Date published: 17 July, 2026
Date last updated: 17 July, 2026

Mental health personalised care framework: the modern care programme approach

Publication (/publication)

Content

- Introduction
- Context: why this framework is needed
- Scope
- Enablers of mental health personalised care
- Principles of the mental health personalised care framework
- Acknowledgements
- Appendix: Summary of core principles and key actions

Introduction

The mental health personalised care framework sets out the approach and related principles and actions for delivering personalised care (https://www.england.nhs.uk/personalisedcare/what-is-personalised-care/) for adults and older people with severe mental health problems (summarised in the appendix). Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. Central to providing personalised care is supporting people to be active participants in shaping the support that meets their health and care needs, aspirations and chosen lifestyle. For some personalisation will be about having reliable and consistent standard services and treatment pathways; for others, using support networks more effectively but with the security that expert support will be available at times of crisis or difficulty.

It is relevant to any provider of NHS commissioned secondary mental health services or integrated primary, community and voluntary, community and social enterprise (VCSE) mental health services.

For people with a severe mental health problem this framework describes what they should expect as the standard from mental health services when they seek support, care or treatment, irrespective of their diagnosis.

For mental health services it provides clarity on the core elements of care that they should provide to everyone with severe mental health problems in their services. This includes people' whose needs are in scope for intensive and assertive care.

This framework reiterates the principles that have been national policy since the development of the care programme approach (CPA) in the 1990s, and were more recently set out in the Community mental health framework (https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf). These are that people using NHS commissioned community mental health, crisis and inpatient services should:

- have **a personalised care and support plan** that is current and reflects the needs of the person at that point
- have a **person within the service** responsible for their care and support plan and developing a trusted therapeutic relationship with them

- be able to have their **care and support plan reviewed** when things change and to quickly **re-access help** when they need to (such as when their mental health deteriorates following a period of stability)

However, it seeks to redress the CPA's too narrow a focus on processes by adding a fourth principle that puts the patient voice at the centre:

- have their **experience** of and **response** to care and treatment measured and acted on

The 'patient voice' can be inclusive of information from families, carers and the person's support network and should give focus to ensuring care plans and contacts are meaningful and impactful.

A note on language

In line with the terminology used in the Professional Record Standards Body's personalised care and support plan standard (https://theprsb.org/standards/personalisedcareandsupportplan/), we refer to 'person' and 'people using services'. We recognise that other relevant guidance may refer to people with severe mental health problems as 'patients' or 'service users'.

We use the term 'care and support plan' where other guidance may use 'care and treatment plan'.

We emphasise the need for co-production with people, but recognise there will be situations where clinicians must act without the person's consent and in their best interests, for example where the person is detained under the Mental Health Act or being cared for under the Mental Capacity Act. In these circumstances, services need to be transparent about actions they take and the reasons why.

Context: why this framework is needed

The NHS is committed to learning when things go wrong. This Framework focuses on the foundations of good care and aims to improve the quality of care for all people with severe mental health problems. It also responds to recent learnings from failings of care. The guidance sets out the expectations on services around the assessment, planning and management of safety and risk, including where there is a risk of harm to others or history of violence. Detailed guidance on this has been included in annex A (https://www.england.nhs.uk/publication/mental-health-personalised-care-framework-the-modern-care-programme-approach/#heading-2).

Despite having established core principles through the CPA and more recently the Community mental health framework, too often people with severe mental health problems do not receive the level of care to which both policies aspire.

The Community mental health framework, published in September 2019, proposed "replacing the CPA for community mental health services, while retaining its sound theoretical principles based on good care co-ordination and high-quality care". NHS England's CPA position statement (2022) (https://www.england.nhs.uk/publication/care-programme-approach-position-statement/) confirmed a move away from the CPA to address issues with it, such as inconsistencies in access, lack of outcomes focus and limited co-production.

However, the Community mental health framework removes 'care co-ordinator' roles and gives no specific guidance on how services should plan and co-ordinate care, meaning many areas have struggled to implement this element of community transformation. Meanwhile, the CPA continues to be the framework used for the planning and management of care in some adult and older adult mental health settings, causing inconsistency and potential barriers to care access for people with severe mental health problems.

The Mental health personalised care framework details how services should plan and co-ordinate the care of people with severe mental health problems in the context of transformed community mental health services. It addresses some of the historical challenges of the CPA (such as the 'cliff-edges' of care between primary and secondary services, the excess burden it placed on the role of the care co-ordinator and the focus on process over quality of care), and is applicable across all adult and older adult mental health services.

Scope

The scope is adults and older adults with severe mental health problems, irrespective of their diagnosis. These are mental health problems that may come and go or endure, but all have a significant impact on a person's social life, relationships, work and health. They include (but are not limited to):

- severe mental illnesses, such as schizophrenia, other psychosis or bipolar disorder
- complex post traumatic stress disorder and severe mental health difficulties from complex trauma
- eating disorders
- severe manifestations of common mental health problems, such as anxiety or depression
- co-existence of frailty (likely in older adults) alongside a severe mental health problem
- co-existence of neurodevelopmental conditions alongside a severe mental health problem
- people given a diagnosis of 'personality disorder'
- co-occurrence of drug, alcohol or other addiction problems, including gambling, with a severe mental health problem
- dementia (with or without mental health co-morbidity) where needs or risks require the intervention of secondary mental health services or integrated primary care mental health neighbourhood services

This scope is provided for guidance only and should never be used to **exclude** people from access to any mental health service. Services should always adopt a 'no wrong door' approach to people with a mental health need.

Some elements of this framework will not be directly transferable to certain settings and further adjustment to care context will be required. For example, the process of communicating a declined referral will not usually apply to inpatient settings and several adjustments will be required in forensic and secure settings. Similarly, it is not expected that all referrals to learning disability services will need a multi-agency care plan where mental health support is not required. Above all, the mental health personalised care framework is an **approach** to the delivery of care – adjustments to and in the spirit of the approach will be required for different people in different settings at different times.

