be expected to demonstrate that they are competent to undertake the Care Co-ordinator role through a mixture of classroom learning and practical skills in the workplace. This will include the completion of the CPA Competency Framework for Lead Clinicians and Care-Co-ordinators. All other clinical staff will undertake CPA awareness learning.

10 Monitoring Compliance and Effectiveness

10.1 CPA and Standard care will be monitored through caseload management and clinical supervision and audited on an annual basis.

10.2 Audit has moved away from a focus on simple numbers and is concentrating more on assessing the quality of CPA implementation.

10.3 The monitoring of compliance with the requirements of CPA is an important element of both local and national clinical performance indicators; this will be monitored through the Mental Health Quality Meeting.

10.4 Data which is sourced from CPA is used for the performance monitoring of the Organisation, notably through the Mental Health Minimum Data Set (MHMDS)

10.5 The Organisation aims to improve services by learning from experience. Following audit each service area will receive a report and an action plan will be developed with clear outcomes.

10.6 Operations Managers are responsible for monitoring the implementation of the action plan.

11 Links to other Organisational Documents

- Clinical Risk Management Policy
- Physical Healthcare in Mental Health and Learning Disability Services guidance
- Mental Health & Learning Disability Services Guidelines for Managing Service Users who Did Not Attend (DNA) or Disengage from Services

12 References

Department of Health (2008) Refocusing the Care Programme Approach: policy and positive practice guidance. Link

Department of Health (2005) New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services Through New Ways of Working in Multidisciplinary and Multiagency Contexts. Link

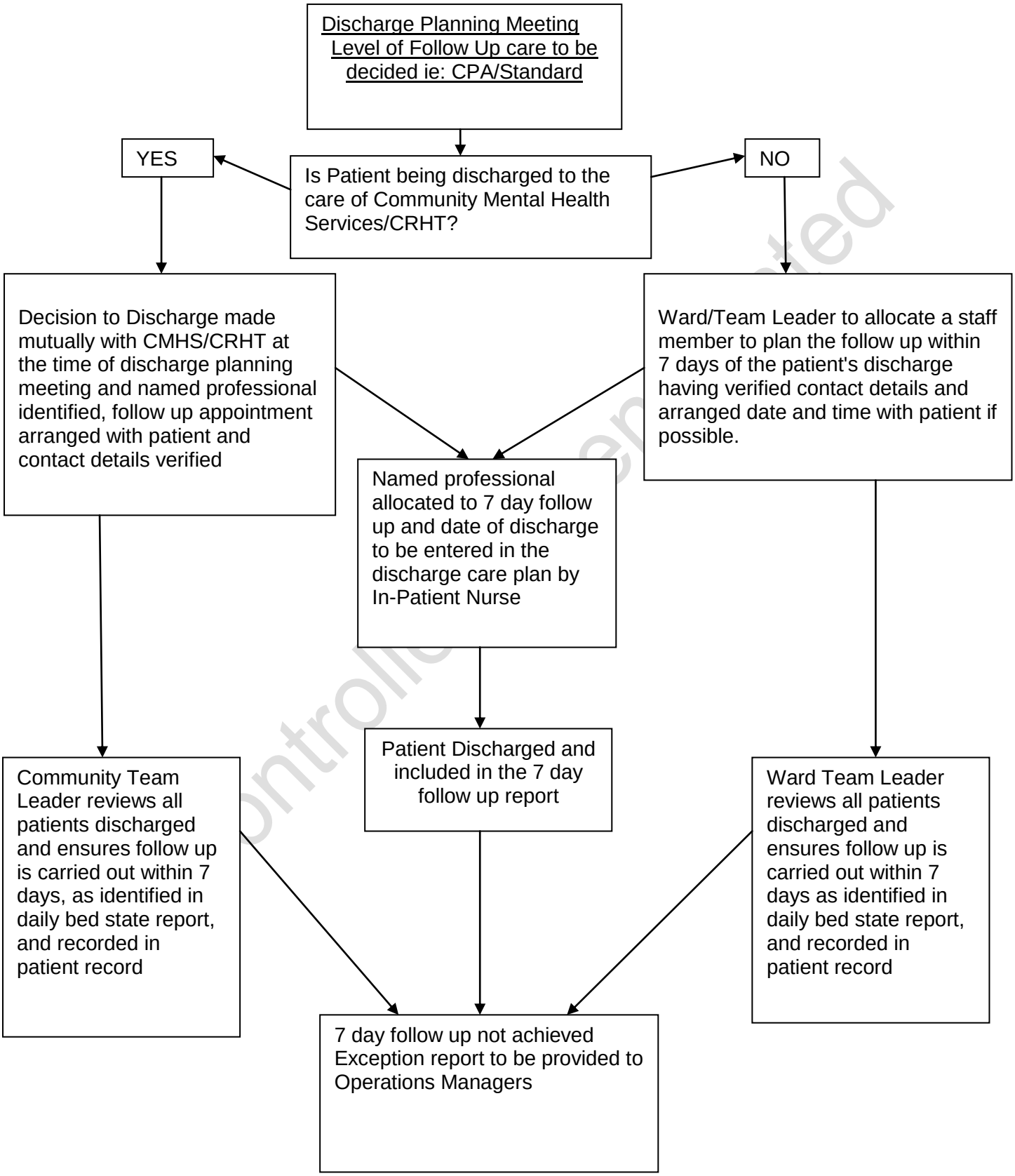
Department of Health (2004) The 10 Essential Shared Capabilities A Framework for the whole of the Mental Health Workforce Link

