CARE PROGRAMME APPROACH (CPA) AND NON-CPA POLICY AND PROCEDURAL GUIDANCE (M-020)

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1. INTRODUCTION

The Care Programme Approach (CPA) was introduced by the Department of Health (DoH) in 1990 as a means of ensuring the organisation and co-ordination of safe and effective care provision of mental health services in England. Its aim is to promote social inclusion and recovery and its main elements are predominantly engagement and coordination.

The national policy was revised in March 2008 "***Refocusing the Care Programme Approach…***", and clearly outlines requirements for co-ordination of service user's care via a (New) CPA or non CPA pathway. The requirements outlined in this document are the focal point for the content of this CPA guidance.

The statutory responsibilities given to NHS organisations and Local Authorities from the NHS and Community Care Act 1990 are integrated and exercised within the CPA process. Therefore, all mental health staff, regardless of professional background, have a duty to arrange and/or undertake a holistic assessment of a service user's health and social care needs. When social care needs are identified in this assessment, those service users eligible for social care support have a legal right to be offered an assessment of their social care support needs as outlined in The Care Act 2014. The statement of values and principles will apply equally to all service users, including those with less complex needs.

This Care Programme Approach (CPA) and Non CPA Policy replace the Trust's current guidance and have been updated to reflect best practice and a recovery-focussed approach. The document provides a framework for the assessment, care, support planning and review of people referred to secondary care mental health services provided by the Trust.

This document sets out the ways in which service users and their carers will be assessed against the criteria for the CPA, in the context of national policy and guidelines developed since 1990.

The principles of personalisation, choice and recovery underpin the integrated approach of this policy and it is aligned with the Care Quality Commission (CQC) guidance principles of the: "Raising Standards Putting People First" Strategy 2013-2016: safe, caring, effective, well led, and responsive.

This policy supports the compliance with the Care Quality Commission Regulation 10, Outcome 16 'Patients who use the service will benefit from quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety'.

Locally there has historically been a relationship between the Mental Health Tariff care clusters and the requirement to co-ordinate patient's care via the CPA framework where appropriate; however it may not always be necessary to undertake a CPA review at the same time as the cluster review. In the Humber NHS Foundation Trust, work continues to ensure that the CPA remains central to the safe and supportive delivery of care to service users and their carers/families/significant others.

CPA is the overarching framework and is the basis for decision making with people about their plan of care. This does not replace the need for a care cluster review. The Mental Health Tariff has maximum review timeframes identified for respective clusters. These reviews can also be co-ordinated to coincide with CPA review requirements as appropriate although not all service users will have their care coordinated within the CPA framework. This is largely dependent on the complexity of need, and whether there is multi-agency/professional working.

CPA is care management in mental health and the principles of good care coordination include ensuring that reviews are coordinated avoiding duplication of review and purpose. Wherever possible CPA reviews should be coincided with other reviews such as Continuing Health Care, care management, or cluster reviews.

If service users' care is delivered under the CPA framework they must have a multi-agency review at least once a year but these are likely to be needed more regularly. Practitioners should decide if reviews are needed more frequently and should arrange them accordingly. Service users with S117 entitlement are likely to require reviews on at least a 6 monthly basis. For those service users whose care is coordinated via case management, reviews must be carried out annually (or earlier if necessary).

2. SCOPE

The Care Programme Approach applies to all service users who are accepted for Trust secondary mental health services if they have complex needs, OR need input from several agencies OR are considered to have a high level of risk.

Non CPA – this group of people accepted for a mental health service from the Trust who do NOT meet the criteria for CPA will have an assessment of their needs with a care plan addressing those needs and a review of their care by the Case Manager.

This policy applies to all Humber NHS Foundation Trust staff, contracted agency staff, students, and supporting agencies that have a responsibility for all service users either in the community or on in-patient mental health and learning disability wards/unit.

3. POLICY STATEMENT

The aim of this policy is to ensure that all Trust Staff working in a clinical environment are aware of their responsibilities in relation to:

- ensuring the physical and emotional safety and wellbeing of service users when assessing needs and planning the provision of care and support
- ensuring that the patient's wishes and those of carers, family and others (where appropriate) are taken into account when planning support
- setting out the roles and responsibilities of staff in ensuring adherence to the principles of the Care Programme Approach
- setting requirements for recording, monitoring and reviewing the service user's care and support plan and any follow-up action

Please note that where this policy refers to 'carers' this includes families/friends/significant others as they do not always want to be identified as carers.

The Trust is committed to working in partnership with people who use our services, and their carers, empowering them to express preferences and make meaningful choices at each stage of their personalised care pathway. Although choice means different things to different people it is actually about being able to express preferences, make decisions and have increased control over their own life. Therefore, having choices is likely to aid recovery and lead to improved outcomes.

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

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. The quality of the relationship between people who use our services and the care coordinator/case manager is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. Care planning is the daily work of mental health services and supporting partner

agencies. It is a respectful process, building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

4. DUTIES AND RESPONSIBILITIES

4.1. Chief Executive

The chief executive has overall responsibility to ensure that policies and processes are in place for the provision of effective care coordination for service users of the Trust.

4.2. Trust Board

The Trust Board members have responsibility to ensure full compliance with the Act.

4.3. Directors and Assistant Directors

Director of Nursing and Chief Operating Officer

The director of nursing and the chief operating officer as lead directors have responsibility to ensure that this policy is understood and adhered to by nursing staff and all other professionals and that all the processes are in place to ensure the policy is fully implemented.

Medical Director

The medical director is responsible for ensuring that this policy is understood and followed by medical staff involved in the multi-disciplinary team care and management of people receiving a service from the Trust.

Care Group Directors

- Have responsibility for ensuring that all clinical staff within the care group are familiar with the requirements of the policy and are able to implement them.
- Have responsibility for ensuring staff adhere to this policy and for monitoring their staff's compliance with its procedures.

4.4. Policy Author

The author is responsible for ensuring this policy and its procedures are up to date, an equality impact assessment is carried out and properly disseminated, and its use audited via the Trust's audit process.

4.5. Specialist Advice

A range of senior staff were involved in the review of the current policy to take account of the recovery and personalisation agenda to ensure our current policy reflects best practice. Examples of staff involved include:

- CPA Development Group, including CPA lead, principal social worker, senior care group representatives, and service manager from East Riding Local Authority
- Heads of Professions
- Information Management
- Care group directors and clinical care directors

4.6. Senior Managers, Managers and Clinicians

Line Manager

The line manager has the responsibility to ensure that all staff working within inpatient areas and community services comply with the policy and ensure it is implemented effectively and safely.

The line manager is responsible for ensuring that:

- Staff receive appropriate advice, monitoring and guidance via regular supervision.

- Relevant training is identified for staff through the appraisal process.
- Staff attend training and subsequent refreshers.
- New employees receive information on the CPA policy and Procedural Guidance as part of their induction.

Registered clinical staff/other clinical staff

CPA Care Coordinator
The care coordinator is responsible for coordinating care, keeping in touch with the service user, ensuring that the care plan is delivered, ensuring that the plan is reviewed when required and documenting recovery/treatment outcomes, including review of the need for CPA.

Case Manager
The case manager has the responsibility for facilitating the delivery of care to a service user who has been identified as having less complex needs, and does not meet the criteria for CPA.

The care must include:

- An assessment of health and social care needs, including the need for CPA.
- A care plan to meet those needs (in a suitable format).
- A review date for the care plan.

4.7. Trust Staff

All staff are responsible for ensuring that all service users in their care:

- have a named person to take a lead in all appropriate assessments, care plans and reviews
- follow this policy and meet the Trust standards
- attend relevant training and subsequent refreshers
- put their training into practice

5. PROCEDURES

5.1. Criteria for Care Programme Approach
CPA is for those people with severe and complex presentations, people who have multiple agencies/professionals involved in their care, people who present with high levels of risk, and people who are in 'transition' (i.e. from an inpatient to community service or CAMHs to Adult).

5.1.1 Characteristics to consider when deciding if support of CPA is needed

General:
- 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
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity, e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team

- Significant reliance on carer(s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities
  - 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

(Refocusing the CPA – DoH 2008 Section 3.)

5.1.2 For people in Learning Disability Services

"The MHNSF (Mental Health National Service Framework 1999) standards and guidance apply to people with learning disabilities as much as anyone else. While there are some excellent examples of positive practice, it is acknowledged that many people with learning disabilities still find it difficult to access mainstream mental health services." (Annex A, Refocusing the CPA – DoH 2008).

