Good practice examples and recommendations

Care Programme Approach Transformation

The Community Mental Health Framework for Adults and Older Adults replaced the Care Programme Approach (CPA) for community mental health services.

It enables services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare.

As local approaches evolve and implementation accelerates, we aim to share some practical examples and resources from different services and initiatives to promote learning between mental health providers.

Healthy London Partnership

What is in this document?

The purpose of this document is to support the CPA Transformation work, in line with the NHSE CPA Position Statement which was developed to support systems to begin moving away from the CPA in line with the five principles and embed personalised care and support planning for everyone receiving community mental health services.

Click on the links below to be directed to each page

To read the full NHSE CPA Position Statement, click on the icon >>>>>

Document development

1. **We have used the outputs from the June 2022 Community of Practice (CoP) meeting across the five principles including Older Adults (OA).**
2. **We have engaged with a group of experts by lived experience including service users and carers to understand their views on each of the five principles, and their feedback has been incorporated.**
3. **We have engaged with a number of Mental Health (MH) Trusts in London and across the country who have shared good practice examples or practical ways of approaching the different principles of the CPA Transformation.**
4. **We have reviewed and included content from existing resources that support the CPA Transformation processes.**

The below themes are key considerations of the CPA Transformation

Capacity/Scale of the CPA transition

- Capacity has been flagged as a key concern throughout the system. Due to the scale of the CPA transition and the current issues with workforce recruitment and retention, services will be challenged to continue their business as usual at the same time that they are working through the CPA transition. This will be particularly challenging for older adult services as the scale of the transition is similar to adult services, however, Older Adult Community Mental Health Transformation (CMHT) services are much smaller and fewer in number than core teams, and support patients with particularly complex mental and physical health needs.

Personnel

- Since the transformation hinges upon key roles for service users (e.g. key workers), personnel considerations will be a key driver of success in the CPA Transformation.

Systems and Processes

- A critical, complex and technical aspect of the CPA Transformation is the information technology systems and processes which underpin discrete system performance and interoperability at large.

Inclusivity

- Crucial to a successful transformation is ensuring that new model architecture is suited to and built with all relevant stakeholders; we will explore good practice approaches for embedding inclusivity.

Mutual-assured safety

- Safety is pivotal to the CPA and the model which will replace it will protect all parties adequately and will allow clinical focus to rest solely on quality of care.

The new models will need to be underpinned by the following six broad principles

1. **A shift from generic care co-ordination to meaningful intervention-based care** and the delivery of high quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high quality care.

2. **A named key worker for all service users with a clearer multidisciplinary team (MDT) approach** to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care. This would allow all staff to make the best use of their skills and qualifications, as well as drawing on new roles including lived experience roles.

3. **High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community:** a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (e.g. section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.

4. **Better support for and involvement of carers as a means to provide safer and more effective care.** This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.

5. **A much more accessible, responsive and flexible system in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.**

6. **Specific considerations for older adults** in the transition to intervention-based care.

This document also includes an additional principle around older adults. HLP aims to ensure that older adults are included as a key consideration within future work and resources developed by the Community of Practice to support the transition.

NHSE - Community Mental Health Transformation Roadmap

NHSE published a draft 'Community Mental Health: Roadmap for Transformation' (August 2022)

We have included here the sections that are relevant in relation to the CPA Transformation

DRAFT

CMH transformation is a complex programme with lots to deliver across the LTP duration

Purpose:

- This document is designed to support systems in the delivery of community mental health transformation.
- It is intended to set out the different elements which will make up the delivery of LTP commitments on community mental health transformation.
- It will also provide a simple and visual way of understanding system progress across the breadth of deliverables required for transformation.

How to use:

- The 'roadmap' sets out the key milestones and deliverables that underpin the transformation of community mental health as set out in the Community Mental Health Framework.
- Whilst the roadmap sets out the expected progress, we recognise that not all systems will be starting from the same point, nor will all systems progress at the same speed. The roadmap should be used as a guide for systems as to what needs to be delivered by the end of 2023/24 and can be tailored according to your systems plans.
- It should be read in conjunction with the 'criteria for data flow' which sets out the minimum criteria that must be met in order for a system to contribute towards the LTP access target – that section describes an interim point, whereas the roadmap is the route towards and beyond that point.

Next steps:

- The second phase of the development of the roadmap will include an Annex with supporting information for systems on each of the components within the roadmap.
- These annexes will include information on what good looks like, service user voice, resources and other information.

DRAFT

Shift away from CPA towards personalised care planning

Getting started

1. Review existing caseload and agree plan to ensure all service users on/off the CPA are phased into the new approach.
2. Bring together all partners involved in delivering care to agree the development of joint approaches, including case management, risk management, training/supervision and interoperability.
3. Set out a clear communication and engagement plan to bring staff and service users/carers/families on the journey.

