NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

POLICY DOCUMENT

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THE CARE PROGRAMME APPROACH (CPA) POLICY

Mission Statement

This Policy confirms the Trust's commitment to the Care Programme Approach (CPA) in line with Government recommendations to ensure an effective and efficient multi-disciplinary approach to care coordination. It represents the aspiration of North Essex Mental Health Partnership Trust (NEMHPT) to deliver high quality health and social care services for people using mental health services and their carers.

1. Introduction

1.1 The CPA is a model of assessing, planning, implementing/delivering care and then evaluating the effectiveness of that care or intervention. It aims to promote effective liaison and communication between agencies, thereby managing risk and meeting the individual needs to those with mental health difficulties so that they are better able to function in society.

1.2 The term 'service user' will be used throughout this policy to refer to those individuals who receive a mental health service from our Trust.

2. Background

2.1 The CPA was introduced in April 1991 as the cornerstone of the Government's Mental Health Policy to provide a framework for effective mental health care to all service users and carers regardless of age, gender, ethnicity, culture, spirituality, disability or sexual orientation.

2.2 The four main elements of the CPA are:

- **Assessment** - systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services.
- **Care co-ordinator** – the appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care.
- **Care planning** - the formation of a care plan which identifies the health and social care required from a variety of providers, including social activity and/or support accessed by means of a direct payment.
- **Review** - regular reviews and, where necessary, agree changes to the care plan.

2.3 The CPA policy was developed to ensure that CPA is fully implemented across NEMHPT. It is consistent with the "Essex Framework for Implementation of the Care Programme Approach (incorporating Assessment and Care Management) ***November 1999***" which has been accepted by Essex County Council, Essex Strategic Health Authority and both NHS Trusts in Essex providing mental health care.

3. Scope of the Policy

3.1 This policy applies to all practitioners throughout all the Trust's services. It is important to note that the provisions of this policy are mandatory and are not optional for practitioners.

3.2 Whilst the CPA is applicable to all adults of working age in contact with the secondary mental health service, NEMHPT acknowledges that the principles of the CPA are relevant to the care and treatment of younger people through our CAMHS service and to older adults through our older adult teams, thus embraces the CPA process throughout the whole Trust. It should be noted that that there are slight modifications to the CPA documentation for CAMHS.

3.3 The policy endorses that working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3.4 It is the responsibility of all those involved with a service user to keep the care co-ordinator fully informed of all significant changes or events.

4. Principles of the CPA

4.1 The CPA is a person centred approach used to inform partnership working in mental health. This partnership should always include the service user, any carers, the CPA co-ordinator, any health and social care professional and other relevant organisations.

4.2 The CPA is the principal vehicle of care assessment and planning for those service users receiving mental health care. The CPA is aimed at ensuring service users have access to support and services to meet their diverse needs, strengths, preferences and choices.

4.3 This whole systems approach to care planning and delivery promotes care activity across the service user's life domains (including housing, employment, leisure, education and other needs).

4.4 The CPA is an inclusive and dynamic process based on effective communication, appropriate information sharing and negotiation between partners. This negotiation is to draw on available resources to deliver an agreed plan of care, which will provide engagement and involvement from all those involved in the partnership.

4.5 The CPA process draws specifically on the 10 Essential Shared Capabilities (see Appendix 11) which is consensual and valued by service users and carers, is person centred, promotes safety, positive risk taking and recovery through a whole life focused approach.

5. Aims of the CPA Policy

5.1 Ensure service users and their carers are involved in the planning to meet their health and social care, leisure, educational and vocational needs and in planning services which support increased social inclusion and recovery.

5.2 Ensure services are non-discriminatory and promote service delivery sensitive to the needs of all service users and carers regardless of age, gender, ethnicity, culture, spiritual, physical or sensory disability or sexual orientation.

5.3 Ensure consistency in the quality of community care by applying CPA to all referrals accepted by the specialist mental health services.

5.4 Promote good communication and the effective co-ordination of services between all agencies involved in the care of the service user.

5.5 Ensure that health and social care agencies work in close collaboration to assess and manage risk through effective discharge planning and the implementation of care plans. This includes co-ordinated care planning between the mental health services, primary care, prison health care, residential establishments, other statutory services, the private sector and voluntary organisations.