Implementing the framework to deliver mental health personalised care for children and young people

Additional guidance for implementing the Mental health personalised care framework in children and young people's services is provided at annex B (https://www.england.nhs.uk/publication/mental-health-personalised-care-framework-the-modern-care-programme-approach/#heading-3).

The framework's core principles and actions to deliver mental health personalised care for adults and older adults apply to children and young people also. However, differences in the needs of and networks of support for children and young people need to be considered across all these principles and actions when planning and delivering personalised care and support for them under this framework.

Ensuring that the framework is also used for children and young people aims to support consistency of care in mental health services across the life course and improve outcomes for them, both in the short-term and longer term as they move into adulthood.

Enablers of mental health personalised care

This framework concentrates on the approach and related actions services should take to deliver personalised care for people with severe mental health problems, but services should consider how they will be enabled. The enablers listed below are all existing expectations of services.

The 'enablers' include:

- understanding local populations, applying population health management approaches and taking action where certain groups are over or under-represented in services
- using tools such as the Patient carer race equality framework (https://www.england.nhs.uk/long-read/patient-and-carer-race-equality-framework/) (PCREF) and Advancing mental health equality (AMHE) framework (https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/amhe/amhe-resource.pdf?sfvrsn=91062ea2_6) to eliminate disparities in access, experience and outcomes
- embedding lived experience in services
- including and supporting a person's carers, family and support network to promote safety and recovery in line with approaches such as the Triangle of Care (https://carers.org/triangle-of-care/the-triangle-of-care)
- utilising tools and technologies to release clinical time to spend with patients, particularly digital technologies such as ambient voice technology (https://www.england.nhs.uk/long-read/guidance-on-the-use-of-ai-enabled-ambient-scribing-products-in-health-and-care-settings/)
- having effective governance and information sharing arrangements (https://www.scie.org.uk/safeguarding/adults/practice/sharing-information/) in place, including with key local partners
- ensuring staff have the required competences and skills for their roles, including knowledge of legal duties (for example, relating to the Equality Act, Mental Health Act and Mental Capacity Act)
- embedding the culture of care standards for inpatient mental health services (https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/)
- delivering trauma informed practice (https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice)
- embedding the Professional Record Standards Body personalised care and support plan standard (https://theprsb.org/standards/personalisedcareandsupportplan/)
- embedding guidance on management of co-occurring conditions and joint working protocols with drug and alcohol services (see Co-existing mental health and substance use delivery framework (https://www.gov.uk/government/publications/co-occurring-mental-health-and-substance-use-delivery-framework/co-occurring-mental-health-and-substance-use-delivery-framework), NICE guideline NG58, 2016 (https://www.nice.org.uk/guidance/ng58))

Reasonable adjustments

Services should ensure they make reasonable adjustments where required to support a person, their family, carers and support network to receive the full benefits of the mental health personalised care outlined in this framework, and have regard to the Accessible information standard (https://www.england.nhs.uk/accessible-information-standard/).

The reasonable adjustments digital flag (https://digital.nhs.uk/services/reasonable-adjustment-flag) on a person's national care record (previously called the summary care record) identifies a person's impairments and the reasonable adjustments to care that they need. Use of this digital flag is mandated (https://standards.nhs.uk/published-standards/reasonable-adjustment-digital-flag) across all health services for people of all ages, but a person needs to consent to it being recorded and shared with other organisations. For people who do not have capacity to give consent (https://www.nhs.uk/tests-and-treatments/consent-to-treatment/capacity/), staff need to follow the requirements of the Mental Capacity Act (https://www.legislation.gov.uk/ukpga/2005/9/contents).

Person's chosen support network

The person's support network is the person or people they choose to be involved in the processes of care and support described in this framework.

Those in this network may include:

- carers
- family members
- friends
- spouse, partner, boyfriend or girlfriend
- members of the person's cultural or faith network

The person may choose members of their support network to be involved in all or some of the processes of care and support, for example:

- attending meetings with the person when they move between services
- being involved in developing the person's assessment and formulation
- being involved in developing and reviewing the person's care and support plan
- being involved in developing and being part of the person's safety management plan
- being provided with copies of key documents related to the person's care and support, with the person's consent (for more information on capacity to consent see NICE guideline NG108, 2018 (https://www.nice.org.uk/guidance/ng108))

Services should regularly ask a person about their support network to keep their understanding of it up to date. They should also recognise the diversity of family structures and the different terms people may use to describe significant relationships, which can vary by culture, community and life experience.

Principles of the mental health personalised care framework

Core principle 1: Everyone has a care and support plan that reflects their needs at that time

Personalised care and support plans

High quality care and support plans are central to the effective delivery of care and treatment for people with severe mental health problems. They are 'owned' by the person and should follow them when they move between services.

Services should align with the Professional Records Standards Body personalised care and support plan standard (https://theprsb.org/standards/personalisedcareandsupportplan/) throughout the development and review of long-term care and support plans.

1. Everyone receives clear and welcoming communication setting out what the next steps will be

Why is this important?

Effective communication is critical in building trust between people and the service and establishing a shared understanding of why the person needs support from that service.

Services need to communicate their offer clearly: what they provide, what help they can give and over what timeframes.

What does this involve?

When a service has been asked to assess a person, the person should be provided with:

- confirmation that the service is or is not the right service to assess their needs
- information about the local offer of care and treatment, including the additional support they may be able to access from partner organisations
- information on confidentiality and information governance

Where the referral is accepted, the person should be warmly welcomed and provided with:

- information about next steps, including either estimated timescales for or confirmation of an assessment with the service
- information to support the person and their support network to request reasonable adjustments regarding their appointment and communication, such as access to interpreters, sensory requirements, physical accessibility of venues
- information about the involvement of carers and the person's support network (for example, attending the initial appointment, if the person wants this) and how to access advocacy services
- information about the support available to the person while they wait for an assessment

- service contact details should the person have any questions or anything changes ahead of the assessment, the location of the service and directions
- information about the care and treatment available within the service; this can be a link to a website

If the service cannot offer the right support, staff should guide the person to other options in the pathway that might be more helpful, such as local charities or community organisations, and explain how to contact them.