Success

1. Processes for delivering care and support focus on the delivery of meaningful intervention-based care and are dynamic and flexible enough to meet changing needs and ensures outcome measures are recorded and improved.
2. All service users have a named key worker who brings together staff from across professions and partners to jointly deliver a recovery and needs-led led approach for service users and their carers.
3. Delivery of care recognises the unique contributions of the members of the multi-disciplinary team and staff are supported to use their individual skills and knowledge.

Resources and guidance

- PRSB care standards
- PRSB Toolkit to support transition
- CPA Position Statement
- Personalised Care – Future NHS page

Service User Voice/Expectations

'People see me as a person not a risk entity'

'I'm involved in deciding my care and support'

'All of my support needs are captured across mental health, physical health, social care and VCSE needs'

Relies upon delivery of:

- Integration with primary care with access to the model at PCN level[2]
- Interoperable standards for personalised and co-produced care planning
- Commissioning and partnership working with range of VCSE services
- Routine collection of PROMs using nationally recommended tools
- Integration with Local Authority services
- Staff-caseload ratios to deliver high quality care

The Community Mental Health Transformation (CMHT) Roadmap details all of the different aspects that need to be delivered as part of the CMHT programme in line with the Community Mental Health Framework. As highlighted in the diagram below, the 'Shift away from CPA towards personalised care' (red box) is dependent on a lot of other priorities (blue boxes) being delivered at the same time. The National team recognises the challenge and how much of the success of the programme relies on a successful move away from CPA.

By 2023/24 - Priorities for Community Mental Health transformation

Dedicated focus[6]

Model development	Care provision	Workforce	Data & outcomes	CEN / 'personality disorder'	Community rehab	Eating disorders
Joint governance with ICB oversight[1]	"Must have" services[3] commissioned at PCN level tailored for SMI[7]	Recruitment in line with indicative 23/24 MH workforce profile	Record access data from new model (inc. primary, secondary and VCS orgs)	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services[4] commissioned at PCN level tailored for SMI[7]	Expand MHP ARRS roles in primary care	Interoperable standards for personalised and co-produced care planning	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level[2]	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Routine collection of PROMs using nationally recommended tools	Development of trauma-specific support, drawing on VCSE provision	Ensure a strong MDT approach[5]	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model[5] in place	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place to support a diverse group of users	Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Interoperability for activity from primary, secondary and VCSE services		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
100% PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input	Impact on advancing equalities monitored in routine data collection		Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with IAPT, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

To access the full draft 'Community Mental Health: Roadmap for Transformation', join the NHSE Adult and Older Adult Mental Health Programme on Future NHS Platform, click the icon >>>>

Case study examples

The following slides provide examples or practical ways of approaching the different principles of the CPA Transformation as shared by a number of Mental Health Trusts in London and across the country

Click on the links below to be directed to each page

1. Central North West London NHS Foundation Trust
2. East London NHS Foundation Trust
3. Midlands Partnership NHS Foundation Trust
4. Somerset NHS Foundation Trust
5. Herefordshire and Worcestershire Health and Care NHS Trust

Central North West London NHS Foundation Trust – case study

Central North West London (CNWL) is developing a new population-based model for mental health care in the community.

The new model of care is currently redesigning and reorganising the existing borough based community resource to form new Community Mental Health Hubs, each of which is aligned to the local Primary Care Networks (PCNs).

CNWL has developed leaflets that explain how changes in the Community Mental Health services are relevant to adults who use health services in CNWL boroughs.

Leaflet 1

Leaflet 2

Click on these icons to access these leaflets >>>>

Community Mental Health Hubs

- ✓ Providing intervention-based care, delivering a high quality and safe services.
- ✓ Named worker for all service users with a clear MDT approach, involving all staff on the service users journey.
- ✓ A more accessible, responsive and flexible system in which support is tailored to the service user.

For more information about the development of the **Community Mental Health Hubs in CNWL**, click on the icon >>>>>>>

Central North West London NHS Foundation Trust – case study

On the 3rd May 2022, DIALOG+ launched across all CNWL London boroughs and Milton Keynes with step-by-step implementation across all Adult Community Mental Health services. DIALOG+ will be used in place of Care Programme Approach across Adult Community Mental Health services.

CNWL held 'Train the Trainer' events throughout April 2022 to help guide staff through the approach. The recordings of these were made available to CNWL staff which allowed them to become familiar with the new model.

DIALOG+ in CNWL

Governance

A central steering group (monthly) with local implementation groups across each locality.

Training & Development

Co-produced training material including role play scenarios with service users.

Standard Operating Procedure (SOP) / Policy

Centrally developed an SOP for DIALOG+ of which teams will locally operationalise.

CNWL Policy being updated to incorporate DIALOG+.

Co-production

Established a service user working group to support the design and implementation.

Bring documents, discussions and next steps to the group.

IT

Incorporated DIALOG+ as part of our EPR.

Feeds through to a care planning tool.

Soft Launch

Soft launch began in May 2022 with a team from each borough going live.

Phased implementation to be agreed across each locality.

