South Essex Partnership University NHS Foundation Trust

Non Care Programme Approach (Non-CPA)

Procedural and Professional

Handbook

For

Practitioners/Clinicians

Version 1.2

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1.0 Introduction

1.1 Purpose of the handbook

1.1.1 This handbook has been designed to assist Clinicians and Practitioners in understanding the principles of assisting service users who do not meet the criteria to be assisted under the Care Programme Approach. This handbook is a guide for those professionals following the non-Care Programme Approach policy (CLPxx).

1.1.2 This handbook's main objective is to inform service users, carers and workers in the statutory, voluntary and independent sectors about the non-Care Programme Approach (non-CPA) as well as setting out clear expectations for mental health professionals directly involved in the delivery of services.

1.1.3 The purpose of this handbook is to ensure that service users and their carers receive comprehensive, non bureaucratic care which is sensitive to their individual needs.

1.2 Background

1.2.1 The 'Refocusing the Care Programme Approach' document (DH 2008) presents a restatement of the Care Programme Approach (CPA) principles and practice. Therefore in accordance with the new guidance this handbook is concerned with those service users who have straightforward support needs and who receive care from secondary mental health services. Such service users will not be treated under CPA.

1.2.2 SEPT adopts a non-CPA approach for caring and treatment of such service users. Non-CPA applies to service users with a mental illness or who are in a mental health crisis but do not have the higher risks and complex clinical symptoms or care management requiring multi-agency intervention with care coordination.

2.0 Guiding Principles

The document 'Refocusing the Care Programme Approach (2008) sets out a statement of values and principles that have always underpinned good practice in mental health services.

2.1 Social Inclusion

2.1.1 The overarching principle of socially inclusive practice is to ensure that people experiencing mental health problems do not experience barriers to achieving individual goals and participation in society. The

manner in which individuals are cared for and supported should put them at the centre and promote social inclusion and recovery.

2.1.2 In line with the Government' Social Inclusion Agenda, South Essex Partnership University NHS Foundation Trust is committed to delivering socially inclusive services through comprehensive assessments which identify service user and carer strengths as well as their needs. Care plans will place the concept of self directed care central to the identified aims/outcomes.

2.1.3 Assessments need to identify the educational and employment needs of the service user and care plans should incorporate such resources to enable service users to develop the skills and knowledge they might need to get into employment. Care plans should utilise mainstream activities such as local sports centres, arts and social clubs to enable service users to remain members of the community, prevent stigmatisation and social exclusion and thus promote good citizenship.

2.1.4 To achieve social inclusion, which enhances recovery, all assessments should be culturally competent and gender aware and incorporate housing and employment needs, welfare benefits/rights and community participation.

2.1.5 Self directed support is a further aspect of change in which services can be delivered. Direct Payments are one aspect of this approach and must be offered in lieu of a community care service to all people eligible for a service under Fair Access to Care Services (2003) guidance.

2.2 Housing

2.2.1 Housing has a critical role in ensuring the independence and social inclusion of people with mental health problems. The majority of people with complex mental health problems live in rented accommodation with a high proportion living alone. Too often people with mental health problems find themselves homeless or living in temporary accommodation which exacerbates their mental health difficulties.

2.2.2 Stable appropriate housing is critical for people to work and take part in their community. It also plays a critical role in ensuring the independence and social inclusion of people with a mental health problem. A lack of stability or unstable housing can lead to worsening mental health.

2.2.3 Supported housing is a term used to describe a range of funding and joint working relationships that enable people who are vulnerable or who experience some form of social exclusion to live in a community

setting. Assessment of non-CPA service users' needs must look at all dimensions of the service user's needs.

2.3 Equality and Diversity

2.3.1 All professionals must ensure that the services delivered are non discriminatory and sensitive to the needs of all service users and their carers regardless of age, gender, race, culture, religion, disability and sexual orientation.

2.4 Information Sharing and Confidentiality

2.4.1 Sharing information about an individual is vital to the provision of coordinated and seamless care to that individual. Reference should always be made to the Trust's policies on Sharing Information and the Copying of letters for detailed guidance.

2.4.2 Service users who come into contact with mental health services should be given information on confidentiality and information sharing, their right to access their own records and how to complain about or make a comment on the service they receive. This will be done at the outset of any contact with a potential service user.

2.4.3 Consent to share information will be sought at the earliest opportunity and will therefore be completed during the clinical assessment service process. If consent is given verbally, this should be recorded in the service user's case notes. All service users should be informed about what information might be shared with other agencies concerned with their well being. All service users should be made aware of the circumstances in which staff will have a duty to disclose information in the public interest.

2.4.4 Failure to share necessary information is viewed as poor practice as is the sharing of information inappropriately.

2.5 The role of a Key Worker

2.5.1 Non-CPA service users by the nature of their assessed need will require service from only one worker. The worker will normally be referred to as the Key Worker. This should be the mental health professional taking responsibility for the person's treatment and/or care.