People should be given information about how to appeal a decision not to accept their referral and any advocacy support they might be able to access. Services should also let the person know when they could speak to their GP about returning to the service or how they can refer themselves again in the future.

What else should be considered?

At point of acceptance, services should review a person's history and speak to the referrer and the person's family, carers and support network to learn what the person has found most engaging when accessing care. This should inform ways to communicate with the person, including about their mental health, and the practical arrangements around their care and support.

All communications should use simple, straight forward language and avoid jargon and complex terminology.

Some people may lack capacity or may not engage with or respond to standard means of communication or access to the service. Services should adapt their approach as required to meet individual needs.

There will be settings (such as inpatient and forensic) where the referral processes described above do not apply. Alternative supportive processes should align with the ethos of the above approach, including warmly welcoming people into services.

2. Everyone has a current assessment based on their presenting mental health needs

Why is this important?

Assessments must be responsive to the immediate presenting mental health needs and safety of the person, but they also provide the opportunity to listen to and start to get to know the person and understand their problems: what they are, what might have led to them and what might be perpetuating them (see NICE clinical guideline CG136, 2011 (https://www.nice.org.uk/guidance/cg136/ifp/chapter/what-should-happen-during-an-assessment-at-mental-health-services)). This 'formulation' should inform the development of a care and support plan and treatment recommendations.

What does this involve?

Initial assessments and formulations should offer the person the opportunity to have their understanding of their distress and needs recognised by services.

The assessment should identify the person's strengths, needs, concerns, problems and goals as well as the next steps in their care and support. The depth of the assessment will depend on the person's presenting problems and what is already known, but the details collected need to be sufficient to develop a care and support plan that can respond to the person's needs, goals and safety.

The assessment should:

- draw information from a range of sources:
    - the person themselves – wherever possible, people should be able to pre-complete their history, which assessors then build on
    - family, carers and other people important in the person's life and care
    - other involved professionals, services and organisations
    - previous assessments and other relevant information held by services
- be comprehensive enough (using reasonably available information) to inform next steps in the care process, including reviewing previous assessments, identifying any further assessments that may be required or initiating an immediate treatment and safety plan if required
- use tools that help identify what is most important to the person (such as the DIALOG scale (https://www.elft.nhs.uk/dialog-scale) where validated for use) or to identify common co-occurring conditions (such as

the ASSIST-Lite screening tool (https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use) to identify substance use)
- seek to elicit any immediate concerns from the person and their support network about safety, risk of possible harms (to others, from others and to self) and how they can be mitigated. See annex A for more information on safety assessment, formulation and management planning (https://www.england.nhs.uk/publication/mental-health-personalised-care-framework-the-modern-care-programme-approach/#heading-2)
- consider the person's needs under the Care Act and, where applicable, any requirements of the Mental Health Act and Mental Capacity Act
- record key information accurately to avoid the person needing to repeat their story at subsequent assessments, and to ensure continuity of care through the assessment process

Assessors should:

- be conscious of potential bias in assessment and consider how to provide culturally competent, trauma informed and autism informed assessments
- understand and acknowledge the potential for people to have previous negative experiences of services (including of not being believed or understood; being passed between services; or receiving treatment against their will) and for this to impact on the current assessment

Services should ensure their staff have the knowledge and competencies to undertake an assessment appropriate to their role and to adhere to NHS safeguarding standards (https://www.england.nhs.uk/long-read/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs/).

The formulation should be developed collaboratively and several contacts or appointments will likely be needed for this. It informs care planning and treatment by developing a shared understanding of a person's mental health difficulties and the factors contributing to them. Staff should respect a person's individual understanding of what is happening for them, remain curious about this understanding and respect the person's right to make sense of themselves.

The person and, if agreed by the person, their family, carers and support network should be involved in the formulation process and provided with a copy of the formulation and care and support plan in a timely manner. They should be given an opportunity to correct any inaccuracies or propose changes. Changes are either made or any differences of opinion with the assessor acknowledged and recorded.

As with care and support plans, assessments and formulations should be available to staff who may need to access them.

What else should be considered?

Known reasonable adjustments or those identified from asking what adjustments could help, should be made to support a person, their family, carers and support network to participate in assessments. These may include flexibility in holding appointments in person or virtually, and in a location familiar to the person (see NHS England's guidance on meeting the needs of autistic people in mental heath services (https://www.england.nhs.uk/long-read/meeting-the-needs-of-autistic-adults-in-mental-health-services/)).

Where available and relevant, previous choices and wishes should be considered when completing assessments (for example, previous advance choice documents; written or spoken records that allow people with mental illness to say, when well, what treatment they would like should they become unwell.).

Meaningful involvement of family and carers is a key element of personalised, co-ordinated care. Services should never use confidentiality as a reason for not listening to or engaging family and carers appropriately, and staff should ensure that people using services understand that sharing relevant information can enable family and carers to continue providing effective support.

Staff should be supported to respond to the needs of a person's chosen support network, including help with their own wellbeing.

Where it is not possible to include information from a range of relevant sources, the reasons for this should be stated. Those sources that would have been useful should be noted and a plan included to follow these up as part of the assessment process or in the person's ongoing care and support.

3. Everyone is given clear information about their available treatment options, including their likely benefits and harms

Why is this important?

People with severe mental health problems should be supported to have informed choice over their care and treatment and to be involved in decisions about them and their care. No one intervention (for example, psychological therapies, medicines) works well for everyone and all interventions can cause harms for some people.