For more information about the implementation of DIALOG+ across Adult MH services in CNWL, click on the icon >>>>>

For more DIALOG resources, you can visit the HLP website >>>

Central North West London NHS Foundation Trust – case study

CNWL signed up to the Carers Trust's Triangle of Care scheme in January 2020 and their inpatient wards and Home Treatment, Urgent Care and Psychiatric Liaison Teams achieved Stage 1 of the National Triangle of Care accreditation award from the Carers Trust in October 2021.

Progress to date:

- ✓ Over 130 dedicated carer champions across the Trust
- ✓ Over 500 members of staff trained in Carer Awareness
- ✓ Co-produced a wide range of resources and guidance to support teams with the scheme and to support carers

Progress within Community Teams:

- ✓ 50 champions across all community-based mental health teams
- ✓ Approx. 200 staff from community teams trained in Carer Awareness

What comes next in CNWL:

- ✓ New carer dashboard for SystmOne
- ✓ Ongoing Carer Awareness Training (monthly sessions offered)
- ✓ Carer Champions lanyards and mugs to be distributed

Patient, Carer and Public Involvement Strategy 2019-2023

A partnership approach for patients, carers and staff

This document has been produced by the CNWL Patient and Carer Involvement Team, the Patient Involvement Forum and the Carers' Council, with input from other patients, carers, third sector organisations and CNWL staff. This strategy applies to all CNWL services and the children, young people, adults and families who use them.

To access the document, click on the icon >>>

CNWL Communications Strategy

"Moving away from CPA is a huge change to our staff and service users. It is incredibly important we communicate in a clear and timely fashion to alleviate any worries or fears as well as provide as much information as possible"

So far:

- 3 minute Read announcement– *Released December 2021*
- CNWL Press Release – *Released January 2022 – to access it, click **here***
- Community Adult Mental Health Transformation Programme page updated – *to access it, click **here***

In the future:

- Targeted emails sent out to VCSE organisations
- Letter for patients, families and carers containing the Trust's position statement
- Digital poster to display at various sites (will include QR code leading to further information)
- Scope for more '3 minute read updates' as changes are implemented

For more information about the Triangle of Care Scheme in England, click on the icon >>>>

East London NHS Foundation Trust – case study

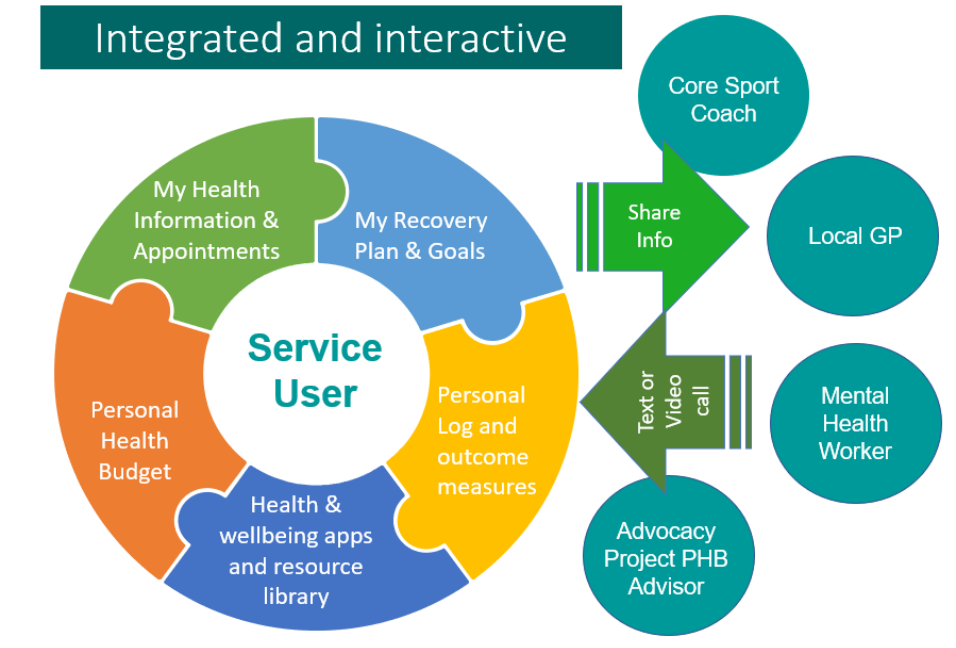
Across East London, a portfolio of work has been delivered which aligns to the five principles of the NHSE CPA Position Statement:

- The formation of Neighbourhood Mental Health Teams and new ways of work to enable more flexible access.
- Further work to embed DIALOG+, including standing up an implementation board.
- The introduction of a CQUIN target relating to paired DIALOG scores.
- The development of a trust-wide carer's strategy, and the initiation of a carers' Working Together Group.
- The introduction of a patient-held record (Patients Know Best).
- The expansion of the Personal Health Budget offer.
- Further workforce expansion to diversify the MDT offer, including the introduction or expansion of a variety of new professional roles.

