CARE MANAGEMENT AND CPA

1. INTRODUCTION

Partnerships in Care (PiC) is committed to providing excellent service user care through a care management process in which recovery is embedded and focused on positive outcomes.

The Care Programme Approach (CPA) (updated in 2008 in: 'Refocusing the Care Programme Approach') sets out guidance for services on the management and support of people with complex mental health needs. Although not all of our service users fall within the definition of CPA, our clinical strategy is to provide services that reflect the values set out in this guidance. These relate to:

- Person centred care & service user involvement
- Helping people reach their potential & encouraging independence
- Comprehensive assessment, care planning & review
- Including family and friends
- Effective therapeutic relationships
- Continual commitment to care planning and achieving outcomes.

However, some very specific standards exist for people assessed as eligible for CPA level care and this Policy also deals with those arrangements.

2. SCOPE

This policy applies to all PiC services that carry out Individual Care / CPA reviews. This is an over-arching policy. Local procedures are required at all hospitals.

This should be read in conjunction with the following policies:

- PiC Operational Policy – *Advance Decisions & Advance Statements*
- PiC Operational Policy – *Assessment & Management of Clinical Risk*
- PiC Operational Policy – *Data Protection & Confidentiality*
- PiC Operational Policy – *Mental Capacity Act & DOLs*
- PiC Operational Policy – *Safeguarding Children & Child Protection*
- PiC Operational Policy – *MAPPA*
- PiC Operational Policy – *Referral & Assessment for Admission*
- PiC Operational Policy – *Advocacy in PiC*
- PiC Operational Policy – *Policy for Working within the Mental Health Act 1983*
- PiC Operational Policy – *Discharge – Leaving the Service*

This policy reflects PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone

- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

3. MENTAL CAPACITY & LEAST RESTRICTION PRINCIPLE

Adults with mental health problems or learning disabilities may not always have capacity to make decisions for themselves. Effective working requires that, in line with the principles set out in the Mental Capacity Act 2005, every practical step to help someone make a decision must be taken, and any act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

For those individuals who are not detained, an assessment of capacity and review of care should be completed to flag up whether there are any issues with respect to Deprivation of Liberty. If there are deprivation of liberty issues the individual will have access to an Independent Mental Capacity Advocate (IMCA).

4. CARE PLANNING AND REVIEW

Care planning is underpinned by long-term engagement, requiring trust, teamwork and commitment.

All service users (regardless of diagnosis, projected length of stay or detention status) will have a comprehensive Plan of Care. This Plan of Care will include:

- Needs Formulation
- Pathway Plan
- Health Outcomes plan
- Activity / therapy plan
- Individual Needs Plans

Service users should be able to access the most recent version of their plan at any reasonable time.

Plans of Care, the progress of service users and their changing needs will be subject to continual review in addition to a formal individual care review (ICR).

Individual Care Review (ICR) meetings are held for the benefit of the service user and carers and should be run in ways they feel comfortable with and which maximise opportunities for involvement. At each meeting the date of the next review should be set and recorded.

5. CARE PROGRAMME APPROACH (CPA)

Service users assessed as eligible for CPA-level care will be entitled (in addition to standard care reviews) to:

- A pre-admission CPA / s.117 meeting to ensure effective handover between agencies

- A CPA Care Co-ordinator (who is a registered practitioner) appointed to them
- A say in who their CPA Care Co-ordinator is
- Involvement of external agencies in the construction of the Plan of Care
- A formal CPA meeting at a minimum of every 6 months to which external agencies will be invited (this may replace the usual Care Review).
- Representation from an Independent Mental Health Act Advocate (IMHA) at a CPA meeting without needing RC clearance.

A solicitor and advocate may attend part of the CPA meeting at the appropriate time, that is when and if Section 117 (aftercare planning matters) is being discussed, at the invitation of the patient.

A solicitor and advocate may attend other parts of the CPA meeting at the invitation of the patient but only with the approval of the Responsible Clinician.