If service users' care is to be organised within the CPA framework it will be based on clinical presentation and should follow multi-disciplinary discussion and decision making. Decisions should be based on characteristics for consideration for inclusion in the CPA Framework.

Locally this would include:

- patients using inpatient services
- people supported by the Continuum team
- those individuals who present with complex needs including a chaotic lifestyle, vulnerability, and/or self-harm even where there is limited involvement from an MDT
- current or significant history of severe distress/instability or disengagement
- multiple service provision from different agencies

5.1.3 For children and young people (Annex B: Refocusing the CPA – DoH 2008)

- Severe mental disorder with high degree of clinical complexity
- Significant current or potential risks, including:
  - Suicide, self-harm, harm to others, eating disorder
- Currently admitted or recently discharged (either informally or detained under the Mental Health Act 1983) from a CAMHS inpatient unit
- those young people with s117 aftercare following detention under the Mental Health Act 1983)
- Presence of co-morbidity, e.g. substance/alcohol/prescription drugs misuse
- Multi-agency involvement
- Transition to adult services is being planned

5.1.4 For older adults (Annex C, Refocusing the CPA – DoH 2008)

The range of mental health problems experienced in later life is wide. Older adults and their carers should not be subjected to age-based discrimination in terms of the health and social care service they receive. They may have particular health and social care needs associated with ageing, including complex physical and mental health co-morbidity. These needs must be met within and across services that currently often have age-based exclusion criteria.

When to use CPA for older adults:

- When a person's mental health and social care package is complex, predominantly mental health related and the characteristics referred to on page 4 of this guidance are present,

their care will normally require care co-ordination using CPA and a mental health lead care coordinator should be allocated.

5.2. Mental Capacity

The underlying philosophy of the Mental Capacity Act 2005 is to support individuals in making decisions for themselves and to ensure that an individual who lacks capacity is the focus of any decisions being made, or actions taken on his/her behalf.

The inability to make a decision can be caused by a range of problems, such as a mental health problem, dementia, learning disability, and physical problems such as toxic confusion, a stroke, brain injury or the effects of drugs or alcohol.

It is important to remember that where a person lacks capacity to make a particular decision, he/she can neither consent to it nor refuse it. Any person acting on behalf of a person who lacks capacity must act in that person's best interests.

All those involved in the care and treatment of a person who may lack capacity should keep a record of long term or significant decisions made about capacity.

It is important to note that where a service user lacks capacity to make a particular decision, e.g. for treatment, or sharing information, then he/she cannot sign a consent form or any other document relating to consent or refusal. In these cases, those acting on his/her behalf must act in the person's best interests and records should reflect this.

Where children are able to take part in decision making, they should be asked if they are happy for their parents to be involved in decisions they need to make.

5.3. CPA Process

The five components of CPA are:

Assessment - a multidisciplinary / multiagency / family/carer/significant other inclusive assessment of the service user's needs and risks (including vulnerabilities and strengths); and an **assessment of risk** using validated tools approved for organisational use.

- Planning of care and treatment – **care plan** to be developed with the service user and carer if possible, to meet the agreed outcomes which will address the identified needs and the management of identified risk (including vulnerability). This includes achieving maximum individual potential. Additionally a '**contingency plan**' (risk and relapse/long term safety plan) needs to be formulated which **indicates personalised signs and symptoms of relapse** and contact details for how the service user and/or carer can contact services both in and outside of normal working hours.
- Delivery of care and treatment – in line with the plan, and where applicable, coordination with other services.
- Monitoring and review – reviewing the care provided and delivery of services on a regular basis to ensure it continues to meet service user's needs. Also there is a need to ensure the expected outcomes have been achieved, and where necessary revising the plans for delivery of care and treatment.
- Discharge/transfer – the planning for (from the beginning of entry to service) and constructive discharge of the service user from secondary mental health services when they no longer require the intervention of such services.

All of the above process needs to be done by working collaboratively with both the service user, the carer (unless there is a specific and documented reason not to include them) and other relevant agencies such as the Local Authority, Housing, GP, Police etc. Please refer to the Mental Health Crisis Care Concordat.

A lack of consent to share confidential information does not preclude sharing general information, or (most importantly) seeking information/views from family/friends/significant others. There is a marked distinction between general information and confidential information as described in the Information Sharing with Carers and Significant Others Standard Operating Procedure: “General information relates to a patient’s general wellbeing and the routines of the unit or service. Confidential information relates to information about the care and treatment of the patient”.

Requirements for the assessment for community care services under The Care Act 2014 do not sit separately from CPA. The local authority’s responsibilities under the requirements of this Act are met through the defined processes. CPA aims to promote effective liaison and communication between agencies, thereby managing assessed risk, and meeting the individual needs of people with mental health problems so that they are better able to function in society.

An initial assessment considering biopsychosocial needs of the service user and associated risks should be completed, enabling the allocated clinician to identify the relevant cluster to assign service users’ needs to at that point in time. Where the assessment/cluster determines that care should be managed through the CPA process, the responsible team must allocate a care coordinator.

For those service users with less complex and more straight forward needs, which are generally met with a care package comprising of interventions from one staff member, they will not need to be managed under the CPA Framework and a Case Manager will be allocated.

More information about roles and responsibilities can be found within the *Refocusing the Care programme approach (2008)*.

NB – requirements outlined in this guidance do not apply to forensic services but they will follow separate procedures set out by NHS England (see link to CPA Review Document under references section).

Those patients looked after in forensic services will have a CPA meeting within three months of admission and at least six-monthly thereafter – these are commissioner and Royal College quality network standards. Due to the length of the admissions it is appropriate that the named nurse takes over as CPA care coordinator during the admission.

5.4. CPA Documentation Process

All CPA-related documentation can be found on the Trust Intranet using the following pathway: Home – Directorates – Nursing and service delivery – Care Programme Approach Forms.

At the point of a referral being accepted into HFT services, the relevant information should be entered into the system by the clinician or administration staff for the respective team.

The information required is outlined on the Trust’s initial assessment form, or if not identified at assessment, on the CPA Review Form. This form also can be used at the point of any CPA review to document that a review has occurred, who attended and the outcome of the review. This information can be entered directly onto the system by clinical/administration staff. The form will be available on Lorenzo as a clinical note and there are instructions identified next to particular sections that need to be recorded in Lorenzo under other tabs by either the clinician or Administration staff.

For any change in demographics (i.e. marital status, address, telephone number) the care co-ordinator/case manager would need to make these changes directly onto the Lorenzo system, or ask administration staff to input these changes.

5.5. Care Co-ordination Role

The role of the care coordinator should usually be taken by the person who is best placed to oversee care management and resource allocation, and can come from most professional backgrounds depending on capability and capacity. Decisions regarding the allocation of care coordinator responsibility will be undertaken with due regard to the complexity/risk and need of the service user. Staff who are not professionally registered may take on this role under delegation and supervision where the specific need of the patient can be met with actions, commensurate with grade discipline.

Senior grades within the team would usually lead more complex care coordination requirements. Care co-ordination should generally not be a role for Consultant level clinicians or some senior Allied health professionals who are required to deliver a specialist consultative role.

The care coordinator should have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin. It is important that they are able to support people with multiple needs to access the services they need.

However, it is not the intention that the care coordinator necessarily is the person that delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required. This approach supports the principles of New Ways of Working, which aims to use the skills of all in the most appropriate, effective and efficient manner.

The care co-ordinator's primary role is to collaborate with the service user, carers (unless there is a specific and documented reason not to include them) and other professionals and agencies to ensure service users' care is co-ordinated as required. They should ensure the service user receives additional assessments as required that a plan of care, risk assessment and risk and relapse plan are completed, agreed and reviewed on a regular basis in line with the CPA/case management requirements.

When using **CPA within CAHMS**, the CPA care co-ordinator will have ultimate responsibility for co-ordinating care and if a lead professional (see Glossary) is involved the two practitioners should be clear on their role on a case by case basis.

5.5.1 Case management

Where a service user has straightforward needs, low levels of risk and often (though not always) has contact with only one agency then an appropriate professional in that agency will be the person responsible for facilitating their care.

The same obligations for regular review of care exists for service users who have care organised through case management however there is not the same requirement of a formalised care plan and risk and relapse plan; this can be articulated through a comprehensive professional letter outlining assessed needs, plan for care and treatment, identified risks and how it is proposed these will be managed.

This documentation will constitute the care plan. However, as a minimum, service providers must continue to maintain a record of essential information on all individuals receiving secondary mental health services and that reviews take place regularly.

It is worth noting that the system is not unyielding and that people can move between CPA and Case Management as required depending on the stability of their mental health and wider social needs.

