

1903

## Care Programme Approach (CPA)

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### Partners in Care

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## 1 Introduction

- 1.1 Torbay and Southern Devon Health and Care NHS Trust (TSDHCT) aims to provide high quality patient care to 0-18year olds in line with department of health, Mental Health Act 1983 (amended 2007) and is committed to the values and principles which apply generally to modern mental health services. The trust ensures that service users receive treatments that are, care planned and that address their mental health needs. It is essential that a package of care is detailed and that there is a clearly identified passage of care from referral through the care pathway to subsequent discharge and appropriate after care services are engaged. It is essential that all patients have an identified key worker to ensure a safe, clear and effective treatment pathway is maintained with the service users and their carers at the centre and an integral part of the treatment and planning processes.
- 1.2 First introduced in 1991, the Care Programme Approach (CPA) is a framework designed to promote the effective co-ordination of care of people suffering from poor mental health and being treated within secondary mental health services such as those provided by Torbay Child Adolescent Mental Health Service (CAMHS). CPA is a framework that describes the process of assessing, planning, reviewing and co-ordinating the range of treatment, care and support required.
- 1.3 The CPA process robustly supports the following:
- Promotion of social inclusion and recovery.
  - Seeing any person "in the round", looking for example at their diverse roles in life, their strengths as well as their difficulties.
  - Promotion of self-care wherever possible and encouragement of independence and self-determination.
  - Recognition of the support given by informal carers.
  - Promotion of mental health practice based on fulfilling relationships and Partnerships.
  - Care planning based on short/long term engagement between service users, mental health professionals and partner agencies and not simply focussed on formalised meetings or reviews.
- 1.4 It is the responsibility of TSDHCT to ensure that all CAMHS users (who meet the criteria for CPA; sec 2.3) are subject to a CPA process.
- 1.5 CPA will encompass four main elements as below:
- Systematic arrangements for comprehensively assessing both mental & physical health needs, social care needs and risk.
  - The development of a care plan which identifies the health and social care required from a variety of providers.
  - The appointment of a CPA care co-ordinator to keep in close touch with the service user, to monitor and co-ordinate care.
  - A system of regular review to evaluate the effectiveness of the care plan and to agree changes as necessary.

- 1.6 During induction all staff should be made aware of the CPA policy and how it should be implemented in the Torbay Child and Adolescent Mental Health Service.

## 2 Statement/Objective

- 2.1 The purpose of this policy is to clearly set out Torbay and South Devon Health Care Trusts (TSDHCT's) requirements when providing treatment and care within the framework of the Care Programme Approach (CPA). It seeks to incorporate the principles of care management. It is based upon national policy and positive practice guidance "Refocusing the Care Programme Approach" (DoH March 2008) which became effective on the 1st October 2008. This document is designed to set out the trust's policy and procedure for CPA. Expectations of the roles of care co-ordinator, responsible medical officer key worker will be described.
- 2.2 The purpose of this policy is to ensure that service users are at the heart of their care, receive a clear treatment pathway and that there is a clear and robust line of accountability for their package of care.
- 2.3 The following service users will be managed under CPA: Those requiring and exiting In-patient psychiatric wards, children looked after, service users who are subject to child protection/child in need plans, complex cases where there are high levels of concerns/risk.

## 3 Roles & Responsibilities.

- 3.1 The Trust's Chief Executive through the senior manager of the public health provider arm of TSDHCT has overall responsibility to have processes in place to:
- Ensure that staff are aware of this policy and adhere to its requirements.
  - Ensure that appropriate resources and systems are in place to meet the requirements of the policy
- 3.2 The management team and clinical leadership team act as leads for CPA within the Trust. They are responsible for supporting the implementation of policy by:
- Ensuring that there is an up to date written CPA Policy for the Trust.
  - Ensuring that relevant training and advice is available and appropriately targeted.
  - Monitoring care planning standards and liaising with informatics staff to provide appropriate reports.
  - Providing, via the implementation of the Trust's Information Standards, suitable information for service users and their carers about care planning and CPA Liaising with the Informatics/information governance staff to ensure the provision of electronic records/documentation for the CPA.

- 3.3 Associate Medical Directors/Consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the CPA process.
- 3.4 Practice/Team Managers are responsible for implementing the policy with their immediate staff and ensuring that staff under their management adhere to the policy's requirements.

CPA Care Co-ordinators have specific responsibilities within the CPA. They take responsibility for a service user from the point of allocation through all phases of care including when a service user is admitted to hospital, Home Their core functions are to undertake:

- Comprehensive needs assessment
- Risk assessment and management
- Crisis planning and management
- Care planning and review
- Transfer of care and discharge

- 3.5 Staff have a duty to understand the policy requirements of CPA, cooperate and support its implementation.
- 3.6 Holder of Parental Responsibility – the parent/carer with PR or responsible authority for a child looked after.

#### **4 General Policy Statements & Principles:**

##### 4.1 Application of CPA.

4.1.1 The CPA should be used to support service users who are seen to have “complex characteristics” These characteristics have been established nationally and should be considered by clinical staff when deciding whether service users would benefit from support using the CPA. There are also a number of key groups who would normally have the support of CPA unless there are clear reasons why this is not appropriate.