What does this involve?

The available range of interventions should reflect the requirement to address clinical and social needs of people with severe mental health problems. This should include treatments and self-management advice recommended by NICE, non-clinical options delivered in the community and digital interventions where available and appropriate.

For shared decision-making, people and their family, carers or support network where appropriate should be:

- given clear information about the likely benefits and harms of each intervention, balanced against those of doing nothing (NICE guideline NG197, 2021 (https://www.nice.org.uk/guidance/ng197)). This information should be based on best available evidence, and considered alongside the person's own experience and history of treatments (for example, compliance with medication, relapse risks, etc.)
- given information about limitations on availability and waiting times to access different treatments. If a person would have to meet certain requirements before starting a particular treatment (for example, around 'readiness for therapy'), these should be communicated alongside the evidence for treatment

- given information in the ways they find most useful and sufficient time to consider their options
- supported to choose their preferred treatment from the range of options
- for any intervention, given guidance on how to maximise the benefits of treatment, minimise any adverse effects and work in partnership with their care team to monitor for adverse effects

At times circumstances may require the delivery of interventions that the person does not agree with. In these instances, staff will work within the requirements of the relevant legal framework (for example, Mental Health Act, Mental Capacity Act), record differences in views and be clear and transparent in explaining why choice is not possible.

The goals for treatment should be included in care plans and response monitored in partnership with the person and as appropriate their family, carers and support network. For all interventions:

- outcome measurements to assess progress should include the person's desired goals. A tool such as the Goal-Based Outcomes (GBO) tool (https://www.goals-in-therapy.com/the-gbo-tool) can be used where validated
- the person should be able to seek support via their named worker if they feel an intervention is not working or they are experiencing an adverse effect. The named worker should ensure those issues are reviewed by someone with the appropriate expertise and any urgent advice provided where necessary. The reviewer could be a specialist mental health pharmacist, nurse or other appropriately trained professional
- a timely review of the person's care and support plan is required if an intervention is not delivering the expected improvements or adverse impacts are outweighing potential benefits or have led the person to stop treatment. Timely in this context means before any likely deterioration can occur or within the timeframe specified in the care and support plan for expected improvement

What else should be considered?

Care and treatment options should take into account eligibility for s117 aftercare under the Mental Health Act (https://www.legislation.gov.uk/ukpga/1983/20/section/117), personal health budgets, rights to advocacy, capacity to make decisions about care and best interests in line with the Mental Capacity Act (https://www.legislation.gov.uk/ukpga/2005/9/contents). Some people may require additional practical support with their day

to day lives such as those requiring intensive and assertive mental health care (https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/) or community mental health rehabilitation services (https://www.england.nhs.uk/long-read/commissioner-guidance-adult-community-mental-health-rehabilitation-services/).

Where a person has a history of non-adherence to medication or where legal requirements apply (for example, community treatment orders or court mandates), the use of long-acting injectable medication should be considered.

Robust oversight of medication management is essential. This includes having appropriately trained staff to support adherence, monitor for side effects and administer medication, and systems with sufficient infrastructure to optimise safety and efficacy of medications.

4. Everyone has a current, co-produced and personalised multi-agency* care and support plan

*where appropriate

Why is this important?

Personalised care and support plans provide a structured, shared understanding of the person's needs, goals and preferences, and set out how the service will work with them to improve their mental health. As described in the Professional Record Standards Body's personalised care and support plan standard (https://theprsb.org/standards/personalisedcareandsupportplan/#aboutthisstandard), people should have

"a single shared personalised care and support plan to which all health and care professionals can contribute. The aim is to avoid what currently happens too often, where separate care plans are created by different professionals or teams of professionals and they are not widely visible, don't join up, and don't promote a holistic approach to meeting a person's care needs".

This does not preclude individual services having their own necessary documentation for care planning purposes but this should link to the multi-agency plan.

Multi-agency input into the care and support plan may be facilitated through embedding dedicated roles in the team (for example, social workers, drug and alcohol workers) or liaison with external agencies (for example, housing, local authority, VCSE partners).

What does this involve?

Completion of personalised care and support plans. Services should monitor multiple domains of quality of plans, including safety, timeliness, personalisation and effectiveness, to support high quality care.

Following assessment and formulation, an initial plan should be completed within the assessment meeting or the days following that assessment and shared with the person. It should include:

- any immediate next steps arising from the assessment
- the treatment and support to be provided
- how the person will be cared for, including any reasonable adjustments
- the person's named worker
- the safety plan
- details of the person's support network and how they should be involved

A full care and support plan should then be co-developed and agreed with the person and, where appropriate, their family, carers and support network. This will take longer to complete but the appropriate timeframe will depend on the person's needs and the care and treatment being considered. This timeframe should be agreed with the person and appropriate and responsive to their needs and goals.

The full care and support plan should:

- meet the national Personalised care planning standard (https://theprsb.org/standards/personalisedcareandsupportplan/) and be accessible, relevant and responsive to when things change
- be personalised and reflect the assessment and formulation (see above): it should set out what the service can do to help the person maximise their strengths, address their mental health needs and achieve their goals
- seek to address fundamental needs like safe housing, financial security, employment and physical health, as well as social connection and healthy relationships
- be supported by outcome measures (the specific outcome measures and how often they will be used should be discussed and agreed with the person):
    - patient reported outcome measures (PROMs; questionnaires completed by patients and designed to help patients and their practitioners understand and measure their health and wellbeing before, during and after care and treatment)
    - patient reported experience measures (PREMs; questionnaires completed by patients about their experience of their care and treatment)
- ensure that any prescribed medication is reconciled with any other prescribed medication (for example, from primary care or private providers)

Timeframes for meeting goals and outcomes should be agreed as part of care planning. These will guide the frequency of plan reviews.