13 Appendices

Appendix A 7 Day Follow Up - CLINICAL PROCESS
Appendix B Financial and Resourcing Impact Assessment on Policy Implementation
Appendix C Equality Impact Assessment (EIA) Screening Tool

Appendix A

Care Programme Approach (CPA) & Standard Care Policy
7 Day Follow Up - CLINICAL PROCESS



Appendix B

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Care Programme Approach and Standard Care Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs			
Training Staff	**0.2**	**5000**	
Equipment & Provision of resources			

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	0	0	0
Totals:			

Staff Training Impact	Recurring £	Non-Recurring £
Affected areas / departments		Affected areas / departments
e.g. 10 staff for 2 days	All staff within mandatory training requirement	e.g. 10 staff for 2 days

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed	0	0
Building alterations (extensions/new)	**0**	**0**
IT Hardware / software / licences	**0**	**0**
Medical equipment	**0**	**0**
Stationery / publicity	**0**	**0**
Travel costs	**0**	**0**
Utilities e.g. telephones	**0**	**0**
Process change	**0**	**0**
Rolling replacement of equipment	**0**	**0**
Equipment maintenance	**0**	**0**
Marketing – booklets/posters/handouts, etc	**0**	**0**
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix C

Isle of Wight NHS Trust

Equality Impact Assessment (EIA) Screening Tool

Document Title:	**Care Programme Approach and Standard Care Policy**
Purpose of document	To set out roles and responsibilities of the Care Programme Approach
Target Audience	All staff working within Adult Mental Health Services
Person or Committee undertaken the Equality Impact Assessment	Su Tomkins and Bev Fryer

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	*n*	*n*	
	Women	*n*	*n*	
Race	Asian or Asian British People	*n*	*n*	
	Black or Black British People	*n*	*n*	
	Chinese people	*n*	*n*	
	People of Mixed Race	*n*	*n*	
	White people (including Irish people)	*n*	*n*	
	People with Physical Disabilities, Learning Disabilities or	*n*	*n*	

	Mental Health Issues			
Sexual Orientation	Transgender	*n*	*n*	
	Lesbian, Gay men and bisexual	*n*	*n*	
Age	Children	*n*	*n*	
	Older People (60+)	*n*	*n*	
	Younger People (17 to 25 yrs)	*n*	*n*	
Faith Group		*n*	*n*	
Pregnancy & Maternity		*n*	*n*	
Equal Opportunities and/or improved relations		*n*	*n*	

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	