5.6 Make available the option of direct payments to meet social care needs to all those eligible to receive them.

5.7 Enable staff to work in partnership with carers and carer led organisations and other voluntary and statutory agencies.

5.8 Ensure that carers who provide substantial and regular care are offered an assessment, assessed and provided with a separate care plan detailing required support.

6. Referrals to our Services

(Please cross refer to the Appointments Policy and the CareBase Operational Policy, which are available on iconnect)

6.1 NEMHPT receives referrals from a wide range of sources including GPs, local authority social services, the voluntary sector, probation services, police service, carers, family members, neighbours, other organisations, any other professionals (eg district nurse, pharmacist etc) and in some instances, service users may self refer.

6.2 When a referral is received, the receiving team acting as the point of access to services, must enter the referral onto the clinical IT system (Carebase) showing the receipt date.

6.3 All referrals should be assessed to determine eligibility and this may be done through duty screening and/or at pre-allocation meetings.

6.4 The referral allocation process to allocate referrals to an appropriate healthcare professional may take place within the Crisis Resolution and Home Treatment Team or during the Community Mental Health Team's multi-disciplinary referral meeting.

6.5 At the referral meeting, the team and/or team manager will make a judgement as to the nature of the referral and the degree of urgency. This judgement will take into account the best information available to the worker (ie whether the referrer has stated whether the referral is 'routine' or 'urgent').

6.6 Service users must at minimum be given a choice of time and date of appointment and all appointments must be made within the national timeframes, which are set out within the Appointments Policy.

6.7 Where a service user is to see a consultant for their first appointment, all such appointments are made by the Trust's Appointment Centre. During 2007 referrals into the Trust will begin to be received electronically and the Appointment Centre will begin to make all first appointments.

7. The Care Co-ordinator

(For detailed guidance, please refer to the CPA Association Handbook)

7.1 The role of the care co-ordinator is to oversee the assessment process, care planning and resource allocation.

7.2 The appointed care co-ordinator is responsible for:

- providing support to the service user irrespective of setting (ie inpatient unit, residential care, prison etc) by ensuring regular contact and monitoring their progress;
- co-ordinating the formulation and updating of the CPA care plan, ensuring that all those involved understand their responsibilities and agree to them, and ensuring that the CPA care plan is sent to all involved;
- monitoring the delivery of the services and arranging and ensuring that regular reviews with the service user take place;
- supporting the use of direct payments, in a manner agreed with the service user and consistent with the purposes of direct payments;
- arranging the multi-disciplinary CPA review meeting, where the CPA care plan will be reviewed and agreement made for a new CPA care plan to be written;
- ensuring that those entitled to Section 117 aftercare (see Appendix 7 on S117), consideration is given to the continuation or otherwise during the 6 monthly CPA review ensuring that the procedure for S117 aftercare for individual service users is followed and that consideration is given at minimum to the continuation or otherwise during the 6 monthly CPA review;
- ensuring that the service user understands the care co-ordinator role and knows how to contact them and whom to contact in their absence.

7.3 All service users accepted for mental health services will be allocated a care co-ordinator, who will be a qualified and suitably experienced mental health worker from within the multi-disciplinary team. **Note:** An identified care co-ordinator cannot be the name of a professional group or service; it **must be a named individual**.

7.4 The responsibility for ensuring that a care co-ordinator is allocated to a particular case will rest with the **team manager**. He/she will assume the responsibility of the care co-ordinator role on receipt of the referral, until the case is allocated within the team.

7.5 The allocation of the care co-ordinator should take account of:

- the service user's mental health and social care needs;
- the wishes of the service user/carer;
- the particular skills of the health or social care professional (HCP) involved;
- the workloads of the team members-consideration should be given not only to number of clients but complexity of cases;
- availability/accessibility of team member.

7.6 Where a service user receives more than one service and delivery of these services is shared with another service (eg the service user is seeing a CPN and attending the drug and alcohol team), the role of care co-ordinator will be undertaken by the most appropriate worker within the mental health team or the drug and alcohol team, dependent upon the service user's needs.