4.1.2 There is no minimum number of characteristics that should apply before CPA is deemed appropriate and clinical staff are required to make judgements when assessing individuals using the list as a guide. The characteristics & key groups are provided below in figure 1. (Adapted from; Refocusing the Care Programme Approach – DoH March 2008)

##### Characteristics to consider when deciding if support of (new) CPA is needed:

- Severe mental disorder (including personality disorder) with high degree of clinical complexity
- Current or potential risk(s), including: Suicide, self-harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self-neglect/non concordance with treatment plan
- Vulnerable adult; adult/child protection e.g. exploitation e.g. financial/sexual, financial difficulties related to mental illness,

disinhibition, physical/emotional abuse, cognitive impairment, child protection issues.

- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability.
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/recently detained under Mental Health Act or referred to a home treatment team.
- Significant reliance on carer(s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of: Parenting responsibilities, Physical health problems/disability, Unsettled accommodation/housing issues, Employment issues when mentally ill, Significant impairment of function due to mental illness, Ethnicity (e.g. immigration status; race/cultural issues; language difficulties religious practices); sexuality or gender issues.

#### Key Groups:

Guidance indicates that members of certain key groups should benefit from new CPA unless a risk and needs assessment shows otherwise.

The key groups are service users:

- who have parenting responsibilities
- who have significant caring responsibilities
- with a dual diagnosis (substance misuse)
- with a history of violence or self harm
- who are in unsettled accommodation
- who are seeking political asylum

It is also expected that those subject to Community Treatment Orders (Section 17A MHA) or subject to Guardianship (Section 7 MHA) will be subject to (new) CPA although if this is not considered appropriate then the reasons should clearly be documented.

The needs of individuals from these key groups should be fully explored to make sure that the range of their needs are examined, understood and addressed when deciding their need for support under (new) CPA.

4.1.3 If after considering these characteristics and key groups, it is felt by clinicians that CPA is not appropriate or beneficial to the service users, then the reasons must be clearly documented and recorded in progress notes on IAPTus .

4.1.4 Service users detained under treatment sections of the Mental Health Act 2007 (i.e. sections 3, 37, 47 and 48) will be eligible to receive statutory aftercare under Section 117 of the Act. CPA is likely to apply in most cases and should be used to fulfil the requirements of Section 117. If CPA is working effectively, it should provide the appropriate framework for planned,

monitored and managed aftercare, which service users subject to Section 117 need.

- 4.1.5 All staff must be aware of Safeguarding being everyone's business and responsibility and all staff have a responsibility to work within a multi-agency framework when responding to concerns of abuse and neglect and follow the local Safeguarding procedures.
- 4.1.6 Staff also have the duty to report and ensure the immediate safety of someone who is a victim of harm, mistreatment or neglect.
- 4.1.7 Appendix 1 provides guidance as to the service response when the CPA is applied.

#### Service application

Child & Adolescent Mental Health Services:

Community services CPA may apply in tier 3 cases particularly when transition to adult services is to take place.

Inpatient Services CPA will apply in tier 4 cases.

## **4.2 Allocation and Choice of CPA Care Co-ordinator**

- 4.2.1 The CPA Care Co-ordinators role, should usually be taken by the person who is best placed to oversee the care management and resource allocation for the individual concerned and may be from any discipline subject to the criteria described below. Although it may often be appropriate, the care co-ordinator need not necessarily deliver the majority of care, for example when specialist care is required or when for a temporary period an individual is admitted into hospital.
- 4.2.2 Care Co-ordinators must have the ability and authority to co-ordinate the delivery of the agreed care plan and be able to support people with multiple needs to access the services they need. They should possess the skills and competences described in appendix 3 of the policy.
- 4.2.3 CPA Care Co-ordinators will be experienced and qualified health or social care Professionals. These professionals will demonstrate skills in assessment, planning, implementing and evaluating care within the CPA model and ensuring the child/young person and their carers are at the centre of all care plans. This will be decided by the multi-disciplinary team, who will consider with line managers, who is appropriately skilled and positioned to undertake this role.
- 4.2.4 The views of service users should be considered and as much choice as possible given when allocating the care co-ordinator. Such choice may be on the basis of gender, cultural or religious needs when such factors may contribute to the development of a more successful therapeutic relationship. Such choice must not however be used to support discrimination such as racism, misogyny or homophobia.

#### 4.3 Assessments, Care Plans and Reviews

- 4.3.1 For those newly referred to secondary mental health services, an initial screening assessment process will be undertaken to determine eligibility for entry into the service.
- 4.3.2 If it is felt that it is appropriate for the Torbay CAMHS to provide a service, then a comprehensive assessment including that relating to risk will take place. This assessment will be used to determine whether an individual is likely to benefit from support under the CPA.
- 4.3.3 Safeguarding is everyone's responsibility. It is the responsibility of staff to work within a multi-agency framework when responding to concerns of abuse and following the local safeguarding procedures. Staff also have a duty to report and ensure the immediate safety of vulnerable adults who might be at risk of harm, mistreatment or neglect.
- 4.3.4 As an overview, assessments of a young person should be systematic in approach and cover psychiatric, psychological and social functioning, risks to the individual and others (including child protection), any needs arising from co-morbidity, physical health needs, personal circumstances including friends, family, parenting responsibilities, other carers, housing, financial, employment/ occupational status, other social inclusion matters and diversity and equality issues. The assessment must also consider the strengths, aspirations and coping strategies of the service user. In all cases the assessment must consider if the service user (if a parent themselves) is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user.
- 4.3.5 The risk assessment will be carried out in accordance with local guidance and be recorded on IAPTus.
- 4.3.6 Every effort should be made to promote understanding and engage the service user (and carer as appropriate) in the assessment process.
- 4.3.7 The assessment included within the IAPTus electronic documentation will be used including FACE risk assessment. These together provide a comprehensive series of headings to guide and record the assessment.
- 4.3.8 Professionals have a responsibility to refer a child to LA children's social care when it is believed or suspected that the child:
- Has suffered significant harm or is likely to suffer significant harm or has developmental and welfare needs which are likely only to be met through provision of family support services (with agreement of the child's parent). Referrals should be made to children's social care services under the above procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's needs are not being met.