Input from external agencies is imperative and in cases where MAPPA is involved a member of the clinical team will liaise with MAPPA in order that their views are represented.

The views of the victim (if there is one) may form part of the professional's discussion and can be collated outside the CPA meeting either in writing or through liaison with the Victim Liaison Officer.

6. RISK ASSESSMENT & FORMULATION OF NEED

- A Preadmission Baseline Risk Assessment (PABRA) will be completed with adults prior to admission; this will inform care planning until a validated risk assessment tool is completed where appropriate.

- In hospitals a medical admission summary should be completed in a timely manner following admission and an admission care plan should be developed and followed.

- We work with service users to understand their illness better and pinpoint what led them to their current placement.

- When appropriate we use diagnostically suitable, clinically validated tools and instruments to assess risk.

- We help the service user to identify strengths; the things that are going to help them succeed and any vulnerability they have that we need to help them deal with.

- We give service users opportunities to tell us about what they want out of their care from us, what they want from the future and how they see their pathway from here.

- We help service users understand their disorder in ways that make sense to them and help them develop ways of managing it.

- We help service users understand options for medication, any side effects and help them manage them.

- Spiritual, racial, cultural, sexuality, gender, ability, socio-economic and physical health differences should be identified, respected, and steps should be taken to combat any disadvantage people experience as a result of them.

- Some individuals may not always have capacity to make decisions for themselves. In these circumstances the principles set out in the Mental Capacity Act 2005 are applied and every practicable step to help someone make a decision is taken, and any act done, or decision made, for or on behalf of a person who lacks capacity is done, or made, in their best interests.

- We encourage and support service users to involve their family and friends in the planning of and reviewing their care when they wish.

7. PLANNING A PATHWAY OF CARE

- Based on the Formulation, we agree with service users the most realistic pathway they're likely to take from here and we talk to them about each point of the pathway, what the services are for and what those services aim to achieve. We keep the pathway plan under review and if things change we re-look at the plan with the service user to make sure it's still the best thing for the future.

- We plan pathways with a primary goal of ensuring the most appropriate environment for a service user's needs and risks.

8. CARE PLANNING

- Advance directives / decisions or statements of wishes are considered and referenced in care planning when these are available.

- Using the formulation we decide with service users what health outcomes are going to be important to work on to demonstrate recovery.

- We communicate to service users, which health outcomes are going to be essential in order to move on and which ones they'll work on with us but can take with them if they haven't finished when they leave.

- We encourage service users to engage with a recovery tool of their choice. Examples include the Recovery Star and My Shared Pathway.

- We will only ask service users to work on issues that are relevant to their needs.

- We tell service users where we think they are against each of the outcomes they're working on and we give them the same chance to say where they think they are. If we don't agree, that's ok, we talk about why there's a difference in what we think.

- We encourage service users to engage with activities and therapies that we think will help them achieve their health outcomes and prioritise access to activities and therapies which help them achieve their essential health outcomes.

- Using the least restrictive principle we help service users understand how activities and therapies we ask them to engage in help them achieve their goals.

- We try to ensure service users have a range of fulfilling activities available in addition to the crucial therapies, but we won't insist they do anything that isn't essential.

- We work with service users and help them to work out if and how they would like family and friends involved in their care planning.

- Based on what we know about a service user's level of engagement with activities and the work they need to do, we build a plan that estimates their length of stay with us. It won't always be an easy message but we are honest with them about it and work with them to keep that length of stay with us as short as possible, unless this is longer term care.

- Contingency Plans specify what should happen if something specified in the Care Plan is not available.

- Crisis Plans set out details of early warning signs / relapse indicators / potential risks and identify action to be implemented if there is a crisis – for instance if the service user's mental health deteriorates.

- When a service user is in longer term care we will talk to them about practical things we can do that will help them improve the quality of their life.