2.5.2 Key Workers can be from any discipline depending on capability and capacity. They will usually be; Community Mental Health Nurses, Social Workers, Occupational Therapists, Psychiatrists or Psychologists. The choice of a Key Worker should, where necessary, be discussed with the service user. Gender, culture and ethnicity

specific requests should be met where possible within the limits of resources. Choice of gender may be a crucial factor in the development of a therapeutic relationship with people who have experienced sexual abuse or violence.

2.5.3 Cultural or religious factors should be taken into account, though the worker does not have to be from the same racial, cultural or religious group as the service user and choice must not be used to support discrimination. If requests cannot be met decisions should be explained to the service user. Service users should be offered assistance in requesting support from an advocate, PALS worker or using the complaints procedure if requested.

2.5.4 Key Workers should not be from the independent or voluntary sector. The following workers cannot be key workers; GPs, Support Time and Recovery (STR) workers, unqualified or unregistered health or social care workers, welfare rights workers. Key Workers must not be assigned without their knowledge or without negotiation. They should have a choice in accepting any work with service users or carers. Team managers must maintain an efficient system of workload management to ensure fair and manageable workloads.

2.5.5 The Key Worker will deliver treatment and/or support and oversee the treatment if it is provided by someone else, conduct reviews, collaboratively draw up care plans and arrange discharge as required.

2.6 Standards

2.6.1 The following standards are expected of all Key Workers in relation to all non-CPA service users. Individual cases will be audited to ensure standards are being consistently met in practice.

2.6.2 The care plan (which may be in the form of a letter) must have a record of where and by whom services will be delivered, the intended outcomes and timescales. The service user should be given a copy of their care plan with a copy also sent to their GP and carer (if appropriate).

2.6.3 All care plans must have a review date.

2.6.4 A decision on what to do next will be made for every service user who does not attend their appointment or is unavailable when visited. Where risks are identified it may necessary to hold a review and for other action to be taken.

3.0 Referrals

3.1 Referrals in various forms will be received from professionals, organisations or private individuals including potential services users and carers. Referrers will be asked to provide an outline of the

concerns and enough information to identify individuals and other agencies involved.

3.2 If referrals are misdirected the receiving team should immediately identify the appropriate referral point, re-direct the referral and advise the referrer.

4.0 Assessment

4.1 All persons assessed by the Clinical Assessment Service, Duty Desks, A& E Liaison and Primary Care Mental Health services, will receive an initial assessment which will include an overview of the person's mental health, medication, substance misuse, Safeguarding issues employment, housing and physical health needs.

4.2 All referrals should be assessed to

- Determine whether they have a mental illness
- Identify what the illness is
- Identify the type of support/treatment needed
- Determine how the service user should be managed by secondary services, either through CPA or non-CPA

4.3 Assessments should be carried out in partnership with the person (and carers where appropriate).

- Advocates and interpreters should be involved to facilitate this where necessary

- Assessments must identify service user strengths, skills and abilities

- Assessments must identify what the service user understands by recovery and what is required to promote it.

- Assessment should take account of service users' beliefs and opinions about their mental health issues and focus on their needs, hopes, aspirations and choices, not just what the service can provide

- Assessments must consider the needs of the service user's family, carers, dependents and/or children

4.4 Assessments of needs should address:

- Capacity
- Psychological, psychiatric, and social needs
- Physical health needs
- Medication and side effect monitoring
- Family roles, including parenting and other caring roles
- Self care and domestic functioning

- Employment, education, and training needs
- Housing / Resettlement needs
- Financial needs, debts and benefits
- Cultural, racial, gender, religious, spiritual and access needs
- Communication needs, language and literacy
- Substance misuse
- Safeguarding children and/or adults
- Statements of wishes or advance decisions

4.5 Specialist assessments may be indicated and/or requested such as:

- Psychiatric assessment
- Activities of daily living assessment
- Psychology assessment
- Carer's assessment
- Vocational needs screening form
- Forensic Risk Assessment

4.6 Assessments should be recorded on the appropriate health and social care assessment form/s for the service.

4.7 Risk assessment will be an integral part of all assessments and will be a continuous process as with all other forms of assessment. Reference should always be made to the Trust's Risk Policy. Risk assessments, using various formats and risk management plans should be completed and form part of the care plan (see below) in partnership with service users and carers. Any risks would normally be shared with service users unless doing so would increase risks to the service user or others.

5.0 Care Planning and Reviews

5.1 Following the assessment and the secondary mental health services are to provide treatment or support, a Key Worker will be allocated to them.