7.7 Due to the complexity of certain client groups and the co morbidity of their illness (eg those being seen being seen by the eating disorders nurse), such service users should always be **joint worked** with the CMHT. For those seen within the drug and alcohol service, please refer to the Dual Diagnosis Pathway.

7.8 If a change of care co-ordinator is necessary, either within the existing team or to another team within the Trust, the current care co-ordinator can only relinquish responsibility through a CPA review (which can be at the service user's request) and the following process must be followed:

- Once a new care co-ordinator has been identified, all information relating to the CPA care plan will be made available and a review date agreed.
- The date of transfer and the change of care co-ordinator must be entered onto the clinical IT System CareBase ensuring all involved are aware of this.
- At the handover CPA review, the service user's care plan needs to be updated and re-issued to the service user.
- When a service user moves to a different area within NEMHPT and thus requires a change of care co-ordinator, this should take place within one month.
- Any disputes as to who the care co-ordinator is must be resolved in the first instance by team managers. Failing a satisfactory resolution, the operational Associate Directors must intervene and resolve regarding appointing a care co-ordinator.

8. Assessment

8.1 All mental health service users will receive a comprehensive holistic assessment of their mental health and social care needs. This should be carried out by a professionally qualified member of the mental health team and must always include an assessment of risk.

8.2 The agreed Trust wide multi-disciplinary CPA Assessment and CPA Assessment Guidelines should be used. The Assessment must be signed, dated and timed by the assessor and recorded electronically on the service user's electronic clinical record (CareBase) under the CPA assessment module.

8.3 A genogram should form part of the holistic assessment.

8.4 Assessments must identify service users' strengths, skills and abilities and must identify what is required to promote recovery. The assessment should take into account service users' own beliefs and opinions about their mental health issues.

8.5 Assessments of needs should identify all aspects where specific support and further assessments are required, including:

- Psychological/psychiatric
- Physical and medical
- Social functioning
- Self care and domestic functioning
- Employment (vocation) and leisure
- Housing/resettlement
- Finance/benefits
- Cultural/racial
- Religious/spiritual
- Substance misuse
- The needs of children and/or vulnerable adults

8.6 Examples of specialist assessments are:

- Psychiatric (medical) assessment
- Activities of daily living assessment
- Dual diagnosis assessment (refer to the dual diagnosis pathway)
- Essence of Care assessment (see Appendix 9)
- Psychology assessment
- Carers assessment
- Vocational needs assessment
- Forensic risk assessment
- Pharmacy medication review assessment

8.7 There are four assessments within the Single Assessment Process (SAP) – please refer to Appendix 12 for full details of the four assessments.

8.8 The Community Care Act 1990 imposes a duty on Local Authorities to carry out an assessment of need for community care services with people who appear to them to need such services, and then having regard to that assessment decide whether those needs call for the provision of services by them. This is referred to as a Community Care Assessment.

8.9 Assessments for service users presenting with complex needs should take account of physical, sensory, cognitive, behavioural and social care needs, and eligibility for social care provision against these needs must be assessed against the Fair Access to Care Services (FACS) framework.

8.10 If following the CPA assessment, the person is deemed not to require any further intervention from our mental health service; they should be discharged from CPA back to the referrer.

9. Risk Assessment

(*Please refer to the Trust's Clinical Risk Management Protocol)*

9.1 Risk assessment is an essential and ongoing part of the CPA process and there must be a specific assessment of the level of risk posed to self and/or others using the Trust's approved risk assessment tool.

9.2 Risk assessments should take into account all the available information from the service user and other sources, such as GP, carers, family members, other professionals and agencies who have knowledge of the individual.

9.3 All members of the multi-disciplinary team have a responsibility to consider risk assessment and management as a vital part of their involvement and to record those considerations.

9.4 Risk assessments should include an estimation of the degree of risk presented in respect of:

- aggression/violence;
- child protection;
- hazards;
- neglect;
- self harm;
- suicide;
- vulnerability; and
- adult protection.

9.5 Risk assessments must always be signed, dated and timed and must be recorded electronically on CareBase and communicated to colleagues on a need to know basis.