The same good practice principles for collaboration with the service user and their carer/family/friend/significant other (see 5.3 above for guidance on sharing information), and ensuring they have a copy of any correspondence including how they can contact services both in and out of normal working hours, are inherent to this process.

5.5.2. Change of care coordinator/case manager (within the Trust)

A change in care coordinator/case manager may occur for several reasons, e.g.:

- Relocation of MH care coordinator/case manager
- Transfer to/from another element of service, e.g. CAMHS or a specialist service
- Medium/long term sickness of the care coordinator
- The geographical relocation of the service user
- A request by the service user – N.B. consideration should be given to the reasons for this request and whether it would be in the best interests of the service user. It is possible for the CPA care co-ordinator to continue coordination of the person's care whilst other practitioners have the face to face contact. The service user needs to be aware that communication between those involved in their care is key to ensuring they receive the most effective treatment to maximise their potential for a prompt and positive recovery, and ultimate discharge from mental health services.

Any change should be undertaken sensitively and correctly in order to minimise disruption to the service user's care. The service user, their carer/family/friends (see 5.3 above for guidance on sharing information), and other relevant professionals should be kept fully informed in relation to the allocation of a new case manager/care co-ordinator, and the service user should be in agreement to the new member of staff undertaking this role.

The existing CPA care coordinator should where possible hold a review with the new care coordinator/case manager (and any other relevant services in a new area) to formalise the arrangement prior to any change.

5.6. CPA Approach for Patients Receiving Inpatient Care

It is reasonable to assume that any service user admitted for acute inpatient care will have complex needs and will need a multi-disciplinary approach. Therefore, all people receiving care in inpatient services must be made subject to CPA and initiated on the clinical system.

The exception to this rule is for those patients who are admitted to an adult mental health inpatient unit who only use mental health services in crisis i.e. 72 hour admissions, or for those with no previous contact with mental health services and for whom the need for a future CPA coordination approach is unclear. In these circumstances the patient will undergo an initial assessment period of 72 hours. On or before that third day of the admission a decision will be made to place the person either on CPA or not, this allows a period of assessment to understand care needs. Daily planning meetings will facilitate this decision making.

All admissions for patients already known to services, or transfers to adult treatment units (Mill View Court, Westlands, Newbridges, and Hawthorne Court) regardless of previous level of care, are required to have their care co-ordinated within CPA.

- Existing care co-ordinators/case managers should continue to maintain a relationship with the patient. The care coordinator and the identified key worker on the admitting unit will review the patient's care cluster within two days of the admission taking place (where possible, given the exception of weekends) to ensure it reflects the patient's presentation and needs at the time of admission.
- Where a patient is not known to services, an allocated keyworker on the inpatient unit will take on the role of care coordinator on a temporary basis. The inpatient care coordinator and where possible a member of staff from the admitting team will allocate the patient's care cluster within two days of admission. Consideration will be given to the patient's social care needs, where appropriate, in order to facilitate a timely discharge.

Inpatient staff will make a referral to the most appropriate community based team who will ensure a community care co-ordinator is allocated. The appointed care coordinator must begin to build the

relationship with the patient and liaise closely with inpatient staff to gain a clear picture about the patient's assessed needs, progress, CPA reviews and discharge planning.

The community team manager/leader shall be informed by the charge nurse if the appointment of a care co-ordinator does not occur within five working days of the admission taking place.

5.6.1 Post-admission CPA Meeting

Within **five working days** of the admission taking place, a **post-admission CPA meeting** should occur and should be attended by:

- The patient's existing CPA care coordinator (or a deputy from the community team responsible), member of inpatient staff, responsible clinician or member of medical team, patient and, if patient consents, carer/significant other (views of family/significant other should still be sought and taken into account regardless), and any other professionals involved in the patient's care.

Please note unless otherwise agreed there will be an expectation that the existing CPA care coordinator will complete the CPA review form where a patient becomes an inpatient.

Where a patient was not receiving services prior to admission an identified member of inpatient staff (preferably the member of staff who has been adopting the care coordinator role) would also attend.

The purpose of this meeting is to:

- Review the patient's current life situation, presentation and recent history that has led to admission
- Ensure an assessment of risk is completed using the standard clinical risk assessment tool
- Revisit and review (when necessary) the care cluster indicated at the time of admission
- Agree a care plan for the inpatient stay
- Begin the development of a discharge plan in line with the Expected Date of Discharge as identified within 48 hours of admission

The patient may have repeated reviews if their presentation regularly changes.

5.6.2. Inpatient Pre-discharge CPA Meeting

This should be attended by:

- The patient and, if patient consents, carer / significant other (views of family/significant other should still be sought and taken into account regardless), the CPA care coordinator or in exceptional circumstances their deputy, member of inpatient team, responsible clinician or member of medical team, and any other professionals involved in the patient's care.

The purpose of this meeting is to:

- Review the current life situation, presentation and recent history that has led to admission
- Agree whether the patient requires aftercare co-ordinated via CPA or case management.
- Agree time, date and venue for seven-day follow up to take place.
- Review care cluster
- Agree any care plan revisions required for inpatient stay
- Finalise the development and resourcing of a discharge care plan (ensuring CTO and or Section 117 requirements are met if required. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs. The type of aftercare required will depend on the circumstances of the individual and health and social services are entitled to consider their resources when assessing needs)

- Ensure the patient and their family/carer/significant other is aware of how to contact mental health services out of hours if the need arises

NB. Services provided to a person before admission to hospital, and which meet needs identified under Section 117, will become part of the aftercare package. Therefore, if someone was paying for their residential care before they were detained in hospital under Section 3, this will become part of their aftercare following discharge and responsibility for payment will pass to the clinical commissioning group or to the local social services authority. If medication was being paid for before detention then that should also be provided free of charge.

The pre discharge meeting should occur close to the patient's expected date of discharge and should finalise:

- A care plan/management plan/recovery plan, drawn up in consultation with and agreed by the patient and carer/significant other (as per Confidentiality and Information Sharing with Families and Significant Others Policy), inpatient staff and the community MH care coordinator, designed to cover the return to the community which includes specific reference to the first post-discharge week and provides more intensive provision for the first three months following discharge
- Ensure risk assessment is completed/reviewed in line with local policy
- A risk and relapse plan or long-term safety plan
- Any other assessments that are required and ensure referrals for these have been made as appropriate
- Agree a date for a care transition review/CPA review which should take place within one month of discharge
- The ongoing needs of the carer including, where required, a carers assessment, and consideration as to whether the carer can continue to provide the previous level of care if patient's care needs have changed significantly

The risk and relapse plan/long-term safety plan must contain:

- Personalised signs and symptoms of relapse, and positive coping strategies
- Clear information for the patient and their carer/significant other on how to contact the Mental Health Services for help, advice and support during normal working hours and outside of these hours including contact numbers where applicable

The National confidential inquiry into Suicide and Homicide by people with mental illness (October 2016) highlighted that there are now around three times as many suicides by CRHT patients as in in-patients. "A third of CRHT patients who die by suicide have been under the service for less than one week and a third have recently been discharged from hospital. The first three months after hospital discharge continue to be a period of high suicide risk. In England the number of deaths rose to 200 in 2014 after a fall in the previous year. Risk is highest in the first two weeks post-discharge: in a previous study we have shown that these deaths are associated with preceding admissions lasting less than seven days and lack of care planning. There has been a fall in post-discharge deaths occurring before first service contact, suggesting recognition of the need for early follow-up".

Direct contact following any form of discharge from an in-patient unit will be within a **maximum** of seven days. Where it is identified that the patient requires follow up earlier, the arrangements for this must be clearly described in both the discharge care plan and to the patient, being clear about the more intensive or specialised care that will be in the first hours or days following discharge. Extra care should continue to be available, if necessary, for at least the next three months. It is good practice for the patient to be reviewed by a Consultant after 4 – 6 weeks of discharge from hospital.

Should a person discharge himself or herself against medical advice, the requirement for CPA should be determined at the seven-day review point following discharge.

People discharged from inpatient care to Mental Health Response Service (MHRS) on either CPA or Case Management will be followed up within seven days either face to face or via telephone contact. If the patient has been discharged on CPA the MHRS will review the continued requirement for CPA after 72 hours.

This particular group of service users (post discharge) will be given the **highest priority** when managing caseload commitment.

5.7. What can Carers expect from the CPA and Case Management Process?

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

It can be difficult for carers to see their caring role as separate from the relationship they have with the person for whom they care, whether that relationship is as a parent, child, sibling, partner, or a friend.