To access the ELFT 'Carers, Friends & Families Strategy (2022-26)', click on the icon >>>

To access the DIALOG resources that ELFT has developed, click on the icon >>>

Patients Know Best (PKB) – a patient-health record



- ✓ The platform facilitates recovery - supports the setting of recovery goals and monitoring progress in achieving the goals.
- ✓ Service users have more control over own health and more personalised care when needed.
- ✓ Service users have access to physical health check data and information on their devices and through the setting of physical health goals and the monitoring of health improvement on the platform.
- ✓ Access to self-management tools which will enable more service users to be reached with the available resources.
- ✓ DIALOG can be completed on the PKB app and DIALOG data flows between RiO and the app.
- ✓ Service users can also invite people involved in their care to view their health care data.

Service users are at the heart of the use of their data and PKB's patient-held record will greatly support the change towards supporting service users to interact with their records, their services, and the professionals involved in their care.

For more information about the rollout of PKB in NEL, click on the icon >>>

Midlands Partnership NHS Foundation Trust – case study

They have developed a strong and robust Partnership approach between the voluntary care sector, local authorities, ICB and Midlands Partnership NHS Foundation Trust.

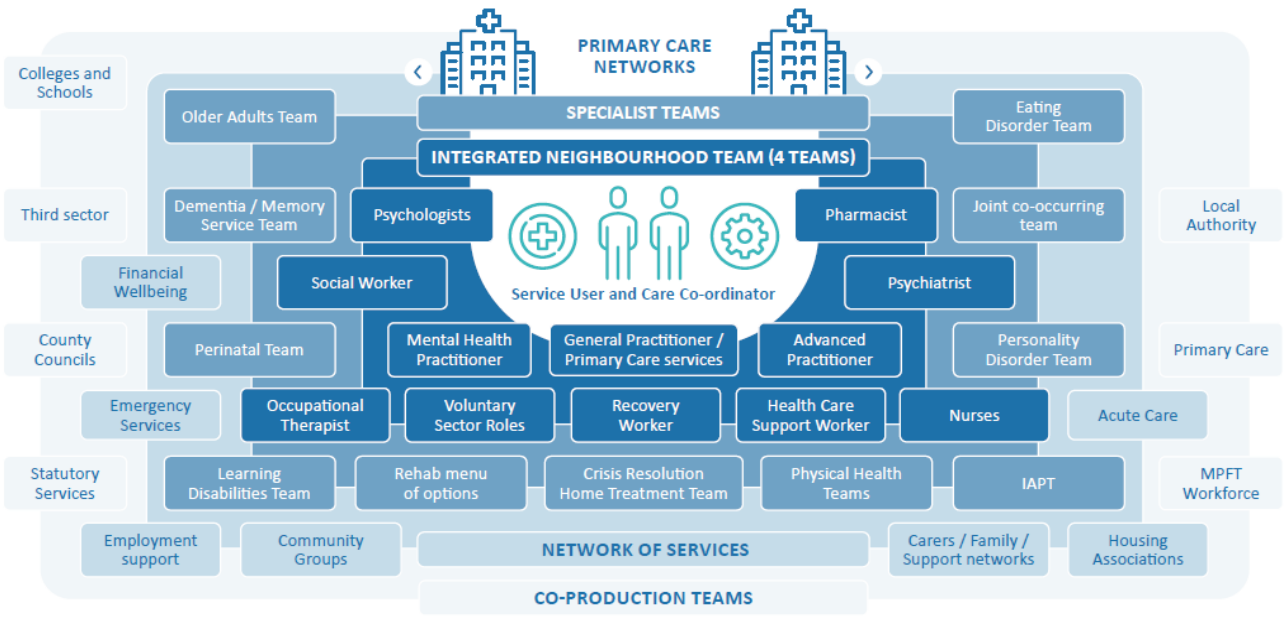
Staffordshire County Council | Support Staffordshire | Together We're Better | NHS Midlands Partnership NHS Foundation Trust

They use population health and have used the Health Equity Assessment Toolkit (HEAT) developed by Public Health England (PHE) to identify the wider determinants of health, under-represented groups, identify gaps in provision and agreed priorities with system partners and service users. They have developed data packs for every PCN, co-produced with local authorities and Clinical Services Unit, and they have also created a PCN Dashboard.

They run a series of consultation events with service users, primary care, local authorities and the voluntary care sector to triangulate the information that came out of the HEAT data packs to determine the wider determinants of health and then commissioned their partner VCSE services.