- 4.3.9 The care plan will identify health, social care (including as appropriate accommodation and safeguarding children) needs and risks, interventions or actions designed to meet those needs, together with anticipated outcomes, those responsible and timescales. It may also refer to any recovery plan that the service user has chosen to develop. Crisis and contingency plans must however be included with appropriate contacts given in case of emergency.
- Contingency plans are intended to prevent crises or emergencies happening because; a key element of the care plan fails or cannot be delivered.
  - Crisis plans set out what should happen if the service user becomes very ill, or their mental health deteriorates rapidly.

Further guidance on crisis and contingency planning is given in Appendix 2.

- 4.3.10 The care plan should be developed with the clear involvement of the service user and where appropriate their carer/s and any disagreements between the parties concerned should be appropriately recorded.
- 4.3.11 Copies of the completed care plan must be offered to the service user and normally, to any carer involved. Involved professional staff with access to IAPTus will be able to view the care plan directly but it may be necessary to circulate hard copies to others involved, i.e. to the GP and external agencies. Due regard must be taken of the confidential nature of the care plan and the fact that the care plan is normally circulated to those involved should be made clear to the service user when seeking his/her consent to share information. Account should be taken of any objections that may arise to the sharing of the care plan and limiting circulation in accordance with the service users' wishes should be carefully considered.
- 4.3.12 The care plan must be continually monitored, particularly by the person designated as the care co-ordinator and regular reviews of the plan must be undertaken in order to assess progress and outcomes, identify problems or new needs and any fresh interventions or actions that may need to be taken. Risk should also be formally reviewed and unmet needs identified as part of the review.
- 4.3.13 There will be only one current care plan – that which is on IAPTus. This will effectively follow the service user irrespective of the setting in which he/she is being cared for. It is expected that on any change in setting, for example on admission to or discharge from inpatient care to the community, the care plan will be updated to describe the arrangements in the new care setting.
- 4.3.14 Review and evaluation of care planning is an ongoing process but there is a requirement to formally review and document changes to the care plan on a regular basis. The period between reviews should be determined by the care co-ordinator, in conjunction with the multi-disciplinary team, but should be done at least every 6 months. The date of the next review must always be specified, although it is acknowledged that changes to this may occur, especially if the review date is some months away.

- 4.3.15 The service user, carers or any professional member of the team responsible for care and treatment may call for a review at any time and such requests must be considered by the care co-ordinator. If the decision is not to review the care plan then along with the rationale for this decision then the young person/carer/professional will be directly communicated with.
- 4.3.16 Subject to agreement with the service user, care planning and review meetings within the framework of CPA should be used as an opportunity to discuss advanced decisions, statement of wishes and an individual's recovery plan.
- 4.3.17 Service users should normally be asked to sign the care plan. This does not necessarily signify agreement and comments to the contrary may be added. It does however help indicate service user involvement in the drawing up of the care plan. The care co-ordinator should always sign the care plan and if the service user does not or cannot sign the care plan, it is helpful to record the reasons. The carer may also sign the care plan as appropriate. The service user will be offered a copy of the care plan to take away.
- 4.4 Documentation/Recording CPA
- 4.4.1 Documenting and recording CPA will be in accordance with the Trust's Primary Electronic Health Records Policy which requires that "IAPTus" is used as the principle means of recording CPA.
- 4.4.2 There will be no paper based forms produced for CPA as the assessment, risk assessment, care planning and review documentation is incorporated in electronic form within IAPTus together with "CPA Management" details.
- 4.4.3 CPA Management information will be completed on IAPTus and service users who are being supported on CPA will be recorded as being on "CPA" and those that are not being supported under CPA will be recorded as CPA being not applicable.
- 4.4.4 Information relating to carers are also on IAPTus.
- 4.5 CPA and the Trust's Care Planning Standards
- 4.5.1 The Torbay CAMHS service clinical leadership and governance group introduced the use of care plans for all clients entering the service. The Trust is developing a standard operating procedure that includes care planning.
- 4.5.2 There are many similarities between the care planning standard and the requirements of CPA and the values and principles associated with the care planning standard should be seen as completely supporting the CPA and vice versa.
- 4.5.3 Whereas the care planning standard apply generally across the Service, there are additional specific requirements when CPA applies, as described in this policy to help address the needs of service users with complex needs.

## 4.6 Service User and Carer Involvement

4.6.1 Service users and their carers should be given every opportunity to be involved and become engaged in CPA through the processes of assessment, care planning and review.

4.6.2 The Trust undertakes to promote such involvement by:

- Observance of good practice as described within the Trust's Care Planning Standard and that described for the conduct of care planning or review meetings in appendix 5. This will include the use of the Trust's "pre meeting checklists" for service users and their carers
- Providing information to service users and carers about CPA and care planning processes both verbally and via written information. Information about CPA should be regarded as part of "essential information" produced to underpin the Trust's Information Standards.
- Ensuring that service users and their carers are aware of advocacy services and how to contact them. The support available to service users should be discussed with them as part of the preparation for the CPA meeting.