9. REVIEWING CARE

- We review how service users are doing against their goals as frequently as we can in one-to-one sessions and in formal care review meetings (such as Individual Care Reviews (ICR's) or Care Programme Approach meetings).

- Formal Individual Care Reviews are held with each service user, their care team and any advocate/family/friend they want there. The frequency of formal reviews will change depending on the type of service.

- At a minimum of every six months, service users subject to CPA guidance will have a Care Review to which we invite additional external attendees such as the CPA Care Co-ordinator, MAPPA representative, the service user's solicitor and the people the service user wants to discuss their care with, such as family or friends.

- The Primary / Associate Nurse or keyworker will work with the service user in preparing a progress report for the ICR / CPA Review.

- Either the Primary / Associate Nurse or keyworker will directly support the service user throughout the Review meeting, except where neither is available.

- We give service users the opportunity to tell us how they want care review meetings to run, what they want to discuss, who they want there to support them, anyone else they want to receive copies of their most up to date care plan and progress reports.

- We support service users to prepare for care review meetings and encourage them to say where they think they are against their goals.

- We give service users a copy of their current care plan report before any formal reviews of care. This includes individual professional reports when these are needed.

- After formal reviews of care, we give service users the opportunity to tell us whether the meeting achieved what they hoped and whether they felt they were heard.

10. DISCHARGE PLANNING

- In principle discharge planning starts at the point of admission and helps inform the care pathway.

- Consideration needs to be given to issues pertaining to the Mental Capacity Act for services users who lack capacity who are not detained or will be discharged from their section, This includes the best interests meeting and whether there will be a deprivation of liberty

- For service users detained under the MHA issues around discharge planning should be addressed prior to a Mental Health Tribunal to allow the Tribunal to exercise their powers of discharge.

- We do our best to ensure service users have a smooth transition from our service to the next place in their pathway. This includes transfers between PiC services.

- We are honest with service users about anything that's blocking them moving on and what we're doing to resolve it.

- Working with the next service we try to reduce the chance of service users having to repeat therapies and make sure they understand everything service users have accomplished and what's left to work on.

- We make sure service users have copies of all their plans to support their achievements while they were with us.

- We make sure crisis and contingency plans are shared between services and through section 117 meetings when this applies.

- Service users should not be discharged without a robust care plan, however, there are circumstances when a person will not allow the time for the package to be organised. In these situations we liaise closely with the local service to minimise the risks to the person and others.

- An interim discharge summary should be produced within the first 24 hours if a full summary is not available The full discharge summary will be completed in line with Discharge – Leaving the service policy.

- We work with young people from 17.5 years to prepare them for the transition to adult services.

11. WORKING WITH YOUNG PEOPLE

Inpatient services

- Care of young people in inpatient services is managed under CPA. The initial CPA meeting will be 6 – 8 weeks with subsequent CPAs at intervals outlined in the NHSE service specification.

- We will work closely with friends and family of the young person unless there is a care order in place which prevents this, or the young person has capacity and does not want them involved.

Residential Services

- In line with their legal responsibility Social workers visit the child in their new home within 1 week of them moving. Subsequent visits should be every 3 months as a maximum.

- Children will always have access to their social workers, advocates and solicitors at any point irrespective of whether a review is due or not.

- Looked After Child (LAC) reviews will be held in the child's new home area every 3 months.

- Staff at the home prepare a report with the child's views and comments clearly documented in advance of the review. The child is given a LAC preparation form in order for them to be given time to prepare and think about their review.

- The Independent Reviewing Officer (IRO) will be included in all correspondence regarding the reviews and, may wish to speak to the child independently prior to the review. Their primary role with looked after children is to have an independent and effective oversight of the child's case. Ensuring that the care plan represents an effective response to the assessed needs of the child and that progress is being made towards achieving the stated outcomes and goals.

12. DOCUMENTATION

- The format of the document may differ depending on the type of service but this will be standardised across service lines.

- We'll make sure service users are offered copies of all their plans at regular intervals including Care and CPA reviews.