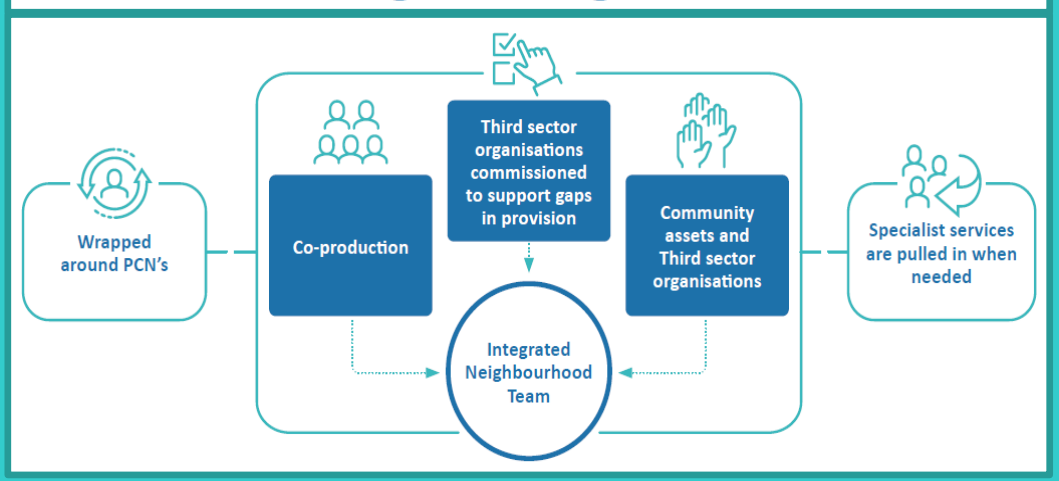
They also identified their under-represented groups through the HEAT analysis and commissioned The Community Foundation for Staffordshire to administer grant provision to hyper-local organisations who are very good at engaging with under-represented groups.

What is an Integrated Neighbourhood Team?



They have set up four Integrated Neighbourhood Teams, who act as a core mental health team. They also used population data to determine the size and composition of each Team - they used mental health weighted population.
The visual below describes what the Integrated Neighbourhood Teams aim to do and that consists of a co-production element, all voluntary care sector provision and the community assets. They pull in specialist provision as required and the Integrated Neighbourhood Teams are wrapped around their PCNs.

What does an Integrated Neighbourhood Team do?



Midlands Partnership NHS Foundation Trust – case study

Their Core Community Mental Health offer is based on population, a strength based model, based on needs and not diagnostics. It links to specialist services and it integrates with VCSE and local authorities. They have shared records - all partners use the same clinical system. They have a trusted assessment at the beginning, used to build on the conversation with the service user.

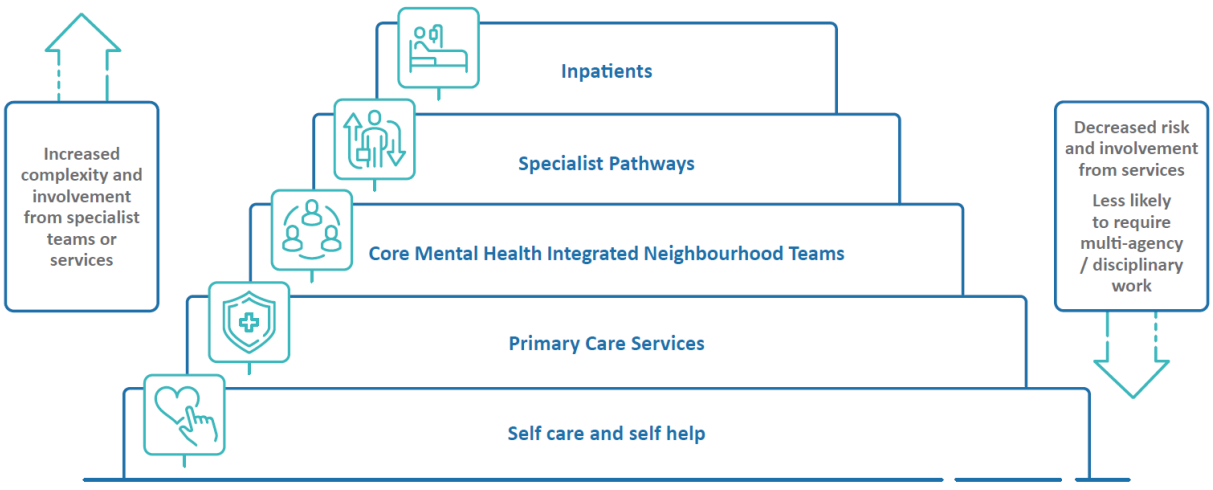
This is the **Stepped Model of Care** they will be using to move away from CPA. They have a self-care and self-help offer through SilverCloud that has a range of self-help type tools. They have Band 6 mental health practitioners working in primary care, from a range of backgrounds: occupational therapists, nurses and social workers working to a prescribed model.

They have recruited **Complex Trauma workers** to bridge the gap between IAPT and secondary care services to take on caseloads of patients that are too complex for IAPT services but not complex enough for secondary care. People with trauma that IAPT services would ordinarily exclude.

Care planning tool – they have performed a gap analysis against the Professional Record Standards Body **(PRSB) standards**, and are working on developing forms that will help them to capture the required information. By implementing the PRSB standards, by default, they will be moving away from CPA.

Patient Recorded Outcome Measures (PROMs) - they plan to incorporate DIALOG+ into the trusted assessment carried out by the Access Team and their mental health practitioners. ReQol will be used during clinical or therapeutic interventions. Their VCSE sector services are already using Goal Based Outcomes (GBO) and they use the same clinical system.