4.6.3 Any information given to service users should be in a form that they can readily understand. This may involve, for example, the use of interpreters or translated material to promote understanding and engagement.

4.6.4 In general, the Trust encourages the use of advocates to support and represent service users who wish to have such help and therefore does not favour the routine use of legal representatives where advocates are more appropriate. Further guidance is included as appendix 5.

## 4.7 Hard to Engage Service Users

4.7.1 Except in circumstances set out in legislation, users are under no obligation to accept the services that are provided and may choose not to engage with professional staff in any programme of care.

4.7.2 The issue of engagement is one that needs to be fully discussed with the service user as part of developing the care programme. It should help if the purpose, frequency and venue of contacts were specified and agreed with the service user and/or informal carers and are reflected appropriately in the care plan.

4.7.3 It is recognised that there may be conflict when a service user does not wish to engage and yet there is a duty of care owed towards them. There is a need for time and patience to be spent on the part of professionals as well as working in a flexible manner in order that engagement becomes more possible.

4.7.4 Any action taken by professionals must be 'proportional' to the degree of concern or risk attributable to an individual service user. Generally those on

CPA will be considered to have complex needs and be at potentially greater risk but nevertheless, each case should be considered in accordance with individual circumstances.

- 4.7.5 In considering what steps to take, a balance must be struck between the service user's rights, e.g. to privacy, confidentiality and freedom of choice, and the degree of risk of harm to themselves or to others if engagement does not occur or contact is lost. The service users rights are not absolute rights and must be weighed up against the risk factors identified.
- 4.7.6 For service users being treated within the framework of CPA and who choose not to engage or avoid contact, the following actions should be considered as appropriate:
- A review of care/risks by the care co-ordinator and all members of the multidisciplinary team in order to decide action. The urgency of such a review should depend upon the degree of concern and any need for a Mental Health Act assessment should be considered.
  - Follow up non-attendance by letter / phone call(s) / visit(s)
  - Making contact with carers, seeking information
  - Contact family and friends to try to resume contact through them;
  - Contact the GP and other primary care staff to see if they have had recent contact, such as having prescriptions renewed etc
  - The Team Manager should be kept informed of any cases where there is concern over engagement or contact has been lost
- 4.7.7 If someone is considered missing, the use of missing person's alerts or involvement of the police can be considered. Careful thought is required however in respect of the confidentiality/disclosure of personal information issues. (See 4.13 below).

## **4.8 Mental Capacity Act and CPA**

- 4.8.1 CPA is a decision making process and some service users will lack the mental capacity to participate within the CPA as described within this policy. Decisions about their care and treatment will then be taken on their behalf and in their best interests.
- 4.8.2 The assessment of capacity is a day to day task for the care co-ordinator and other clinical staff although there will be occasions when a formal assessment of capacity will need to be made and recorded. This would apply when a particularly important decision needs to be made or when mental capacity fluctuates or is unclear.
- 4.8.3 Even in circumstances where a service user is deemed to lack capacity, it remains important to allow and encourage them to participate as much as possible within the CPA process. The views of carers associated with a service user are important and can help determine best interests.

4.8.4 Important decisions may relate for example when serious medical treatment, a significant change in accommodation is being considered or when it appears necessary to share confidential information.

#### 4.9 Confidentiality and Information Sharing

4.9.1 Service users should be made aware of the necessity to share information as part of the CPA in order to provide safe and effective care. Such information would be limited to that which a professional or agency would “need to know” to provide care or treatment.

4.9.2 Consent to share information should be obtained from the service user in accordance with the Trust’s guidance for staff on consent to share information and recorded on IAPTus. If objections are raised then these should be considered and discussed with the possible consequences of withholding information explained.

4.9.3 If consent continues to be withheld (or is withdrawn at some later stage) then this should be respected wherever possible. Information may still be passed on in certain circumstances described below:

- When it is clearly in the interests of the service user’s care or when there are overriding considerations to prevent or reduce serious risk to the individual.
- If information is in the ‘public interest’ or in the interests of public protection. This could include where not providing certain information would create or increase a serious risk to other people.
- If information is required by statute or by court order.

4.9.4 Normally, details of a service users’ treatment and care plans will be shared with their carers.

#### 4.10 CPA and Eligibility for Services

4.10.1 CPA is intended purely as a process for managing complex cases and is not to be used to determine eligibility for any secondary mental health service or entitlement for other services or benefits provided by other agencies.

4.10.2 Access to services should not depend upon the service user being cared for within the framework of CPA or not, but should be based on assessed need and any other statutory criteria that exists.

#### 4.11 Inpatient Services and CPA

4.11.1 CPA is relevant irrespective of setting and applies equally during any period of inpatient care. Admissions should be treated as part of a wider episode of community based care and CPA should be used to help communication, co-ordination and continuity between community based services, including Home Treatment services and hospital units.