The sort of roles and responsibilities that carers have to provide varies widely. They can range from help with everyday tasks such as getting out of bed and personal care such as bathing, to emotional support such as helping someone cope with the symptoms of a mental illness.

(NHS England – www.england.nhs.uk/commissioning/comm-carers/carers)

Under the Care Act 2014 “Carer” means an adult who provides or intends to provide care for another adult (an “adult needing care”); this includes providing practical or emotional support.

The duty to carry out a carer’s assessment applies regardless of the authority’s view of:

- the level of the carer’s needs for support, or
- the level of the carer’s financial resources or of those of the adult needing care. (Section 10, Care Act 2014)

Care coordination should always include the involvement of families/significant others whether or not they consider themselves to be carers. The family may not always have specific ‘roles and responsibilities’ but are an important resource and can always contribute to understanding and solutions to problems.

The CPA recognises that carers are providing valued and vitally important care and support, sometimes on a full-time basis and acknowledges that carers can often feel cut off and ill-informed about their relatives/friends. CPA care co-ordinators/case managers have a duty to explain the importance to service users of sharing information with carers at all possible opportunities. If service users do not agree to their confidential information being shared staff must still offer time to listen to carers and keep revisiting the issue with service users at regular intervals.

Carers may also have their own individual needs and these should be considered in their own right rather than being added to the patient’s assessment and care plan.

In April 2015 The Care Act 2014 replaced most previous law regarding carers and people being cared for. Carers can be eligible for support in their own right. The threshold is based on the impact their caring role has on their wellbeing. Staff should ensure they offer and carry out or arrange for carer’s assessments to be completed in order to identify the carer’s needs. Carers should be signposted to appropriate services for support in circumstances when the care coordinator might be less able to provide the type of service they require.

5.8. Parents with Mental Health Problems and their Children

Between 30% and 50% of users of mental health services are parents with dependent children (Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children April 2008).

The national CPA guidance recommends that the needs of the parent, the child and the family are assessed routinely at each stage of the care pathway from referral to review – Think Family.

For a family with children and young people under 18, an episode of mental ill-health can represent a significant crisis, not just in terms of a parent's individual mental health but in family life overall. It may involve a period of hospitalisation, which may have long term repercussions. When parents with mental health problems are admitted to hospital this can also disrupt the stability of their children's lives and may alter the relationship between them (Mental Health Foundation 2007, Parents in Hospital. Summary report July 2007).

The impact on children's' emotional development should not be underestimated. An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves. Children may develop attachment issues, causing difficulty for them in the interaction with others and personal independence. An example may be a mother with a persistent depressive disorder with high anxiety levels who is emotionally unavailable to her children. The impact on the child's health and development may be greater at significant times in a child's life, e.g. when they are studying for GCSEs.

These parents may fear losing their children and the reality of it happening. They may feel on trial about their parenting abilities and though they may need help, they may fear the consequences of asking for it. Such anxiety can be an impediment to recovery. "Worry about mental illness being 'passed on' to the children is another common fear, and one shared by the children" (Hugman & Phillips (1993)).

5.8.1 The importance of safeguarding children

It is a requirement of the safeguarding children policy that Humber staff working in mental health and learning disability services, know whether their service users have children or are in contact with children. In order to safeguard children of service users, mental health practitioners should routinely record details of service users' responsibilities in relation to children and consider the support needs of the parents and their children in all aspects of their work using the Care Programme Approach. To support this process, a flowchart has been created to remind clinicians of safeguarding considerations that should be made during a parent's/carer's episode of care with Humber NHS Foundation Trust. This flowchart entitled "*Safeguarding Children actions within Adult Mental Health services*" has been added to the Safeguarding Children Policy for future reference and review.

Close collaboration and liaison between the mental health services and children's services are essential in the interests of children. This may require the sharing of information and safety planning to safeguard and promote the welfare of children or protect a child from significant harm. It is essential that information is shared to support any potential Children's Social Care (CSC) assessment process.

Assessment should identify whether there is a child or a young person carrying out caring responsibilities and a carer's assessment should be offered and carried out as soon as possible.

Consideration should be given to the significance of the timing, duration and severity of illness and its impact on parenting, the parent child relationship and the child. The needs of adults and carers may be different at significant times, for example, following initial diagnosis, six months after first diagnosis, during hospital admissions, after a significant spell in hospital, or when the young carer is just about to sit their exams. Care plans and carer's plans should be amended accordingly and

should reference each other at these times to ensure that the individual and family goals are interrelated, supported and reviewed.

If at all possible the direct involvement of children in the CPA process (or ascertaining their views beforehand (with parental consent)), e.g. assessment, care planning and review is preferable. Children are often the first people to notice when things are going wrong and can identify changes in the parents behaviour that signify they may be becoming unwell (see Appendix 4).

Agreeing and including realistic targets and outcome measures can acknowledge where the real difficulties lie and therefore can promote recovery and support family life, for example targeting housing difficulties, accessing nursery or child minder support, or parenting support.

Risk management and crisis plans should include any identified potential risks to the child, in and out of crisis and over time, and the steps being taken to safeguard the child. They should ensure that parents and children/young carers can recognise when to ask for help and who to ask if they are worried about their parents or themselves.

Protective factors include helping parents to understand: their mental health problems and their treatment, the potential impacts on parenting, the parent-child relationship and their child. The care plan should detail how parents will be assisted in understanding their own mental health problems and ways to avoid these difficulties affecting their parenting role.

5.8.2 Community Treatment Orders

Under the Mental Health Act 1983 Community Treatment Order (CTO) requirements will mean for some families that children will be spending longer periods with their parents when they are acutely unwell. CTO plans should include the potential positive and negative impacts this may have on the parent-child relationship, the child and how these should be addressed and monitored during and after acute episodes.

5.8.3 Hospital Admission

Whether patients admitted to hospital are already subject to CPA or not a CPA review meeting should be arranged as soon as possible. The review should detail what arrangements are in place for the children's care whilst their parent is in hospital. Contact arrangements between the parent and child should be detailed in the notes making reference to the hospital policy for children visiting parents.

Discharge from hospital or 'hospital leave' planning meetings need to ensure that enough time is given to put any identified support in place for the parent and child on discharge as 'coming back together' for families can be a very stressful time with high expectations. If children and families services or other services are involved in the parent's care or children's care then it is imperative that they are either involved or given adequate notice of leave and discharge arrangements.

5.9. Review process for CPA/Case Management

Trust Standards expected:

- **Least overwhelming format/environment to enable service user's attendance**
- **time and venue to suit service user's wishes**
- **the offer of advocacy to ensure service user's views represented**
- **clear record of meeting**

Who should attend/be invited to the review?

- service user
- relatives, informal carers or advocates (with the service user's consent); a clear rationale should be documented in the notes if the family/carer/significant other is not invited

- CPA care coordinator/case manager
- professional staff involved in the service user's care (Trust, Local Authority, voluntary agencies)
- service user's GP

This list is not prescriptive and not exhaustive.

The above individuals should have the opportunity to contribute to the review, even if they cannot attend in person. Any written reports should ideally be prepared well in advance of the review taking place (not always possible within inpatient settings) so that these can be shared with the service user in a timely way.

Part of the care coordinator's role is to ensure that the views of all those involved in the care of the service user are adequately represented and communicated throughout the CPA review process. However there is an expectation on all staff involved with the service user to take responsibility in ensuring service users receive a holistic review, which can only be achieved by contributions (in whatever format) from all those involved in that person's care. There should be clear documentation of any areas of disagreement or identified unmet needs.

The coordination of all agency input and support is essential to the CPA process, and especially with regards to maintaining this role and involvement for people who have gone into hospital (including out of area).

The review must include consideration of all health and social care perspectives, review of the care plan and risk management plan to ensure things are progressing as originally anticipated and that the aims and objectives are still appropriate.

The CPA meeting discussion and agreed outcomes should be recorded on the CPA Review Form and a brief entry made in the service user's integrated notes in order to ensure a contemporaneous record of the review and its objectives until such a time when all staff are inputting directly into Lorenzo.

The occurrence of the CPA/Case Management review should be recorded onto the Lorenzo system directly, by the clinician or administration staff. A provisional date for the next review should be identified.

Any decisions/changes to the care plan must be made in conjunction with the service user in relation to how well the goals have been achieved. The care coordinator will be responsible for communicating the review/care plan to those involved.

The agreed objectives and associated actions should form the revised care plan, this is the document that should be the outcome from any CPA review or meeting (format agreed by care group for example – recovery star) including the risk/relapse element, which will be agreed, amended as necessary, and then copied to the patient, the carer (with the service user's consent) and all other relevant persons, including the GP, involved in the service user's care.