Stepped Model of Care



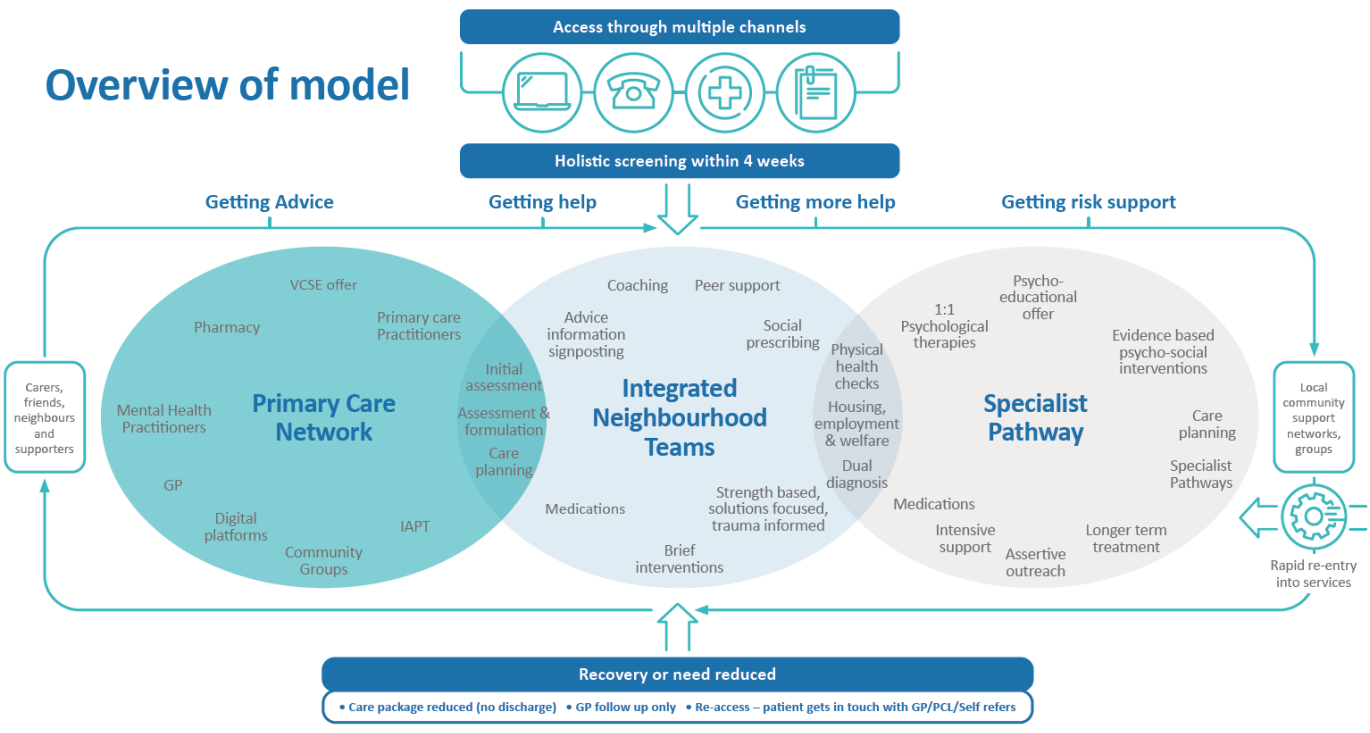
They have developed a discharge pathway - the first four weeks of someone being discharged is when they are most vulnerable, and this pathway wraps support around for up to four weeks. They have support workers, and before patients are discharged they will work with them in the inpatient unit to understand their needs and will co-produce a discharge plan. It will focus mainly on their holistic needs in order to integrate them back into the community to avoid risk of relapse into an inpatient setting again (e.g. making sure they have food, taking them shopping, etc).

Midlands Partnership NHS Foundation Trust – case study

The overview model shows how they will move away from CPA. There is overlapping provision that closes the gap in between pathways that did not exit before. As the patient becomes more complex, there is greater specialist support that wraps around them.

Holistic screening within four weeks: They have looked at the reasons why people are entering the services and they have embedded some of that provision into the **Access Team:** they have a financial wellbeing person, a housing officer, and a substance misuse specialist that sit within the access function. If from the trusted assessment, these are the aspects that are causing the mental health difficulties, then patients will start treatment and this prevents the referral into the model. By starting these social holistic interventions, by the time service users are seen by clinical members of staff (if this is still required), the impact on their mental health is drastically reduced which means that clinical interventions could also be reduced.

Overview of model



Safety and caseload management

Planned activity – The Integrated Neighbourhood Teams deal with planned activities.