- 4.11.2 Someone newly referred to the service and having been admitted should be assessed to determine whether they would benefit from being cared for within the framework of the CPA.
- 4.11.3 In the event that a service user is admitted to hospital who does not have a care coordinator, the named nurse in consultation with the multi-disciplinary team should formulate a discharge care plan.
- 4.11.4 It is normally expected that on admission, a short-term care plan should be agreed. Service users should always be offered these and other care plans that are produced whilst an inpatient.
- 4.11.5 Risk assessment as part of CPA care planning should not only focus on the inpatient aspects of risk but include risks to the service user that are to be faced on discharge. This will assist in discharge planning at an early stage and can deal with issues.
- 4.11.6 Community care co-ordinators and/or staff should be fully involved in the CPA process on the inpatient unit. They can not only contribute their knowledge of the service user when considering treatment in hospital but can be 'familiar face' to the service user and offer reassurance. As the community care co-ordinator is responsible for the delivery of the care plan once the service user leaves hospital, it is his/her responsibility to complete the discharge care plan on IAPTus in consultation with ward based staff and the wider multi-disciplinary team as appropriate. The direct involvement of community staff helps continuity of care and removes barriers that sometimes exist between community and inpatient services.
- 4.11.7 Planning for discharge needs to occur as soon as possible after admission with the allocation of a community based CPA care co-ordinator treated as a matter of priority. Where inpatient staff consider that a service user should be treated within the framework of CPA, a request for allocating a CPA Care Co-ordinator should be made within 7 days of admission. The response from the community CAMHs team should be given within a further 7 days.
- 4.11.8 Service users on CPA who are discharged from inpatient care must be followed up by a mental health professional, preferably face to face but may be by telephone contact within a maximum of 7 days of discharge. The arrangements for such follow up need to be incorporated into the care plan at the time of discharge. Discharge care plans should also take account appropriately of the heightened risk of suicide in the first 3 months after discharge.
- 4.11.9 In cases of self-discharge there is still an obligation on the part of the clinical team to implement discharge plans as far as practicable.
- 4.11.10 Service users detained under longer term sections of the Mental Health Act 2007 have the right of appeal to Mental Health Review Tribunals (MHRTs) and the Hospital Managers. The development of care plans and discharge arrangements prior to hearings is important because they have a bearing whether the service user can be discharged immediately or not.

4.12.9 MHRTs and Hospital Managers may discharge a service user from the Mental Health Act, after which the service user is free to leave hospital. It is therefore crucial to have appropriate aftercare arrangements developed as part of CPA in place in such cases. Further, if the discharge is from a treatment section, there will be a statutory obligation placed upon services to provide such aftercare under section 117 of the Mental Health Act.

4.11.10 Where possible and appropriate therefore an MHRT or Hospital Managers hearing should be preceded by a CPA review meeting to produce a care plan that could be put into place if the service user is discharged and leaves the hospital. This should be provided to the appeal panel.

4.12.11 Where it is not practical to have CPA review meeting as above, because it is too early in the admission episode or the service user is very distressed and discharge is considered a long way off, this must be made clear to the appeal panel. In such cases if the panel decide that the service user should be discharged from detention, they may have to consider a deferred discharge to allow time for a discharge care plan to be written.

#### 4.12 Transfer & Discharge of Service Users

4.12.10 Transfers between services within the Trust or to other care providers external to the Trust shall provide clear requirements when transferring or discharging service users and applies to those who are being cared for with the support of the CPA. Relevant transfer protocols for example between CAMHS and adult services or adult services to older adult services also apply.

4.12.11 The continued need for support under the CPA should be considered as part of the regular CPA review. (See model agenda – appendix 5). CPA should not be withdrawn without a thorough re-assessment of risk and clear arrangements set out for future care. Such arrangements should include:

- A review and handover to the lead professional (if the CPA Care Co-ordinator is no longer taking that role)
- An exchange of all appropriate information with all concerned including carers
- Plans for future care/support as appropriate
- Clear arrangements put in place should there be a relapse and increased
- Support becomes necessary.

4.12.12 Service users are not likely to be discharged entirely from the Trust whilst on CPA (unless they are being transferred out of area to other care services). It is more likely that CPA will be withdrawn for a period with continuing lower level support from the Trust prior to a final decision being made to discharge back to the GP.

4.12.13 Service users and their carers should be reassured in situations where CPA is withdrawn to ensure they understand that eligibility for services will not be

affected and that they should continue to receive the level of support appropriate to on-going needs and risks. This underlines the importance of having clear future plans following the withdrawal of support under CPA.

#### 4.13 Expectations of the Independent Sector

4.13.1. Independent mental health hospitals are not exempt from the requirement to work to the CPA, particularly if they are treating publicly funded patients or any other patients who may be discharged back to NHS community mental health services.

4.13.2 For patients on CPA who are transferred to or otherwise admitted to independent hospitals there should be an expectation that:-

- CPA care co-ordinators remain involved and in contact with the service user and the inpatient team during the period of admission.
- CPA Meetings will be held prior to discharge and appropriate members of the local multi-disciplinary team/CMHT invited;
- CPA care plans will be drawn up for periods of home leave
- Suitable arrangements are in place for the involvement of service users and their carers in decision making about treatment
- Reports on progress will be prepared and sent as necessary to care co-ordinators, GPs and others involved;
- Co-operation will be given to the local team in preparing and distributing care plans prior to discharge.

4.13.3 The same requirements following discharge from the independent sector to community services apply e.g.

- A requirement to follow up within 7 days of discharge
- For those who were under a treatment section of the Mental Health Act the statutory duty to provide aftercare under Section 117 applies in the same way as described above.