Consideration should be given to the appropriateness of the current level of care provided, i.e. appropriate level of cluster and whether a transfer between CPA/Case Management (non-CPA) status is necessary.

When faced with an emerging complex case problem, the first step to effective management of the issue should be through the care coordination process. In some cases this may require the lead professional/Care co-ordinator arranging a review meeting. Support may be gained throughout this process by consulting with appropriate colleagues within a multi-disciplinary framework, who may have the necessary knowledge, skills or experience to help the team resolve the complex case issue/s. The service user's Responsible Clinician **must** be a key part of the CPA process in these

circumstances (Managing Inpatient and Community Complex Cases for the Adult Mental Health Care Group).

Clinical supervisors should discuss the case management/CPA coordination of individual service users within their regular supervision of staff who are acting as case managers or care coordinators, reviewing clinical notes to determine evidence of CPA process and the appropriateness of the service user's care CPA Pathway (Non-CPA/Case Managed or CPA).

5.9.1 Section 117, Mental Health Act 1983

Section 117 of the Mental Health Act 1983 states that aftercare services **must be provided** to patients who have been detained in hospital:

- For treatment under Section 3
- Under a hospital order pursuant to Section 37 (with or without a restriction order) or
- Following transfer from prison under Section 47 or 48.
- This also includes patients on authorised leave from hospital and patients who were previously detained under Section 3 but who stayed in hospital after discharge from section.
- It also includes people who are living in the community subject to a community treatment order and restricted patients who have been conditionally discharged

Section 117 imposes a **duty** on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act 1983.

Service users with S117 entitlement are likely to require reviews on at least a 6 monthly basis.

5.9.2 Community Treatment Orders

It is a statutory requirement under the Mental Health Act 1983 for a Community Treatment Order (CTO) to be reviewed and it is good practice to do this as part of the CPA review process. It is considered best practice for CPA reviews for people on CTOs to be held at least every six months rather than annually. Reviews of CTOs should cover whether the CTO is meeting the treatment needs and as to whether the patient continues to satisfy the criteria for a CTO. Where they do not, they must be discharged without delay.

There is an expectation that all patients subject to CTOs will be regularly reviewed at MDT meetings, which includes discussions around timescales for planned medical reviews, and Actions to be considered following medication changes and when family voice concerns/distress.

In England, detained patients and people on CTOs, conditionally discharged restricted patients and people subject to guardianship orders have the right to have an Independent Mental Health Advocate (IMHA) to support them in understanding their rights and expressing their views. It may be helpful to ask for an IMHA to attend assessment and aftercare planning meetings.

5.10. Discharge from Mental Health Services

Where it has been agreed at review that discharge from secondary care services is appropriate then this decision should be recorded on the appropriate documentation. **The only criterion for discharge from the Trust is that the patient no longer needs support from any part of the Mental Health Services**.

Where the patient requests that care be discontinued against the advice of the MH care coordinator and/or multi-disciplinary team, then every effort must be made to develop/present a care plan that is acceptable to that individual. This could mean delivering only part of the original plan or making substantial modifications. (See also service users requesting self-discharge within Discharge/transfer Policy.)

Where compromise cannot be reached, support should be offered to the patient and/or carer, and they should be given full details of how to contact the Mental Health Services for future reference. Also care coordinators should ensure they notify the service user's GP and other services/agencies that the service user is either involved with or may come into contact with, as it may be that some individuals may quickly relapse in their mental health without the level of service they have been receiving previously. Consideration should also be given to arranging a VARM (Vulnerable Adult Risk Management) meeting if the individual is thought to be vulnerable.

Withdrawal of a particular service or intervention should only take place with the agreement of the team following full discussion with those persons/agencies involved in the service user's care. Unilateral withdrawal of services or discharge from caseloads will be avoided at all times.

Discharge from CPA does not necessarily require discharge from S117 aftercare. An example of this would be where the patient no longer needs secondary level mental health services but, as a consequence of the impact of continuing mental health issues, may need support/care in a residential or nursing home setting funded by the Local Authority and / or CCG.

The discharge of any patient from the CMHT with a history of violent and aggressive behaviour towards others should be discussed and considered by the MDT prior to discharge and recorded clearly in the clinical record and discharge paperwork. The team need to consider the risk of potential violence and aggressive behaviour and whether this is linked to their current mental health presentation. If so then consideration should be given for sharing this historical information with the GP and any other involved parties.

5.11. Service Users Transferring or Arriving from another Organisation Outside of the Trust Area

When service users are either transferred or arrive from another area and are:

- Referred for initial assessment **or**
- They require secondary mental health services to be provided by Humber Teaching NHS Foundation Trust

As a part of the CPA pathway assessment the practitioner/clinician will need to gather clinical information / history and will need to contact the previous mental health service provider(s) directly for any relevant clinical information including Section 117 entitlement and whether care has previously been co-ordinated under CPA.

The Trust's Mental Health Legislation Dept. must be informed and, if applicable, will request copies of the section papers relating to the Section 117 entitlement from the original mental health provider as evidence of entitlement.

The new care coordinator/case manager should attend any planned review prior to transfer or referral into the Trust. This allows them to meet the patient and, where appropriate, the carer.

A copy of the service user's current care plan, risk/relapse plan and any other relevant information should be provided for the new care coordinator.

A date for the formal transfer should be agreed by all parties although, prior to this, good practice would suggest that joint visits are made to the patient by both MH care coordinators to facilitate a seamless transfer and minimise disruption of care.

The change of care coordinator must be entered onto the Lorenzo system to ensure review reminders are sent to the correct care coordinator.

On occasions, it may be appropriate that the existing (out of area) care coordinator/case manager continue to support the service user in a different locality for a limited period of time. The detail of such an arrangement should be agreed at the required review and have authorisation of the team leader/manager clearly stating what care will provided and for how long. This must be recorded in the appropriate documentation.

5.11.1 Service user moving permanently out of area

If there are plans for the service user to move to another area to live, the transferring CPA care coordinator should begin the handover process as soon as practically possible (as soon as they are aware that the service user is moving – not waiting for the move to occur) and remain involved until they have formally handed the person over to another mental health service provider in the new area. This may need to be managed via a multi-agency approach, particularly where the service user has a personal budget for social care needs and/or Section 117 entitlement.

Mental health service providers in other areas of the country can be identified by the transferring care coordinator via the NHS Choices website.

At the point of handover and discharge from Humber Teaching NHS Foundation trust, form: **Protocol for transfer of patients out of Humber Teaching NHS Foundation Trust** (see Appendix 3) should be completed and scanned/uploaded onto the electronic database for reference.

Please note there may at times be issues with transferring service users until they are registered with the transferring locality GP practice. Where difficulties occur, staff should contact the Mental Health Legislation Department or the CPA policy and practice lead on 01482 389228 for support in this area.

5.11.2 Service user handover

The national guidance does not detail a specific time related “handover period” which some receiving Trusts will include within their own local policies.

It infers a “**comprehensive and safe handover of care…**” which is the approach supported by the Trust.

The handover should include information such as:

- **History (including MHA and active S117 entitlement if appropriate)**
- **Recent risk assessments**
- **Current care plan (including carer needs if identified)**
- **Communication between responsible clinicians**

The transferring care coordinator will remain responsible for the communication with the service user (carer if appropriate) and the receiving services until the transfer is formally completed.

The Trust would encourage positive practice in relation to handing over the support and care of service users and would, where practically possible, ensure that the Trust’s care coordinator (or clinician who has been involved in the provision of care) attends the first Care Programme Approach review within the receiving Trust. Where difficulties such as distance are encountered the care Coordinator should discuss these with their team leader.

Again, once the transfer is complete the relevant information relating to the service user’s discharge should be entered onto the Lorenzo system by the clinician or administration staff.

Complete **transfer out of boundaries form** and send to Mental Health Legislation Department, Trust HQ, Willerby, HU10 6ED.

5.11.3 Where service user remains resident in Hull/East Riding area, but has clinical needs met in an 'Out of Area' placement (and or out of contract to the Trust)

When a service user remains a resident in the Hull and East Yorkshire area but because of an assessed need (which may be short/medium or on some occasions, longer term) needs to receive services from an out of area/out of contract provider, invariably in the independent sector this can lead to service users' care planning becoming detached from any local coordination arrangements.

Where commissioners agree to out of area placements they will expect that such short and medium term care packages adequately take account of the resources required to ensure care co-ordination from the "area of ordinary residence" are carried out effectively.