Unplanned activity – The Crisis Response teams and Emergency services will deal with crisis calls. When an individual calls to speak to someone clinically, they have Duty workers aligned to each of their Neighbourhood teams that deal with all the unplanned activity so that the Clinical Teams can focus on their diary appointments (before the new model, they had to cancel their appointments to go out and visit service users). The Duty workers have Band 4 Support workers working alongside and will deal with 'unplanned activity' that needs clinical support from the teams. They also have MDT meetings that the voluntary care sector attends. If something becomes risky, the voluntary care sector staff will speak to the Duty worker and they will go to visit the service user if required. During the MDT meetings they will also discuss stepping up/down of patients.

Communications approach

- **They have a dedicated Communications role for their Mental Health Transformation work.**
- **They use a plethora of platforms to communicate: staff newsletter, PCN newsletter, stakeholder newsletter, Podcasts and monthly 'Lunch & Learn' sessions for staff members to provide updates on the different aspects of their Transformation work.**
- **They have an Organisational Development (OD) specialist working with them to support them to change the behaviour of their Clinical Teams as they are now working side by side with the voluntary care sector and they need to understand the skills and benefits that they provide.**

They consider Comms and OD are some of the most critical elements of the Transformation - by getting these two aspects right, the rest of the Transformation will happen smoothly.

To access a video (09:36min) that provides an overview of their Community Mental Health Transformation work, click on the icon >>>>

Somerset NHS Foundation Trust – case study

Somerset NHS Foundation Trust has been working to implement a new model of delivery for care planning across all mental health services. This model aims to replace the Care Planning Approach with personalised and collaborative care plans that identify a key worker who will be the staff member delivering the primary intervention(s).

At times, the key worker may wish to access the wider multidisciplinary team.

They have developed a paper that outlines the position in relation to rolling out their new approach that includes:

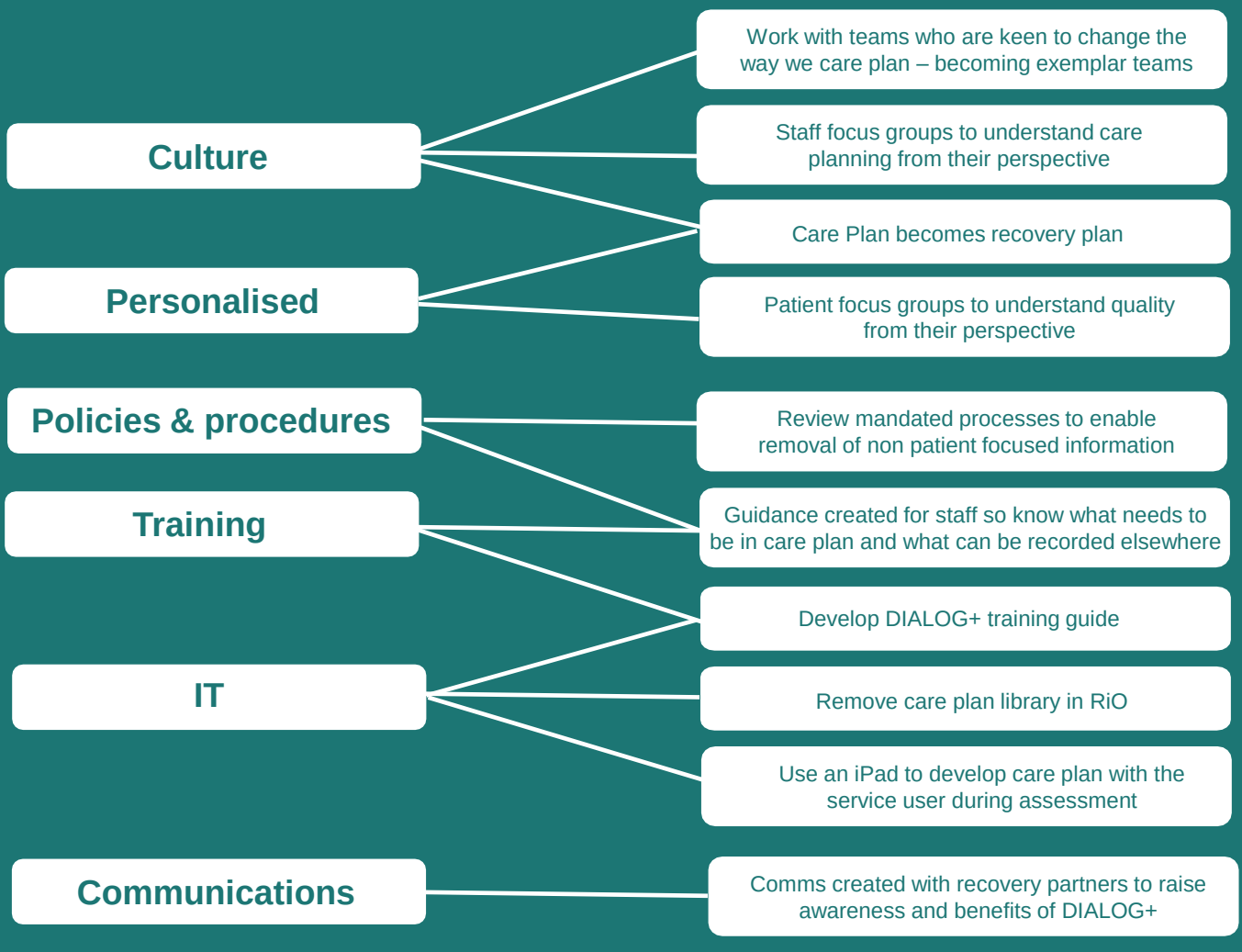
- **The context for the change improvement work undertaken**
- **A summary of the operating model**
- **Risks identified and mitigating actions**
- **A process for review and development**