4.13.4 CPA Status must be recorded for all service users receiving a service

All CPA Recording must be evident via “labels” on the electronic patient record systems – currently “Improving Access to Psychological Therapies; (IAPTus) (patient management software for psychological therapist)

**If a service user is on CPA:**

There must be an identified care coordinator.

If a service user is not on CPA there must be an identified lead clinician.

CPA reviews must be recorded on IAPTus.

**If the CPA status label is not evident**

It means the decision about the service user's CPA status has not been recorded.

**IAPTus care Plan**

Must be used for all service users.

All service users on CPA should have a Crisis, Relapse and Contingency Plan.

When a service user is discharged, their CPA status must also be discharged.

**5 Training**

- 5.1 Training for CPA care co-ordinators has been delivered and will be delivered on a rolling programme to enable new team members to fulfil the role of care co-ordinator and will be based around the competences identified using national occupational standards (see appendix 3).
- 5.2 Training or support given to staff in relation to the implementation of the Trust's Care Planning Standards will include reference to the CPA policy.

**6 Monitoring, Auditing, Reviewing & Evaluation**

- 6.1 Clinical staff should be made aware of the requirements of this policy and associated policies, procedures and guidance by their line managers.
- 6.2 This policy will be made available as a public document on the Trust's website.
- 6.3 Awareness of the policy will be raised via training (section 6 above).
- 6.4 Compliance with appropriate aspects of the policy will be monitored via:
- Care Planning Standards Audits and/or evaluations.
  - Evaluation of the implementation of the Trust's Information standards where these are relevant to care planning and treatment choices
  - Corporate and local Healthcare Record Audits
  - Relevant performance measures developed by the Trust such as compliance with 7 day follow up after discharge from inpatient care.

**7 References**

- 7.1 North East London NHS Foundation Trust

## **8 Distribution**

8.1

## **9 Appendices**

Appendix 1 – Service Responses for CPA

Appendix 2 - Crisis & Contingency Planning Guidance

Appendix 3 - Competencies/role of Care Co-ordinators

Appendix 4 - Good Practice in Care Planning/Reviews

Appendix 5 - Legal Representation at CPA meetings – Further Guidance

Appendix 6 - Guidelines for staff working with service users who are in paid employment/apprenticeship

## Appendix 1 – Service Responses for CPA

The Trust's Care Planning Standards apply generally to all service users but for service users on CPA who have complex needs, multi agency input and are at higher risk, the expected service response is outlined below:

<b>Service Users being treated within the framework of the CPA can expect:</b>
Support from CPA care co-ordinator (trained, co-ordination support recognised as significant part of caseload)
A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks
An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)
Comprehensive formal written care plan recorded on IAPtus including risk and safety/contingency/crisis plan
On-going review, formal multi-disciplinary, multi-agency review at least every 6 months
At review, consideration of on-going need for (new) CPA support
Increased need for advocacy support
Carers identified and informed of rights to own assessment

Adapted from; Refocusing the Care Programme Approach – (DoH March 2008)

## Appendix 2 - Crisis & Contingency Planning Guidance

Service Users on CPA are required as part of their care plans to have crisis and contingency plans. These plans form a key element of the care plan and must be based on the individual circumstances of the service user.

### **Contingency Plans:**

Contingency plans are intended to prevent a crisis or emergencies happening because a key element of the care plan fails or cannot be delivered. An example is specifying the name and contact details of the person who will at short notice take over if the care co-ordinator is unavailable. Depending on the care plan, it could also cover things such as what should happen in the absence of a carer who normally oversees medication at home.

Another aspect of care planning where a contingency arrangement may need to be considered is for example, in the case of a 'high risk' service user being discharged from in-patient care where 7 day follow up is required. In such cases, contingency arrangements should be considered as part of the discharge care plan as to what should happen if face to face or telephone contact within 7 days does not take place for any reason.

### ***A few further points:***

- Contingency plans are expected to be interim, short term, and capable of being put into place quickly
- Information should be clear and specific, with details of those responsible including 'substitutes'
- All 'substitutes' should have previously agreed to act as such.

### ***Crisis Plans:***

Crisis plans set out what should happen if the service user becomes very ill or their mental health deteriorates rapidly. The crisis plan should:

- Specify relapse indicators or early warning signs. This could also contain particular risks that may develop
- Be based on what has worked well in the past (if this is known) Contain details of the person(s) that the service user is likely to respond best to in times of crisis.
- Contain actions to be taken by the service user, carer(s), the care co-ordinator, others. This should include advice to the GP.
- Contain emergency and out of hours contact numbers.

It is good practice to ensure that the service user/carers is aware of the level of service that may be expected from out of hours services. This, for example, may not be the same as could be expected from the Community CAMHs Team during the normal working day. Along with the general care plan, crisis and contingency plans should be regularly reviewed to ensure that they remain relevant and up to date.

### Appendix 3 - Competencies/role of Care Co-ordinators

Competences are descriptors of the performance criteria, knowledge and understanding that are required to undertake work activity. They describe what people need to do, and to know, to carry out the activity – regardless of who performs it.

Competences are classified as National Occupational Standards (NOS). Eighteen NOS have been identified which reflect the task of care co-ordination, and the role of the Care Co-ordinator and are summarised below.