Safety management plans should be developed alongside or as part of a person's personalised care and support plan (see annex A (https://www.england.nhs.uk/publication/mental-health-personalised-care-framework-the-modern-care-programme-approach/#heading-2) for more information on). They should:

- build on a person's strengths and address risks, harms, likelihood of harms and mitigations
- document what helps the person to be and feel safe and what factors lead them to feel and be unsafe
- document any relapse indicator signs, what does and does not help in relapse and what harms could occur if relapse is not effectively addressed in a timely manner. Where possible, mitigations should be described and how quickly actions might be needed

- consider advance care planning for deterioration and the role of more intensive support including crisis houses or inpatient admission. This should include the development of advance choice documents where appropriate

The most important information should be put at the top of these plans so that it is not missed.

Care and support plans and safety management plans should be available to the person and staff who may need to access them. This includes staff in other teams and services such as the person's GP or the neighbourhood team. Services should have systems in place to ensure staff can access plans when the named worker is unavailable. Where agreed, the person's support network should also have access to these plans. Services should discuss with the person how they can access and share their plan with others in their life.

What else should be considered?

For people at risk of future admission, the development of an advance choice document should be considered. This is a written or spoken record of the care a person with mental illness says when they are well that they would like should they become unwell. There is evidence that having an advance choice document can reduce a person's need for inpatient admission and use of these documents is expected to become legislation as part of the Mental Health Act reforms (https://bills.parliament.uk/publications/56782/documents/5311). If a person already has an advance choice document, this should be reviewed and used to inform the care and support plan.

Plans should be sensitive to a person's cultural identity and responsive to their spiritual needs and beliefs.

For people with a learning disability and autistic people at risk of admission, plans should align with Care (Education) and Treatment Reviews (C(E)TRs) (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/).

Where appropriate, plans should reference how any legal conditions (for example, under the Mental Health Act, Mental Capacity Act or court orders) and any relevant safeguards will be met.

Core principle 2: People using services have someone within the service who takes lead responsibility for their care and support plan

5. Everyone has an appropriately skilled named worker co-ordinating their care and support plan

Why is this important?

Positive relationships between staff and the people they support are fundamental to person-centred care. Trusted therapeutic relationships are associated with improved clinical outcomes and their development, alongside continuity of care, are key mediators of safe and effective care.

The named worker is responsible for building a trusted relationship with the person using services and supporting delivery of the person's care and support plan, including by co-ordinating the professionals, services and agencies needed to realise it.

While the named worker will be a person's primary contact point, it is important that they are not seen as the sole person responsible for the person's care and treatment. The multidisciplinary team (MDT) retain overall responsibility for the care and treatment of people within the service. Effective MDT working and associated systems, processes and values are critical to enabling the named worker to carry out their role.

What does this involve?

Every person using secondary mental health services should expect:

- an allocated named worker responsible for developing a trusted, supportive, therapeutic relationship with them (and their family, carers and support network) and co-ordinating the delivery of their care and support plan
- an MDT who take responsibility for the safety, effectiveness and quality of the care they receive
- a variety of professionals, practitioners and services who deliver the interventions set out in their care and support plan

Allocation of a named worker: Every person should be allocated a named worker, their (and their family, carers and support network's) first point of contact for day-to-day aspects of their care and the primary contact for other health and care providers that are supporting the delivery of the person's care and support plan.

All services should have a clear system and governance for allocating named workers and this should operate across integrated teams. This might be a matching and allocation process across the NHS, VCSE and social care staff working in a transformed community service or 24/7 neighbourhood mental health centre. Services should ensure the allocation of named workers is consistent with any service-specific guidance or specifications, for example the 'care co-ordinator' within early intervention in psychosis services (https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf).

The process should have a contingency plan for when the allocated named worker is unavailable or needs to change. Where a change in named worker can be foreseen, this should be discussed with the person and planned for as soon as possible. Service level strategies such as use of duty systems, formal buddy systems or named worker and associate systems can be used to operationalise these requirements.

Matching a named worker to the person should be done with understanding of who the person is most likely to trust and engage with, considering both their preferences and needs. This is important for achieving a trusted therapeutic relationship and supporting continuity of care.

The allocation process should understand and consider the:

- type and nature of the person's mental health needs, their acuity and complexity (including risks) and any legal or statutory frameworks relevant to their care
- skillset of the practitioner; the named worker should possess the necessary skills, competences and experience to engage effectively with the person and co-ordinate the care that addresses their needs and safety
- person's preferences and who they are most likely to engage with given their cultural identify and protected characteristics. The person should be asked directly what is most important to them for engaging with their care and support

- person's safety needs and the reasonable adjustments they may require
- level of engagement and history of non-adherence to treatment

The named worker will be a full member of an integrated MDT or have access to the MDT when needed (for example, through an MDT case review meeting).

Most people with high levels of needs and illness acuity, whose care will be provided across multiple agencies, will likely need a registered mental healthcare professional to be their named worker. However, there may be times when the recovery needs of a person are best met by a VCSE support worker, another registered healthcare professional or social care key worker.

People whose needs are within scope for intensive and assertive care (https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/) should have a named consultant psychiatrist in the community alongside a named worker with the necessary skills and competencies to manage risk and complex needs.

The rationale for designating a specific named worker should be documented as part of care planning. This supports governance of the allocation process and enables ongoing review of the named worker's fit with the person's needs and preferences. People's needs and goals may change over time and the service should be responsive to this, including by considering whether the person's named worker should change.

The named worker should remain allocated to the person during any period of crisis care or inpatient stay and work in partnership with colleagues in inpatient settings to support continuity of care, the person's admission and discharge planning. Where a person is admitted to an inpatient setting without previous contact in the community, the named worker should be decided as soon as possible during the admission. The admitted person may also have a named nurse or professional from the ward team who focuses on their care during their inpatient stay. The named worker and the ward team should be in regular communication.