To read the full position statement, click on the icon >>>

> *We will improve the **quality*** of care plans so that they are created collaboratively with the service user & their family/carer, are written in their words and include what is important to them, while building staff confidence in the recovery planning process **on adult inpatient wards***
>
> ** quality defined by staff & service users as:*
>
> - *Written with the service user*
> - *Always kept up to date*
> - *Relevant to the service user*
> - *Clear and simple to understand*

Initially, a Quality Improvement project group (with Expert by Experience working with Experts by Learning) identified the overarching goals and drivers and developed a

'Driver Diagram' that outlines the scale of their work



Somerset NHS Foundation Trust – case study

This page summarises they key areas that have underpinned the CPA Transformation work in Somerset NHS Foundation Trust

Key enablers

- Communications and engagement:
- **Internal** through newsletters, power points, live presentations.
- **External** with CCG, CQC liaison and local coroner.

- Knowledge, skills and experience:
- Making sure staff are feeling confident using DIALOG+ and delivering meaningful interventions and rolling out significant amount of training around brief interventions. Staff, such as psychological therapists, were not so much up to speed with risk assessment and management, and they have done some comprehensive work with them.

Governance

- They went through all policies in which CPA was mentioned and updated them to reflect the changes (28 policies!) and also SOPs.
- They went through EPR (they use RiO) and looked at references to CPA and care coordination and reviewed them to reflect the new ways of working.
- Interoperability with VCSE and GP partners – DIALOG+ is now live and can be contributed by people in Somerset NHS Foundation Trust and the VCSE.

Managing Clinical risk

- Need to ensure that people feel confident across the board in terms of managing clinical risk.
- They have rolled out training and ensured that EPR reflects what they expect staff to do so that they are including their thinking around clinical risk in their safety element of DIALOG+.
- Making sure they have wraparound governance and reporting structures so they can be assured that clinical risk assessment and management is a key part of what they are all responsible for.

Patient and carer involvement

- They have co-produced their approaches with carers and experts by lived experience and they are involved in the evaluation and training that is taking place as they go live.

Somerset NHS Foundation Trust is using DIALOG+ as their care plan and they have developed resources to support their staff throughout the implementation of DIALOG+ across services

- ✓ DIALOG+ template with annotated prompts for staff to think about when meeting with service users
- ✓ Somerset NHS Foundation Trust DIALOG+ Manual

Click on the icon to access these documents >>>>

Herefordshire and Worcestershire Health and Care NHS Trust – case study

The Community Mental Health Transformation Programme has been implemented for just over two years in Herefordshire and one year in Worcestershire. The programme saw the creation of twelve Neighbourhood Mental Health Teams (NMHTs) across fifteen PCNs.

NMHTs are multidisciplinary mental health teams with roles such as consultants, pharmacists, mental health practitioners (nurses/occupational therapists/social workers), psychologists, mental health wellbeing practitioners, peer support workers and support workers.

The link workers from the VCSE providers are fully integrated within the NMHTs, but also aligned to specialist teams (older adults, complex needs services, eating disorders) - they are fully embedded in the design, delivery, reporting and monitoring (recording into the same EPR system) processes.

CPA Transformation in Herefordshire and Worcestershire

- **The CPA review has commenced - there are processes in place in the interim, but this is likely to be a multiyear process.**
- **Ramification and impact on multiple workstreams including (but not limited to):**
  - **Workforce**
  - **EPR**
  - **Quality and safety**
  - **Finance**
- **There is an obvious interdependency with the Mental Health Community Transformation programme and with the wider system transformations that are also co-occurring.**
- **The replacement to the CPA must be patient focussed, clinically safe and minimise the bureaucratic burden on clinical staff.**
- **Patients' voices are at the centre of the new process.**
- **We are committed to the concept of proportionality.**

Key Achievements:

- **The CPA policy has been re-written in draft format.**
- **The new process has a name selected by service users and carers: 'Personal Care and Management Plan' (PCMP).**
- **Steering group formed and responsible for the development of the new approach.**
- **Links with local system, forums and at the ICB.**
- **All three recommended PROMs embedded into Carenotes. Monthly reports generated on proportion of single PROM completed, paired outcome and improvement trends.**
- **ReQoL 10 implemented as the first of three outcome measures.**
- **DIALOG pilot completed. Clinicians' focus group collected key learning and recommendations for further implementation.**
- **DIALOG awareness/training sessions in planning.**