<p><b>Comprehensive needs assessment</b></p> <ol style="list-style-type: none"> <li>1. <b>Assess individuals' mental health and related needs</b></li> <li>2. <b>Identify potential mental health needs and related issues</b></li> <li>3. <b>Identify the physical health needs of individuals with mental health needs</b></li> <li>4. <b>Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes of care for individuals</b></li> </ol>
<p><b>Risk assessment and management</b></p> <ol style="list-style-type: none"> <li>5. <b>Develop risk management plans to support individual's independence and daily living within their home and educational provision</b></li> <li>6. <b>Assess individuals' needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others</b></li> <li>7. <b>Assess the need for intervention and present assessments of individuals' needs and related risks</b></li> </ol>
<p><b>Crisis planning and management</b></p> <ol style="list-style-type: none"> <li>8. <b>Work with families, carers and individuals during times of crisis.</b></li> <li>9. <b>Respond to crisis situations</b></li> </ol>
<p><b>Assessing and responding to carers' needs</b></p> <ol style="list-style-type: none"> <li>10. <b>Work in collaboration with carers in the caring role.</b></li> <li>11. <b>Assess the needs of carers and families of individuals with mental health needs</b></li> <li>12. <b>Develop, implement and review programmes of support for carers and families</b></li> <li>13. <b>Empower families, carers and others to support individuals with mental health needs</b></li> </ol>
<p><b>Care planning and review</b></p> <ol style="list-style-type: none"> <li>14. <b>Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances</b></li> <li>15. <b>Plan and review the effectiveness of therapeutic interventions with individuals with mental health needs</b></li> <li>16. <b>Implement, monitor and evaluate therapeutic interventions within an overall care programme</b></li> </ol>
<p><b>Transfer of care and discharge</b></p> <ol style="list-style-type: none"> <li>17. <b>Plan and implement transfer of care and discharge with individuals who have a long term condition and their carers.</b></li> <li>18. <b>Work with others to facilitate the transfer of individuals between agencies or services.</b></li> </ol>

## Appendix 4 - Good Practice in Care Planning/Reviews

### Bear in mind throughout the process:

- Talk with the service user to check their understanding of CPA/care planning and how they would want to be involved - particularly important if the person is new to mental health services
- Involve & seek to engage the service user throughout – not just focusing on the review or care planning meetings
- Focus on what is important to the service user
- Involve the service user and carer in planning for their CPA/care planning reviews –who they would want to attend, what they want to discuss etc
- Support the service user to have their say – whether that is via the Named Nurse, Care Co-ordinator, Advocate, family member, friend etc.
- Talk with the service user – not at them or about them
- For inpatients, keep CPA and ward rounds separate – try to arrange CPA meetings at the beginning or end of ward rounds.

### CPA reviews – what are they for?

- Considers/evaluates & updates the care plan
- Reviews or reassesses needs, issues and goals (can include FACS)
- Helps service users & carers understand the care plan and are an opportunity to listen to their views & concerns, can improve engagement & involvement
- Opportunity to discuss recovery plans and advanced decisions
- Shares relevant information & opinion
- Reviews whether support under CPA should continue, legal status, risk

### Reviewing the care plan

- Deal with each goal in turn
- Evaluate progress against the specified goals (what went well/not so well)
- Use evidence/examples and observations to demonstrate progress
- Consider whether previous goals have been achieved or they remain relevant
- Consider new needs or issues which may require further goals & action
- Remember employment/vocational opportunities/housing/financial issues!
- Consider whether the care plan appropriately manages risk, crisis & contingency
- Record & explain unmet need
- Consider CPA status/legal status & arrange the next review – within 6 months

### Good practice

Pre meetings with service user/carers/advocate (decide who chairs!)

- Use pre meeting checklists (see Care Planning Guidance)
- Think carefully & discuss with the service user about who should attend & why! (You don't necessarily have to be present to give information)
- Think about & be flexible about information gathering, timing, venue, room layout.
- Have good administrative arrangements, e.g. adequate notice, on & enough time!
- Observe basic courtesies e.g. introductions, purpose etc.
- Use every day & straightforward language – avoid jargon!
- Focus on, & involve the service user (discuss with not about!)
- Involve advocacy, support and carers as needed (an interpreter if needed)
- Provide an opportunity for the service user to discuss their recovery plan
- Follow up with the service user – check understanding & produce/revise the care plan (within 2 weeks)

### **“Model” Agenda for CPA Planning/Review Meeting**

1. Welcome, introductions & confirm chair/attendees (Chair)
2. Apologies (Chair)
3. Explain purpose/process of the review/how much time we have, check about sharing information (Chair)
4. Acknowledge pre meeting checklist/other information available – does everyone who needs it have access to this? (Chair)
5. Evaluate the existing care plan/assessment, goal by goal, explain unmet need (the service user, carer, advocate, care co-ordinator or person responsible for action)
6. Consider new issues, goals & actions (service user/carer, care co-ordinator, the person that may be responsible for new action)
7. Risk issues/crisis & contingency arrangements – if not already considered (all)
8. Opportunity to talk about advanced decisions/statement of wishes (service user/carer/care co-ordinator)
9. Opportunity to talk about recovery (service user)
10. Legal status (if applicable) including any S. 117 status & whether CPA should continue to be used to support the individual. (care co-ordinator)
11. Summing up/checking understanding (Chair/ care co-ordinator/service user)
12. Final questions (all)
13. Confirm arrangements for writing up the care plan & circulating it. (Care coordinator)
14. Agreeing date & time & venue of next review (Care co-ordinator/service user) (6 months maximum).