5.2 The Key Worker will develop and agree a care plan with the service user. The care plan (which will be in the form of a letter) will specify arrangements to support the service user in meeting their needs and in managing any risks they pose to themselves or other people. Regardless of whether any risks are identified the care plan must address the outcome of the risk assessment. The Care plan will have made note of all issues that have been identified in the health and social care needs assessment and in accordance with the service user's wishes. It will focus on the service user's strengths, promote recovery and recognise diverse needs arising from cultural and ethnic background, gender, sexuality, and any physical disability or health problem.

5.3 The care plan will be developed by the Key Worker, service user and any carers. Advocates and interpreters should be involved where necessary.

5.4 Service users will be sent or given the care plan letter which will explain who their Key Worker is their contact details of daytime and out of hours services.

5.6. The care plan will be reviewed at least annually during normal appointments with the service user. The review should include consideration of whether the needs of the service user have changed, so that he/she should be on CPA or should be discharged to primary care. Larger and regular review meetings and formal care plans are not appropriate for non CPA service users.

5.7 Please see appendix one for a template care plan letter.

6.0 Discharge and Transfers

6.1 Discharge

6.1.1 Discharge will normally be agreed at the appropriate time such as at the end of the course of treatment or when treatment is no longer required. Where discharge occurs following a final review this will be recorded in the form of a letter to the service user and to the GP.

6.1.2 Discharge from the services can occur where a person decides that they no longer require the service and do not attend. The clinician/professional will consider the circumstances and where necessary consider taking other actions. If no action is required then they will discharge the eservice user and write to both the service user and their GP.

6.1.3 The service user will be given information regarding how to access the services in the future should their needs change. Arrangements will be in place to allow service users who relapse or where the GP needs higher input from secondary mental health services, to be accepted quickly back into the service.

6.2 Transfers

6.2.1 Every effort will be made to ensure that service users are involved as fully as possible in decisions about transfer and discharge. The Key Worker must give ongoing consideration to the need to move the service user to CPA if risk or circumstances change in line with the CPA criteria. Key Workers are responsible for coordinating individual transfers until care is accepted by another professional or service.

6.2.2 Managers and the Key Workers are responsible for facilitating transfer processes and consulting with counterparts to ensure transfers are timely, consistent and well managed.

6.2.3 The transferring Key Worker should write to the receiving professional, enclosing appropriate reports, past care plans and any risk assessment details. Responsibility is not transferred until the receiving professional has accepted the referral in writing.

6.2.4 If a need for increased support is identified, the Key Worker is responsible for; reassessing the level of risk and need, contacting the appropriate manager or professional to request transfer to CPA and allocation of a Care Co-ordinator and ensuring that transfer documentation is updated.

6.2.5 The Key Worker should maintain responsibility for overseeing care arrangements, in co-operation with other teams or professional as necessary, until CPA arrangements are established and a Care Co-ordinator is in place. A CPA planning meeting should be arranged. The key worker should attend the first meeting unless there is formal agreement between the service user, any carer/s and the team accepting CPA responsibility**.**

7.0 Carers

7.1 Anyone identified as a carer for someone receiving care from mental health or learning disabilities services is entitled to be given information about the condition and/or treatment, the risks of the treatment and information about available alternatives.

7.2 Carers should be involved in preparing care plans and providing services, unless the service user withholds consent.

7.3 Similarly carers should be invited to review meetings and be involved in any discussions about the persons care

7.4 Carer involvement should be acknowledged and described in service users' care plans. The role of the Key Worker should be explained to all carers.

7.5 Carers will be given information about 'out of hours' support as well as who to contact in case of an emergency.

7.6 All carers will be informed of their legal right to an assessment of their caring, physical and mental health needs, repeated at least annually; their own written support plan, implemented in collaboration with them and to request a review of their support plan at any time.

7.7 Young carers are children and young people under the age of 18 who provide practical, personal or emotional care to another family member. At times this may involve taking on parenting responsibilities for younger siblings. Young carers should receive adequate support to minimise any adverse effects of their caring responsibilities and to

ensure they have adequate opportunities for education, leisure and friendship, as appropriate to their normal development.

7.8 Where concerns are held for the welfare of young carer a referral will be made to the appropriate Children's Services.

7.9 The following carer's entitlements apply particularly to young carers:

- Workers must ensure young carers have access to carers' assessments so that the full range of their needs is assessed and a support plan offered.
- Key workers should normally undertake this assessment and involve others as needed.
- Assessors need to be aware of services available to young carers locally and provide appropriate information about the service user's condition and about services and support that are available
- Young carers should always have access to crisis numbers both within and out of hours
- Interventions should not reinforce the role of the child as a carer.

8.0 Training

8.1 The Trust is committed to supporting continual professional development of its staff.

8.2 The non-CPA process will be supported by the Trust-wide CPA training programme.

9.0 Referencing Information

Clinical Procedure Number:	
Implementation Date:	
Last Review Date:	
Amendment Date:	
Next Review Date:	
Consultation:	
Date Approved by Executive Team:	
Date Ratified by Trust Board:	