These links and processes with the out of area service providers, are crucial to ensuring that placements remain appropriate and quality is maintained and that when the "home" service is in a suitable position to offer the assessed service itself, this happens as soon as possible. The service user will remain open to the relevant Humber Teaching NHS Foundation Trust community team (if an inpatient at the time of the transfer the patient should already have been referred to the community team).

The CPA care coordinator role in this situation is subtly different to the usual one. Under these circumstances the care coordinator will maintain the responsibility for:

- **Keeping in close contact with the patient prior to review**
- **Instructing the independent provider to organise the reporting required, venue and attendance needed for the CPA review to take place**
- **Chairing the CPA review itself**
- **Informing the commissioners (NHS and LA) re current presentation or circumstance that might require review or appropriateness of placement**

When the **out of area care placement is assessed as a permanent need**, this should be made clear to the Care Commissioning Group (CCG)/Local Authority panels that authorise funding.

In these circumstances, it is expected that a care coordinator will be identified from the new providers (the mental health service that is commissioned by the practice that provides general medical services to the "new" place of care).

The transferring care coordinator from the Trust will work alongside the new care coordinator and clinician(s) to ensure a comprehensive and risk managed handover of care which should occur at the client's first CPA review in the new setting as previously described under relevant heading.

Complete **transfer out of boundaries form** and send to Mental Health Legislation Department, Trust HQ, Willerby, HU10 6ED.

5.12. Funding Responsibilities

Please refer to the Care Act 2014 guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance or "Section 117 Aftercare – The Changes At A Glance - Published On: 22 August 2016: https://www.dacbeachcroft.com/es/gb/articles/2016/august/section-117-aftercare-the-changes-at-a-glance/

5.13. Care Programme Approach and Prisoners

The CPA is recognised as extending to the prison context and is incorporated into specific guidance for the prison service and the NHS.

Prison health care services and NHS mental health services share responsibility for both establishing effective links, and liaising on the care of mentally ill offenders who are confined to prison.

CPA Care Co-ordinators should seek to maintain contact with existing service users who are remanded or sentenced to prison **as described within responsibilities where client remains resident in Hull/East Riding area, but has clinical needs met in an 'Out of Area' placement** and liaise with prison based staff to enable:

- Programmes of care which were initiated in the community to be continued as far as possible within the prison service.
- Liaison taking place on release from prison into the community so that community services can provide appropriate support (this may include considerations of sharing management of risk at arenas such as MAPPA (Multi-agency Public Protection Arrangements)).

Where the prisoner is assessed as having mental health care needs that require managing within the CPA framework and is not currently known to Trust services, a care coordinator should be identified from the team serving the prisoner's "home" area. The identified care coordinator should liaise with prison mental health services to enable the provision of seamless aftercare following the same process in which a care coordinator is allocated for any referral. There should be an appreciation that following release the patient may require a higher level of support during the first three months.

It is expected that prior to release from prison of someone being transferred to the care of the Trust, and being cared for within the framework of CPA, there should be a:

- Pre-release meeting/contact of professionals/agencies involved in the individual's care
- Development of a plan of treatment and care (including risk and relapse planning) following release
- Confirmation care co-ordination arrangements/allocation of a care coordinator
- Notification of arrangements to a local GP
- Specific arrangements for follow-up within seven days of release
- Higher level of support during the first three months after release

NB – For patients who are discharged from the Humber Centre they are not routinely followed up by the forensic team for three months following discharge. A decision is made based on clinical factors, risk and legal status (and where they are moving to) regarding whether a patient needs to be referred to a community team or followed up by the forensic community team. The latter does not have the capacity to follow up everyone discharged for three months and this would add more transitional issues to the patient as the forensic team is no more likely to know the patient than the new community team.

5.14. Child and Adolescent Mental Health Services (CAMHS), the Care Programme Approach (CPA) and other Planning/Assessment Frameworks)

An approach such as CPA can particularly add value for those children and young people with more complex needs, such as those who need help from specialist multi-disciplinary Child and Adolescent Mental Health Services (CAMHS). All young people in CAMHS receive a comprehensive assessment (including risk assessment).

Additional use of the CPA process should be considered based on the following guidelines and other information contained within this guidance document.

When using CPA for children and young people, health professionals need to take appropriate account of:

- The fact that the needs of children and young people vary and change over time to a possibly greater extent than adults.
- CPA will be particularly important when a child or young person is in a secure setting or leaving a secure setting.

- Reviews may need to be more frequent for children and young people compared to adults.
- The need to ensure that the child or young person's family are involved in the care plan decision making process and have a good quality relationship with the care coordinator.
- The educational needs of children and young people.

Where care is shared across agencies it must be clear who takes the lead on which areas. This is especially important for children and young people who may have a lead professional appointed from different agencies. The risk, if this is not clarified and agreed, is that professionals might assume that others are taking responsibility e.g. for child protection or mental health, when they are not.

Children, more than adults, are likely to be subject to multiple care plans and review mechanisms from multiple agencies, e.g. Looked After Child Reviews, Special Educational Needs reviews, or social care assessments, which are now known as Early Help Assessments (EHA) and previously known as Common Assessment Framework (CAF). All professionals and agencies need to work together to ensure minimum duplication of information, meetings and clarity of roles (especially who is leading) to avoid confusion and risk. CPA needs to be seen in the context of other planning mechanisms for children with complex needs and agreement must be made locally on how to co-ordinate multi-agency care planning (Annex B, Refocusing the CPA – DoH 2008).

5.14.1 Advantages of using CPA in CAMHS

- Provides clarity regarding accountability and responsibility of others within the care plan
- Whole systems approach – improved information sharing, planned frequent reviews
- Provides a framework for transition to adult mental health services (refer to Transition Guidelines)
- Process is understandable and ensures engagement with families
- Allows children and young people's involvement in planning their care – personalised plan
- Enables the transparency of the care and treatment plan
- System will provide "reminders" for clinicians and provide an easily auditable pathway for management supervision
- System will collect the information necessary to ensure contract compliance.

In terms of implementing the CPA process in CAMHS there are some exceptions to the general guidance:

- Part or all of the review process may be deemed inappropriate for children and young people to be present due to age, capacity or understanding. In all cases parents/carers are invited to the meeting to represent the views and opinions of themselves and their child
- There is no formal advocacy arrangement/ service for this client group

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.

Describe any resources required to implement the policy. If the policy is to be implemented within existing resources state:

This policy does not require additional financial resource.

9. MONITORING AND AUDIT

The Care coordination Association (CCA) produced an audit tool for monitoring compliance and good practice against required standards.

It is recommended that nominated registered staff within individual teams undertake a random sampling audit using the CCA – CPA audit for CPA and Non-CPA tool. The tool is available in Appendix 5 to this guidance

These findings can be entered into an excel spreadsheet to produce a Red Amber Green (RAG) rating of compliance against 37 standards (44 for inpatient staff).

Excel spreadsheet for audit findings: https://intranet.humber.nhs.uk/Downloads/Forms/A-C/CPA%20forms/CCA%20CPA%20and%20Non-CPA%20Audit%20Tool.xlsx. Once completed, analysis of the audit and findings should be formulated into an action plan to address issues relating to lack of compliance with standards.

10. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Aftercare under Section 117 of the Mental Health Act - http://www.mind.org.uk/information-support/legal-rights/aftercare-under-section-117-of-the-mental-health-act/

Department of Health (2008) Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children April 2008.

Department of Health (2015) Mental Health Act Code of Practice. London TSO

Department of Health, *Human Rights in Healthcare – A Framework for Local Action*. (March 2007)

Department of Health, *New Ways of Working for Everyone*. 2007

Forensic Services CPA Booklet: https://intranet.humber.nhs.uk/Downloads/Forms/D-F/Forensic%20Services%20CPA%20Booklet.pdf

Hugman, R., Phillips.N., (1993) *Like Bees Round the Honeypot – Social Work Responses to Parents with mental health needs* PRACTICE 6 (3)

Jones. R. (2015) Mental Health Act Manual (Latest Edition). London. Sweet & Maxwell

Manchester Mental Health NHS and Social Care Trust Assessment, Care and Support Planning Policy Care Programme Approach (CPA) and Non-CPA 2013

Mental Health Crisis Care Concordat: http://www.crisiscareconcordat.org.uk/about/

The National confidential inquiry into Suicide and Homicide by people with mental illness (October 2016) : University of Manchester 2016.