Multidisciplinary team working: Effective implementation of the Mental health personalised care framework will require services to have clear MDT approaches to meet the needs of the person, be responsive to changing needs and allow all staff to make the best use of their skills and qualifications. The MDT retain overall responsibility for the care and treatment of people within the service. Appropriate governance arrangements need to be in place to enable the MDT to fulfil this role (for example, regular MDT review meetings).

While the named worker will be the primary contact point for a person and has the core task of developing a trusted relationship and supporting continuity of care, it is important that they are not seen as the sole person responsible for the person's care and treatment. The named worker role cannot function in isolation and must be fully supported by MDT working and, where relevant, multi-agency working.

Many members of the MDT and wider integrated teams will likely be involved in delivering care and support to the person and teams should work together to build a positive, trusting relationship with the person.

Effective MDT working and associated systems, processes and values are critical to enabling the named worker to carry out their role:

- the MDT will support the named worker to co-produce a care and support plan with the person (and their family, carers and support network) and the named worker will then regularly review the plan with the person (their family, carers and support network) and those involved in its delivery
- the named worker and other professionals involved in the person's care will be able to raise concerns about the person with the MDT in a timely fashion and urgently if needed:
    - the MDT will guide and support the named worker to respond to these concerns safely and effectively
    - if the named worker cannot respond safely and effectively, the MDT should take appropriate action using their wider resources and roles

What else should be considered?

Multidisciplinary team working: Integrated care requires professionals and practitioners from across different sectors to work together around the needs of people, their families and their communities. Teams that bring together the relevant professionals and practitioners encourage better co-ordination of their work.

The Social Care Institute for Excellence (SCIE) identifies a common set of aspirations for MDTs regardless of the goal (https://www.scie.org.uk/integrated-care/multidisciplinary-teams/). They:

- bring together team members from diverse backgrounds to better understand each other's roles and responsibilities as part of a shared identity
- enable better communication and greater trust between team members
- lead to more holistic and personalised care, preventing unnecessary errors and their related harm
- result in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches

MDT membership and multi-agency working: The person using services and their family, carers or support network should be involved wherever possible in the decision-making processes about their care. This means, where possible, they should be considered part of the MDT for that person.

Lived experience adds essential expertise to the MDT. Peer workers can bring the voice of the person using services into MDT conversations to increase understanding between professionals and the person. Peer perspectives can also help the team think more holistically.

The person's needs will determine what MDT oversight and input and whether multi-agency working will be required as part of a dynamic process with an appropriate range of multidisciplinary professionals responding to the person's needs. Where multiple agencies are involved in a person's care, they should work with the named worker to jointly co-ordinate activity.

Effective communication is key to successful MDT and multi-agency working. Teams should have embedded clear mechanisms for how they communicate. MDT and multi-agency decisions and related responsibilities for actions need to be recorded and shared to maintain effective clinical oversight of the person's care.

Core principle 3: Care and support plans are reviewed routinely and when things change

6. Everyone has their care and support plans reviewed routinely

Why is this important?

Personalised care and support plans should be live documents that are easily accessed as and when needed or when things change. Review ensures the plan continues to best reflect the strengths, health and care needs, goals and safety of the person. The focus and frequency of reviews will depend on whether the person is in remission, stable or an active phase of treatment. Flexibility and responsiveness in approach is a key aspect of personalised care.

What does this involve?

Personalised care and support plans should be reviewed:

- as part of routine practice with a clear focus on outcomes and experience
- when there is a significant change in the person's circumstances that impacts on their mental health or a change or exacerbation in their presenting problems or needs
- when requested by the person, their family, carers and support network

Care and support plans for people in active phases of treatment will be reviewed more frequently as part of an iterative monitoring process, while people requiring intensive and assertive mental health care will likely have their care and support plan reviewed at the weekly MDT meetings (see guidance on intensive and assertive community mental health care (https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/)).

Formal reviews should take place every 6 months as a minimum. Formal reviews should be meaningful in supporting purposeful care, not a tick-box exercise initiated to respond to arbitrary timelines. Frequency of reviews should be personalised, flexible and determined by care planning and goal setting. They should always focus on outcomes and

experience of care.

Depending on a person's recovery, their care and treatment may be led by primary care, but in some circumstances, such as due to medication requirements, the person may remain open to secondary care services without any other forms of active treatment. In such circumstances, reviews might be less frequent but should still reflect the individual needs of the person.

The person should feel ownership of a review. They should be asked beforehand if they would like to lead the review themselves or who they would prefer to lead it on their behalf.

Reviews should include the person's named worker, consultant or approved clinician, all the agencies involved in delivering their care and treatment (such as primary care, housing and social care) and the person's family, carers and support network. To conduct reviews, all the professionals involved are not required to meet in one place, but the person should be present other than in exceptional circumstances.

At a minimum, the formal review should consider:

- progress since last assessment or review and any changes in the person's personal circumstances
- changes in PROMs and PREMs and as relevant, clinically reported outcome measures (CROMs)
- whether the person's goals as documented in the plan remain relevant
- what next steps and changes (if any) to the plan are required

If the formal review concludes the person's care needs reviewing or changing, then the care and support plan should reflect the changes when they happen and the initial impact of those changes should be assessed.

The outcome of the review and updated care and support plan should be available to the person and staff who may need to access them. Where agreed by the person, their support network should also have access to these plans.

What else should be considered?

Where multiple agencies are involved in caring for the person:

- reasonably available information from them will need to be collated to inform reviews and in what timeframe
- reviews should identify who needs to be updated and by whom where changes are made to the care and support plan
- services should ensure they have clear protocols in place for escalating issues to involved agencies in a timely manner and notifying them of changes in care

Where a person has been admitted to an inpatient setting, the care and support plan review should consider whether care can be delivered in a less restrictive setting, such as the community.