## Appendix 5 - Legal Representation at CPA meetings – Further Guidance

1. Care Programme Approach (CPA) meetings are intended to either develop an appropriate care plan to meet the assessed needs of the service user or to review, evaluate and update an existing one.
2. The focus of the meeting must be clinical in that it is to determine, review or reassess particular interventions designed to meet the needs of the service user, ideally by agreement and irrespective of the particular setting (inpatient, community etc). Interventions discussed should address both the health & social care needs of the individual, determine who will be responsible for action and specify timescales for completion or further review. It is the opportunity to offer explanation, promote understanding and allow participation by the service user in the development of the care plan. When someone has been subject to a treatment section of the Mental Health Act, the CPA meeting continues to fulfil all of the above but is also used to meet the requirements of Section 117 of the Act – the statutory duty to provide aftercare.
3. Together with the service user and as appropriate their carers or others offering support, all those involved in treatment and care should normally be invited to participate in CPA meetings. As part of preparation for the meeting however, discussion should take place with the service user as to who should attend and what role they will have.
4. There are occasions when service users request that their legal representative or solicitor attends their CPA review or Section 117 meeting. Such requests should be raised in advance of the meeting in order that the clinical team can consider whether they agree to the legal representative being present. Such agreement should not be taken for granted but attendance by a legal representative should normally be agreed unless there are exceptional circumstances. The following points should be taken into account:
  - Based upon the Trust's legal advice and practice elsewhere, there is no specific reason why legal representatives may not attend CPA review/Section 117 Meetings to represent and support the service user.
  - In general, the Trust encourages the use of advocates to support and represent service users who wish to have such help and therefore does not favour the routine use of legal representatives where advocates are more appropriate. The support available to service users should be discussed with them as part of the preparation for the CPA meeting.
  - The Trust should not facilitate the appointment of a legal representative for the purpose of a CPA meeting as this should be done by the service user (or carer) directly. The Trust cannot under any circumstances cover the cost of legal representation for this purpose and any matter of payment is between the service user and his/her legal representative.

Unless the CPA meeting has been urgently called it is expected that all participants in the meeting are made aware in advance that the service user's legal representative is attending i.e. via the invitation process.

- The purpose of the CPA review meeting must be explained to the legal representative before it begins and in appropriate cases the distinction between a CPA review meeting and the more adversarial or challenging nature of a MHRT or Hospital Manager's appeal hearing should be remembered.
- The reason for the legal representative's presence is to advocate on behalf of the service user, and in that sense they should be given every opportunity to represent the service user's views, as if they were the service user, a relative or a member of an advocacy group.
- Legal representatives are not there to make legal challenges to clinical decision making and service delivery and this should be made clear to them and the service user. Litigious debating should not take place in CPA review meetings.
- If the legal representative obstructs the process of the meeting he/she should be warned by the chair. If they continue to obstruct the meeting after the initial warning, the chair should adjourn the meeting and speak to the legal representative outside the meeting explaining again the purpose of the meeting and the conduct expected of a legal advocate.
- If the legal representative does not accept the conditions of conduct requested from the chair then they should be asked to leave the meeting.
- If a legal representative is excluded from a CPA meeting, the reasons for doing this must be made clear to the service user. If they are unhappy with this decision they should be given the option of making a formal complaint.
- The care co-ordinator must record the legal representative's involvement and conduct in the IAPTus review documentation.
- The care co-ordinator and consultant psychiatrist may wish to discuss this with the team manager and write to the legal representative and/or his employer. They may wish to seek advice from the Trust solicitors in complex cases.
- The care co-ordinator should ensure a copy of the CPA care plan is disseminated to all those present including the service user's legal representative.

## Appendix 6 – Guidelines for staff working with service users who are in paid employment/apprenticeship

There is a requirement to comply with the Vocational Commissioning Guidance (DWP; DH; 2006).

To minimise the risk of service users losing their jobs due to their mental ill health it is essential that they are given appropriate advice and support as early as possible.

Research indicates that taking action in the first six weeks of sickness absence is often critical to a successful return to work. (See reference) Only 50% of people return to work after six months sickness absence.

Only 25% of people return to work after twelve months sickness absence.  
Only 5% of people return to work after two years sickness absence.

Losing a job may have many negative ramifications including e.g. Increased risk of Suicide.

### Assessing the Risk of Potential Job Loss

It is important to find out the following information as a matter of urgency where ever possible if the patient is in employment and record it appropriately. \* indicates the minimum pIAPTusrity points to ask in order to assess whether the person is at imminent risk of losing his / her job.

- 1 Employer's name
- 2 Line Manager's name and contact details
- 3 Service User's Job Title
- 4 Brief description of duties
- 5 Length of time in employment
- 6 Permanent or temporary contract
- 7 Current work hours (Full time / part time / shift work /overtime)
- 8 Current work status (Working / reduced hours / off sick)
- 9 Any disciplinary or absence procedures in progress
- 10 Financial status (waged / Statutory Sick pay / benefits /Payment Protection Insurance) SSP, benefits and PPI
- 11 Has G.P. signed a sick certificate and has it been sent to the employer?
- 12 Date first signed off work and duration of sick certificates 6 weeks or more
- 13 Reason for sickness on sick certificate
- 14 Others involved e.g. trade union, solicitor, employment service, occupational health, human resources or personnel
- 15 What contact has the service user had with the employer since being off sick?
- 16 When was the last contact with the employer?
- 17 Has the service user had previous pIAPTusds of sickness absence?
- 18 If yes, what helped him / her to get back to work and was the employer supportive?