Offender health: www.rcpsych.ac.uk/pdf/OffenderMentalHealthCarePathway2005.pdf

Rotherham Doncaster and South Humber NHS Foundation Trust Care Programme Approach Policy

Refocusing the Care Programme Approach, *Policy and Positive Practice Guidance*, Department of Health March 2008 (link to PDF document)

South West Yorkshire Partnership NHS Foundation Trust Care Programme Approach and Care Coordination Policy and Procedural Guidance

11. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Discharge and Transfer Policy

Continuity of Care Procedure

Information Sharing with Carers and Significant Others Standard Operating Procedure

(Managing Inpatient and Community Complex Cases for the Adult Mental Health Care Group).

Information governance

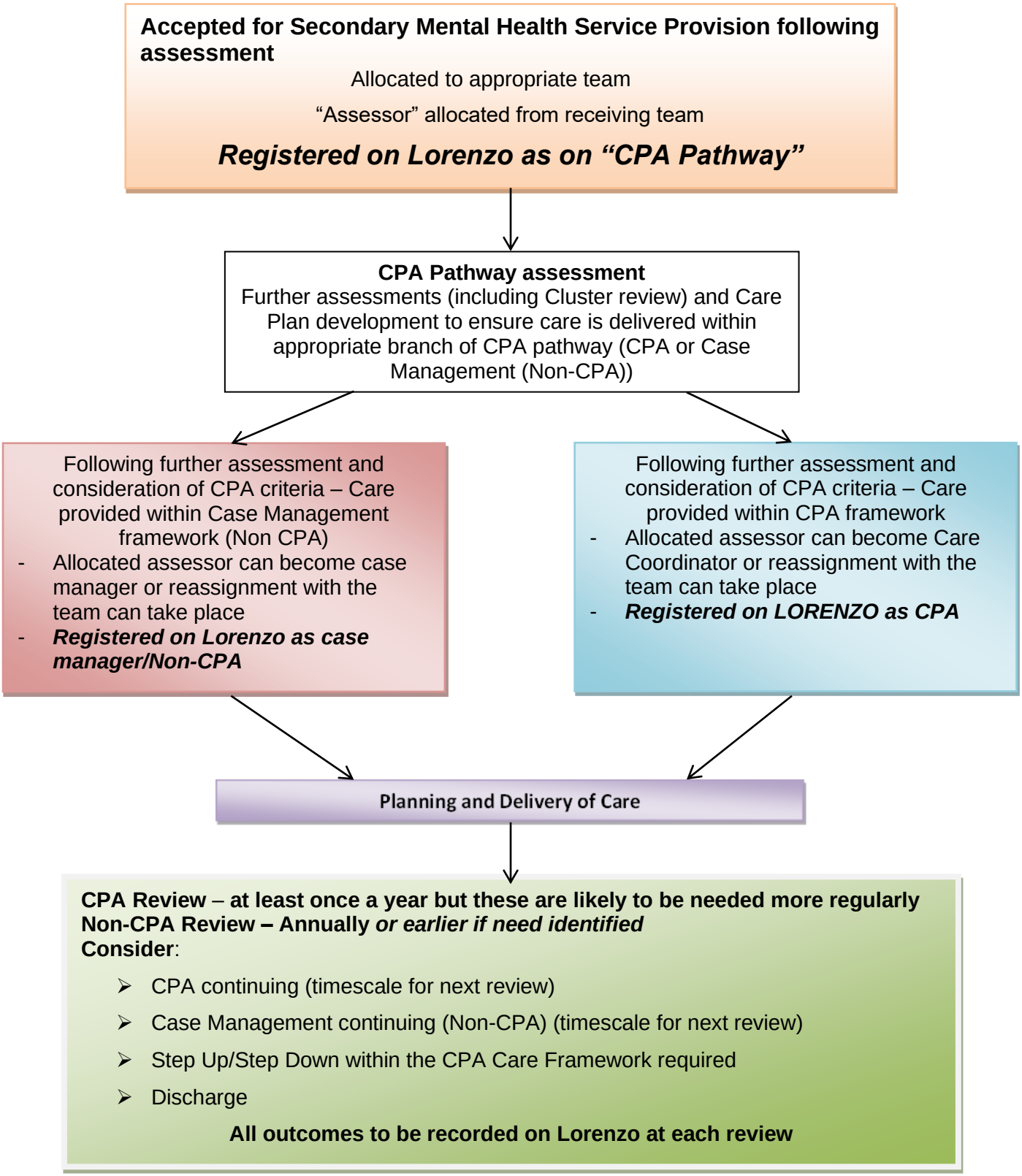
Advance statement/Advance Decision Guidance.

11.1. Other Relevant Legislation

The Care Act 2014

Jones. R. (2014) Mental Capacity Act Manual (Sixth Edition) London. Sweet & Maxwell

Appendix 1: CPA Flowchart



Appendix 2: Glossary of Terms Used

Mental Health Crisis Care Concordat – is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis).

Mental Health Tariff – (formerly called Payment by Results) is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.

Patient – where the word patient is used this is specifically in reference to someone admitted to an inpatient unit.

Service user – where the word service user is used this means any person under the care of Humber mental health service.

VARM – is a formal process for assessing, recording and planning the management of risk in situations where a vulnerable and capacitated adult requires support but will not engage with agencies.

Lead Professional (children and young people's services) – is someone who takes the lead to co-ordinate provision for a child and their family. This person acts as the single point of contact when a range of services are involved with that child or family and an integrated response is required. The lead professional may be a child's social worker, but not necessarily; it should be the person who is best placed to undertake the role. Its functions are to:

- Co-ordinate the delivery of the actions agreed by the practitioners involved, to ensure that children and families receive an effective service which is regularly reviewed. These actions will be based on the outcome of the assessment and recorded in a plan.
- Reduce overlap and inconsistency in the services received.

Every child matters – change for children (July 2007) – CWDC (Children's Workforce Development Council)

Appendix 3: CPA Documentation

The following CPA forms can be found by going onto the Intranet as follows:
Home – Patient Care– Care Programme Approach

1. CPA Review Form
2. Transfer out of boundaries form (Protocol for transfer of clients out of Humber NHS Foundation Trust)
3. Care Programme Approach – Removal of Section 117 Entitlement
4. Patient leaflets:
    - The Care Programme Approach (CPA) Leaflet 1 – What is CPA?
    - The Care Programme Approach (CPA) Leaflet 2 – Your care plan
    - The Care Programme Approach (CPA) Leaflet 3 – Your review
    - The Care Programme Approach (CPA) – How the CPA works for you
    - The Care Programme Approach (CPA) – How the CPA works for you – Information for carers
5. CCA CPA and Non-CPA Audit Tool
6. Forensic Services CPA Booklet

Appendix 4: The 10 Messages from Children and Young People

These 10 messages were written by a group of young carers for people who work in mental health services:

- ✓ Introduce yourself. Tell us who you are and what your job is.
- ✓ Give us as much information as you can.
- ✓ Tell us what is wrong with our parents.
- ✓ Tell us what is going to happen next.
- ✓ Talk to us and listen to us. Remember it is not hard to speak to us we are not aliens.
- ✓ Ask us what we know and what we think. We live with our parents; we know how they have been behaving.
- ✓ Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
- ✓ Please don't ignore us. Remember we are part of the family and we live there too.
- ✓ Keep on talking to us and keeping us informed. We need to know what is happening.
- ✓ Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU.

(For a downloadable copy see Parents in Hospital report at: http://www.barnardos.org.uk/resources/research_and_publications/books_and_tools_health_and_disability.htm)

CARE PROGRAMME APPROACH (CPA) BRIEFING:
Parents with mental health problems and their children April 2008

Appendix 5: CCA Audit for CPA and Non CPA – April 2015

Care Coordination Association
(formerly Care Programme Approach Association)
Supporting quality care standards

Following extensive consultation across the committee members, the Care Coordination Association is pleased to be able to launch a new set of standards to support assessment and care planning audit processes. This new audit tool aims to offer a flexible and adaptable framework that can be applied to service users supported both within and outside of the Care Programme Approach process, across both inpatient and community based settings. Whilst it is being offered as a word document that can be edited and printed to suit, the standards have also been developed into a data capture Excel spread sheet, that not only allows audit of multiple of teams/sites, but also provides statistical analysis and comparison between similar services.