9.6 A service user's key life events should be identified as part of the risk management plan.

9.7 The outcome of the risk assessment must form the basis of a clear risk management plan, which forms part of the CPA care plan.

9.8 The assessment of risk is a continuous and ongoing process which should be considered on an individual basis. It is particularly important whenever a review takes place, or an individual's circumstances change, (eg through admission to an inpatient unit or on discharge), to consider the risk implications to self and others and address accordingly through the CPA care plan.

9.9 Risk assessments must be reviewed at each CPA review and a written record made. All those involved with the service user can contribute to identifying any risk issues and events. All risks **must** be shared with all professionals involved with the service user.

9.10 A risk assessment must be carried out at least six monthly, irrespective of the stability of the individual's situation.

10. Internal Referrals

10.1 All internal referrals to another team/service within our Trust must be to a named individual and should be accompanied by the following:

- CPA referral, outlining the reasons for referral to that service;
- The CPA assessment;
- Up-to-date assessment of risk.

10.2 If a referral made using the clinical electronic record (CareBase), communication must be made from the referring team to the receiving service/team to advise them that a referral has been made. The receiving team must acknowledge receipt of an internal referral and advise the referring team of the plan of action.

11. Levels of CPA

(Please refer to Appendix 2 for a definitive guide to standard and enhanced CPA levels for all service users, including a CAMHS CPA reference sheet).

11.1 The two levels of CPA: **Standard and Enhanced** are designed to meet different levels of need, which are dependent upon the outcome of the service user's assessment.

11.2 Service users placed on **standard CPA** are likely to:

- require the support or intervention of one agency or discipline;
- require low key support from more than one agency or discipline;
- be more able to self manage their mental health problems;
- have an active informal support network;
- pose little danger to themselves and/or others;
- maintain appropriate contact with services; and
- need some vocational support.

11.3 Service users placed on **enhanced CPA** are likely to:

- have multiple care needs, including housing, occupation etc, requiring inter-agency coordination;
- be only willing to co-operate with one professional or agency, but have multiple care needs;
- require more frequent and intensive interventions from specialist mental health services;
- have mental health difficulties co-existing with other difficulties such as substance misuse;
- be at risk of harming themselves and/or others; and
- disengage from services.

11.4 Service users admitted to an **inpatient** setting under a Section of the Mental Health Act will automatically be placed on **enhanced** CPA.

11.5 Service users admitted to an **inpatient** setting informally will automatically be placed on **enhanced** CPA (unless the clinician records reasons for a level of standard CPA to apply).

11.6 Service users in **residential care** will automatically be on **enhanced** CPA in line with Royal College of Psychiatrists recommendations.

11.7 Individual clinical judgement may indicate **enhanced** CPA for children and younger people being seen by the Child and Family Consultation Service.

12. Planning the CPA Care Plan

12.1 Once the CPA assessment has been completed and the service user's needs have been determined, the care co-ordinator, in conjunction with the service user, will develop the overarching the CPA care plan.

12.2 The CPA care plan should be agreed with the service user and must be expressed in a clear and jargon free language. It is a record of the service user's needs (it must recognise the diverse needs and preferences of services users, reflecting their cultural, and ethnic background, their spiritual care needs, as well as their gender and sexuality), and should focus on service user's strengths and seek to promote their recovery.

12.3 The CPA care plan must clearly specify the interventions, actions and responsibilities from all contributing individuals or disciplines involved in the service user's care, including descriptions of components of care to be provided by what agency/professional (these could include: support systems; contact with GP; outpatient appointments; day hospital services; psychological therapies; probation; advocacy; or other care provisions). Contact details (including telephone numbers) of all involved, how the care will be met and the frequency must all be recorded in the CPA care plan.

12.4 The CPA care plan must take account of any risk to the service user, their carer, any worker involved in delivering the plan, and the wider community and incorporate a plan for the management of risk as identified through the risk assessment process.

12.5 Any unmet needs/service deficits should be discussed and recorded on the CPA care plan with an action plan to resolve.

12.6 The CPA care plan must be recorded electronically on CareBase, thus making it available to all those involved with the service user.

12.7 A copy of the CPA care plan must be given to the service user to keep. At this time the CPA care plan should be signed, dated and timed by the service user, the care co-ordinator and if applicable a carer.