Where there are any indications that a person with a learning disability or who is autistic could be at risk of admission to a mental health hospital, there should be a discussion – involving the person and their family, carers or support network – about referral onto the local dynamic support register (https://www.england.nhs.uk/long-read/dynamic-support-registers-and-care-education-and-treatment-review-code-of-practice/) and a clear pathway and named person to make this referral.

People using services are entitled to confidentiality regarding their health and care information. However, meaningful involvement of families and carers, who may play a vital part in providing support and care, is a key element of personalised, co-ordinated care. Where a person does not consent to the sharing of information with their family, carers or support network, services should continue to engage families and carers appropriately to hear their concerns, provide support and obtain corroborative information, and never use confidentiality as a reason for not doing so.

Staff should be supported to respond to the needs of a person's chosen support network, including what help they may need with their own wellbeing.

7. At points of increased risk and change in circumstance, plans are reviewed to ensure care and treatment remain appropriate for the person's needs

Why is this important?

Points of change and transition increase risk of harm to individuals (NICE guideline NG53, 2016 (https://www.nice.org.uk/guidance/ng53/chapter/Recommendations#hospital-admission)). These can include:

- acuity of the person's mental health increases and they require crisis services or admission to an acute hospital
- transitions between children and young people and adult mental health services and between school, higher education and work
- discharge from hospital back home
- discharge from adult secure services back to prison or the community
- significant life events that impact on personal safety, relationships, finances, occupation or accommodation

When people move between services, care should remain consistent and connected. Services should work together, share relevant information and carry forward relationships, knowledge of the person and agreed care plans so that continuity is preserved and care does not feel fragmented.

What does this involve?

National guidance should be followed when a person needs to be admitted to an inpatient setting (see Acute inpatient mental health care for adults and older adults (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/); Commissioner guidance for adult mental health rehabilitation inpatient services (https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/); and NICE guideline NG53 Transition between inpatient mental health settings and community or care home settings (https://www.nice.org.uk/guidance/ng53/chapter/Recommendations)).

For people with a learning disability and autistic people, a pre-admission C(E)TR should take place with the person, their support network and the team around the person.

The named worker should continue to work with and be available to the person if their needs change and transition to a higher acuity care setting is required, including where this is out of area. This work includes:

- in-reaching into a different care setting
- communicating and liaising with involved professionals as well as the person, as soon as the change in setting occurs or is planned

- contributing to formulation, care planning and transition or discharge planning in the new care setting

A planning meeting will take place on a person's admission to hospital to understand the reason and purpose of admission, to plan the best approach to care and support and to begin discharge planning. This meeting should include the person's named worker and other relevant agencies (for example, housing providers) along with the person, their chosen support network and the inpatient MDT. The teams around the person (across community and inpatient) should begin implementing the agreed actions immediately.

Regular reviews of the care and treatment the person is receiving in hospital should take place with the person, their family, carers and support network, their named worker and the inpatient MDT.

The person should be safely discharged from inpatient care as soon as they are clinically ready and receive a follow-up from their named worker (or crisis response and home treatment team where appropriate) within 72 hours of discharge. It is important that these early post-discharge contacts anticipate any imminent deterioration. The acute inpatient mental health care guidance (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/) provides more information on clinical readiness for discharge.

A person's admission to hospital should prompt a review of their care and support in the community and their safety plan. Any changes based on what the person and those around them feel could prevent a future admission should be made.

Other significant changes, such as the person moving home to another locality, require action from services to enable continuity of care. The transferring service has a responsibility to support the transition and share important information, including how best to engage the person, the care and support plan including relapse indicators, risk assessment and safety plan and formulation. The transferring service should be satisfied the receiving service is ready to continue the care and support plan.

Services should ensure joint-working arrangements are in place to support effective transition between children and young people's services and adult mental health services in line with NICE quality standards (https://www.nice.org.uk/guidance/qs140/chapter/Quality-statement-2-Coordinated-transition-plan). The focus should be on

continuing to deliver developmentally appropriate care, avoiding rigid, age-based thresholds. Particular attention should be paid to high-risk groups such as students and care leavers.

Before any transition between services, the person's care and support plan should be reviewed (with other relevant agencies where appropriate) and where necessary updated to include information on:

- what works best for the person in terms of engagement and their preferences around care
- personal relapse indicators: how these manifest, what does and does not work for the person in preventing relapse at different stages of becoming unwell, what harms could occur when they relapse
- how the person can rapidly regain access to higher intensity service when needed following a step down in care – including through self-directed referral when appropriate. Access routes should reflect what is known about the person's illness and relapse indicators. Where significant time has passed or the presenting problems are different, it may be appropriate to include re-referral through primary care
- any current medication prescribed by the transferring team: indication, monitoring requirements, expected duration of treatment and arrangements that should be made if the person wishes their medication to be changed or reviewed

Where a person is moving from one service to another, a transfer of care planning meeting should take place and include the person, their current named worker and the new named worker. In advance of the transition, the person (and their family, carers and support network as appropriate) should be provided with written confirmation of:

- reason for change in care
- who their new named worker is and ways to contact them and the service – including a working hours telephone number and email address
- a copy of the person's updated care and support plan
- medicines reconciliation

What else should be considered?

Where appropriate, decisions at points of increased risk and change in circumstance should consider how any legal conditions (for example, under the Mental Health Act, Mental Capacity Act or court orders) will be met. Decisions about treatments such as long-acting injections and consideration of community treatment orders should be made collaboratively between community and inpatient teams and in view of the individual's clinical history and risk, response to previous treatments, engagement levels in the community and long-term care needs. Equally, effective joint, multi-agency discharge planning is required where a restricted person is being conditionally discharged.

8. Following discharge from community care, everyone can quickly re-access care when needed without having to repeat their initial referral pathway

Why is this important?

For most people, severe mental health problems are life-long, fluctuating conditions; periods of being unwell can be followed by long periods of stability and vice versa. They can be unpredictable, change over the life course and be impacted by life events. It is important that people's access to the right level of care across the continuum of community and inpatient pathways is responsive to changes in their mental health needs.