Assessment	Yes	No	N/A	Notes
1. Is there documented evidence of an assessment appropriate to the SU stage in the pathway e.g. triage, Initial contact, CPA comprehensive				
2. Is the assessment person centred incorporating the SU views and understanding of their problems				
3. Is there documented evidence within the assessment of consideration of the involvement and the role of family and/or carers in the life of the SU				
4. Is there documented evidence of appropriate family and/or carer involvement in assessment process				
5. Does the assessment appropriately consider health and social care needs				
6. Is there clear formulation/summary of assessment identifying strengths and needs				
7. Is there a clear plan/outcome from the assessment				
8. Has the plan been shared with the service user and appropriate others				

9. Is there is evidence that mental capacity has been considered				
Risk Assessment	**Yes**	**No**	**N/A**	**Notes**
10. Has risk been assessed and recorded as required by organisational policy				
11. Is there documented evidence of service user involvement in the assessment of risk				
12. Is there documented evidence of appropriate family and/or carer involvement in the assessment of risk				
13. Does the outcome of risk assessment identify the need for a risk management plan ***if no go to question 19***				
14. Is there documented evidence of a risk management plan				
15. Is there documented evidence that the risk management plan has been shared with the SU				
16. Is there documented evidence that the risk management plan has been shared with appropriate others				
17. Has the risk assessment been updated appropriately e.g. due to changes/incidents or at least on a six-monthly basis (for service users on CPA) or 12-monthly basis (for non-CPA)				
18. Is there documented evidence that the new risk management plan has been completed in response to the change in risk				
Care Planning	**Yes**	**No**	**N/A**	**Notes**
19. Is there a documented care plan				
20. Does the care plan address needs identified at assessment and/or subsequent reviews				
21. Does the care plan show clear description of needs				

22. Does the care plan clearly show a description of the action to be taken and by whom				
23. Does the care plan clearly show clear and well defined outcomes/objectives/goals				
24. Does the care plan incorporate service user determined goals/outcomes/objectives				
25. Is there evidence that the service user has been involved in the development of their care plan				
26. Is there evidence of appropriate family and/or carer involvement in the development of the care plan				
27. Is there evidence that the service user has been offered a copy of the care plan				
28. Is there is evidence that mental capacity has been considered				
29. Is there evidence that patient understands their rights in relation to their care and treatment				
30. Do the records demonstrate the planned interventions have/are being carried out				
31. Is there a crisis/contingency plan				
32. Does the crisis/contingency plan include personalised signs and symptoms of relapse				
33. Does the crisis/contingency plan include specific personalised advice for the service user on what action to take in and out of working hours				
34. Does the crisis/contingency plan include specific information for relevant others on what action to take in and out of working hours				
Review	**Yes**	**No**	**N/A**	**Notes**
35. Is there evidence that care has been reviewed as required by organisational policy				
36. Is there evidence that the service user has been involved in the review				

37. Is there evidence of appropriate family and/or carer involvement in the review				
Inpatient Review				
38. Is there evidence of regular MDT review since admission				
39. Is there evidence that patient understands their rights in relation to their care and treatment				
40. Is there evidence that the service user has been involved in the MDT reviews				
41. Is there evidence of a CPA review to plan discharge				
42. Did the CPA discharge review involve the service user, family and/or carer and appropriate community staff				
43. Is there evidence of an appropriate discharge care plan				
44. Were the arrangements for post discharge follow up coherent with assessed risk				

Appendix 6: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance		
Document Purpose	The aim of this policy is to ensure that all Trust staff working in a clinical environment are aware of their responsibilities in relation to: • ensuring the physical and emotional safety and wellbeing of service users when assessing needs and planning the provision of care and support • ensuring that the patient's wishes and those of carers, family and others (where appropriate) are taken into account when planning support • setting out the roles and responsibilities of staff in ensuring adherence to the principles of the Care Programme Approach • setting requirements for recording, monitoring and reviewing the service user's care and support plan and any follow-up action		
Consultation/ Peer Review:	Date:	Group / Individual	
List in right hand columns consultation groups and dates	24 June 2019	Mental Health Care Group Clinical Governance Meeting	
	26 June 2019	Mental Health Legislation Steering Group	
	21 October 2020	Mental Health Legislation Steering Group	
	21 April 2021	Mental Health Legislation Steering Group	
Approving Committee:	Mental Health Legislation Steering Group	Date of Approval:	21 April 2021
Ratified at:	N/A minor amends	Date of Ratification:	N/A minor amends
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Training by individual divisions.	Financial Resource Impact	N/A
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below – to be delivered by the Author:*		
	• Dissemination to staff via Global email • Individual Units and Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:	The monitoring of this policy will be undertaken via patient complaints, adverse incidents and Trust reporting re CPA review compliance. The policy will be audited via record keeping audits and CPA reviews. The Care Coordination Association (CCA) produced an audit tool for monitoring compliance and good practice against required standards. It is recommended that nominated registered staff within individual teams undertake a random sampling audit using the CCA-CPA audit for CPA and non-CPA tool. The tool is available in Appendix 5 to this guidance.		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.00	*New policy*	*11/04/2017*	*Previously "Guidance on delivery of the Care Programme Approach (CPA) Pathway"*

1.01	*Review*	*21/07/2017*	*Amended to include considerations for children within the families of service users (5.8) including addition of Appendix 4: The 10 Messages from Children and Young People*
1.02	*Review*	*23/11/2017*	*Additional sentence added to 5.9.2 regarding the importance of reviewing at MDTs in response to an action from an SI (SI 2017-17216). Also changed RRS to MHRS.*
1.03	*Review*	*05/12/18*	*Additional sentence added to 5.6.1 regarding the completion of the CPA Review form, as agreed at the NG53 (Transition from Hospital to home) Interface Meeting on 26/09/18.*
2.00	*Review*	*29/05/19*	*Added section at 5.7 to clearly explain and define a carer (in response to recommendation from Internal Audit Report Ref:190412). Also amended to reflect the need for family inclusive care.*
2.01	*Minor amendments*	*21/10/20*	*Made clearer about frequency of reviews for those people with S117 entitlment (Page 5 and 19. Page 14). Added a sentence about promptness of Consultant review following discharge from hospital.*
2.02	*Minor amendments*	*19/03/21*	*Added paragraphs regarding discharge off CPA: a) not necessarliy discharge off S117 also; b) consideration of historic violence and agression on discharge (5.10). Also clarified need for CPA for inpatients (page 12). 20/03/24 - Review date extended to end of December 2024 (as approved at February QPaS meeting and confirmed by Paul Johnson).*

Appendix 7: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Act Clinical Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy and Procedural Guidance

Main Aims of the Document, Process or Service

This Care Programme Approach (CPA) and Non-CPA Policy replace the Trust's current guidance and have been updated to reflect best practice and a recovery-focussed approach. The document provides a framework for the assessment, care, support planning and review of people referred to secondary care mental health services provided by the Trust.

This document sets out the ways in which service users and their carers will be assessed against the criteria for the CPA, in the context of national policy and guidelines developed since 1990.

Effective communication is essential in ensuring accurate risk assessment, appropriate care, and respect for patients' rights. Staff responsible for caring for patients should identify any communication difficulties (language barriers, learning disability, difficulty in reading or writing, visual or hearing impairment, and cultural barriers) and seek to address them. This policy should be adhered to with embedded consideration of how patient involvement and equality can be maximised.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil partnership 5. Pregnancy/Maternity 6. Race 7. Religion/belief 8. Sexual orientation 9. Gender reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	The Policy specifies individual age groups and how the CPA relates to them.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	**Low**	Where an individual has an impairment, disability or literacy difficulties reasonable adjustments are made to the process, timescales and individual needs in partnership with the service user and their families/advocates.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Sex	Men/Male Women/Female	**Low**	The CPA Policy applies to all people regardless of gender.
Marriage/Civil partnership		**Low**	The CPA Policy applies to all people regardless of status.
Pregnancy/Maternity		**Low**	No impact identified.
Race	Colour Nationality Ethnic/national origins	**Low**	The CPA Policy supports non-discriminatory practice as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to race or ethnicity. Language or literacy needs – service users may have difficulty reading or signing written information if English is not their first language.
Religion or belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	The CPA Policy applies to all people regardless of religion or belief. It requires the need for non-discriminatory practice and as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual orientation	Lesbian Gay Men Bisexual	**Low**	The CPA Policy applies to all people regardless of sexual orientation.
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	The CPA Policy applies to all people regardless of gender.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above • Need to ensure all appropriate individual support is identified and provided, e.g. Interpreters or translation of documents and timescales are adjusted to accommodate these needs • Service users with disabilities should be supported to fully engage with services by providing information in their preferred format • There are statutory requirements and obligations built into existing related legislation (MHA 1983 and MCA 2005) and their supplementary Codes of Practice as well as local policies and procedures to ensure that staff are compliant with these requirements
EIA Reviewer: Michelle Nolan
Date completed: 27 April 2021 Signature: M Nolan