When unwell a person may lack capacity or insight. It should therefore be possible for an appropriate family member, carer or member of the support network to initiate a discussion on re-accessing services based on a change in need or risk.

It is important that services discharge (or in newer transformed models 'step down' care) when appropriate, to focus their resources on those who need it at that time and creating capacity to 'step up' or 'accept' people if their needs increase.

What does this involve?

As with transitions between services (see above), decisions to discharge people from a service should be documented, noting any personal relapse indicators and known harms or risks if these are not responded to promptly.

Where a person is being discharged from the community mental health service to primary care, a care planning meeting should take place and include the person (and/or a family member, carer or support network member where the person lacks capacity). At the point of discharge, the person and their GP should be provided with:

- reason for change in care
- a discharge plan that details how the person can re-access support from the community mental health service – including a working hours telephone number and email address
- information about other available community support that may be helpful to the person
- a copy of the person's updated care and support plan and other relevant plans developed as part of their care and treatment
- medicines reconciliation

What else should be considered?

Failure to engage with services should never be the sole reason for discharging people with known severe mental health problems. It is the duty of mental health services to find effective ways to engage a person.

There will be instances where the person has capacity but does not wish to engage with services and there are no clear associated risks to warrant further assertive approaches that could be experienced as intrusive or coercive. In such instances, relevant parties should agree a mitigation plan should risks emerge.

Core principle 4: Response to and experience of care and treatment are measured and acted on

9. Outcome and experience measures are used routinely as part of ongoing planning and reviewing of care and support plans, in a way that prioritises the person's voice

Why is this important?

Appropriate outcome and experience measures, including PROMs and PREMS to amplify the person's voice in their care, should be used routinely as an integral part of practice to inform care and support plans and to monitor the progress and impact of interventions. They should be used:

- in collaboration with the person to guide the need for a care and support plan review. This supports a more flexible, proactive and responsive approach to care than arbitrarily determined review frequencies
- in these reviews to ascertain whether treatments are having the desired benefits and identify any potential harms

What does this involve?

The choice of captured outcome measures, including PROMs and CROMs and PREMs, should consider national and local guidance as well as the specific goals of the intervention.

The selected outcome measures, their benefits and the frequency of outcome reviews should be discussed and agreed with the person using services, recognising that different types of care and support will deliver demonstrable improvement in different timeframes. All should have been designed, developed and validated for the context or population in which they are being used. It may also be helpful to provide written information on use of outcome measures for people using services and their support network. The frequency of outcome reviews should be clearly set out in the person's care and support plan.

Experience measures should also be captured whenever possible. The use of validated co-produced tools is encouraged, for example the Consultation and Relational Empathy (CARE) tool. Mechanisms for garnering people and carer feedback should align with the Patient and carer race equality framework (https://www.england.nhs.uk/long-read/patient-and-carer-race-equality-framework/) to ensure they are culturally competent

What else should be considered?

While outcome measurement supports and enhances care and treatment planning and therapeutic interactions, its use should not dominate or become an end in itself. Outcome measurement has multiple benefits but does not replace learning from the person and their support network about what changes may be needed. When using outcome measures, what the

person needs now should always be front of mind. In line with avoiding a tick box approach to scheduling reviews, use of outcome measurement in the personalised care framework should be flexible to the person's needs.

Where someone is so unwell that they struggle to engage with outcome or experience measures, alternative means of measuring outcomes should be considered. Services must have a clear approach to this, for example continued efforts at the right time to give everyone a voice and choice in their care, use of structured frameworks that enable meaningful involvement of families and carers and use of clinically reported outcome measures.

In services offering short-term or acute interventions where impact on longer-term outcomes is not within the scope of service, relevant adjustments will be required to monitor the impact and experience of care.

In addition to routine use of outcome and experience measures, services should routinely capture the interventions they deliver through use of SNOMED (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submission-guidance/an-introduction-to-snomed) codes. This will support clinical teams to monitor the delivery of evidence-based interventions and treatments, alongside patient outcomes and experiences.

Acknowledgements

We are grateful to everyone who contributed to the development of the mental health personalised care framework. Its development has been a collective effort across the mental health sector and we have benefitted from the advice and support from experts across the NHS and our partners.

We express our particular thanks to Ben Walford, Dr Ian Davidson, Dr Ali Brabban, Jacqui Dyer, Chris Lynch, Tasha Suratwala, Leanne Walker, Jo Lomani, Upkar Jeeta, Ursula James, Dr Mayura Deshpande, Pete Devlin, Robert Lewis, Jo Kirk and Russell Dunmore.

Appendix: Summary of core principles and key actions

Core principles

Everyone has a care and support plan that reflects their needs at that time.

Key actions

1. Everyone receives clear and welcoming communication setting out what the next steps will be.

2. Everyone has a current assessment based on their presenting mental health needs.

3. Everyone is given clear information about their available treatment options, including their likely benefits and harms.

4. Everyone has a current, co-produced and personalised multi-agency care and support plan.

Core principles

People using services have someone within the service who takes lead responsibility for their care and support plan.

Key actions

5. Everyone has an appropriately skilled named worker co-ordinating their care and support plan.

Core principles

Care and support plans are reviewed routinely and when things change.

Key actions

6. Everyone has their care and support plans reviewed routinely.

7. At points of increased risk or changes in circumstance, plans are reviewed to ensure care and treatment remain appropriate to the person's needs.

8. Following discharge from community care, everyone can quickly re-access support when needed without having to repeat their initial referral pathway.

Core principles

Response to and experience of care and treatment are measured and acted on.

Key actions

9. Outcome and experience measures are used routinely as part of ongoing planning and reviewing of care and support plans, in a way that prioritises the person's voice.

Publication reference: PRN02262_i

Date published: 17 July, 2026
Date last updated: 17 July, 2026