12.8 A care plan can be provided to an external agency (please refer to the Trust's leaflet "Your health records – How we look after them and who can see them").

13. Contingency Plans

13.1 Contingency plans attempt to prevent a crisis developing by detailing the arrangement to be used at short notice, for example the care co-ordinator is not available, a service user feels they are approaching a crisis, or part of the care plan cannot be provided,

13.2 The contingency plan should include the information necessary to continue to implement the care plan in an interim situation, for example telephone numbers of service providers, or contact details of substitutes who have agreed to provide interim support.

13.3 The contingency plan must be based around the individual circumstances of the service user and be formulated as part of the CPA care plan.

14. Crisis Plans

14.1 A crisis plan is an explicit plan of action that must be implemented should a crisis occur. Crisis plans may set out the action to be taken based on previous experience, if the service user becomes unwell, or their mental health rapidly deteriorates.

14.2 Crisis plan arrangements must be formulated within the CPA care plan and should include:

- Early warning and signs of a crisis (relapse indicators).
- Key life events (the anniversary date of the loss of a loved one, physical illness, loss of a job etc) which may trigger a relapse.
- Services available and how these can be accessed in a crisis.
- Who the service user has the best relationship with and how to contact that person.
- Previous strategies which have been successful in working with the service user.

14.3 Crisis plans must ensure that all service users know how to contact the service out of hours. Carers, family members and significant others should know who to contact when a crisis occurs at all times.

15. Crisis Cards

15.1 All service users and/or their carers must be given a crisis card as part of their care plan.

15.2 The crisis cards are two credit card size cards in a plastic wallet. One card has space for the servic1e user to write their instructions as to whom to contact to support them in a crisis. The other card contains emergency helpline numbers.

15.3 Advance decision – there is space on the crisis card for the service user to indicate anything they would like taken into account in a crisis.

15.4 It should be noted that crisis cards are for **service users and their carers only** and should not be handed out to members of the public.

16. Advance Decisions *(Please refer to the Advance Directives Policy on Iconnect)*

16.1 An advance decision is where the service user has indicated their preferred treatment choice or anything they would like taken into account if they become unwell. The CPA care plan must indicate whether the service user has an advance decision, and if one is in existence, it should be electronically recorded on CareBase.

17. Care Plan Folder

17.1 A care plan folder should be given to all service users. It is a useful folder in which the service user can keep a copy of their CPA Care Plan and also to help keep information about their care in one place.

17.2 The sort of information service users may wish to keep in the folder is:

- the CPA care plan;
- clinical/specialist care plans;
- A5 information leaflet on CPA;
- A5 crisis information leaflet;
- crisis card in a plastic wallet;
- appointment letters, letters about service user's care;
- information leaflets about support groups/advocacy services/children visiting & information for children and young people and their parents, carers and relatives, where appropriate.

18. Specialist/Clinical Care Plans

18.1 Within the umbrella of the CPA care plan, there should be a specialist/clinical care plan for all care being received from our service (there could be several specialist/clinical care plans, eg day hospital service, drug and alcohol team, psychology etc).

18.2 Clinical/specialist care plans will be discussed and agreed with the service user and will include:

- assessed needs;
- plans/goals;
- implementation/action required;
- evaluation date.

18.3 The role of the care co-ordinator is to co-ordinate the various specialist/clinical care plans to ensure they are reflected in the overarching CPA care plan. All those involved with specialist/clinical care plans must ensure that their specialist/clinical care plans are available at the time of the CPA review.

19. Consultant Care Plans/Copying Letters to Patients

(Please refer to the CPA page on iconnect for full details on Consultant Care Plans)

19.1 The initiative to copy clinicians' letters to patients is part of the Government's policy to increase patients' involvement in their care and treatment, and all letters written from one doctor to another doctor should be copied to service users as of their right.

19.2 For those service users who are seen only in the outpatient clinic, the letter written to the GP by their consultant/doctor following their outpatient appointment will constitute their CPA care plan. The Trust have developed a standard "care plan" letter for this purpose.

19.3 The consultants are responsible for explaining the CPA process to all service users during the outpatient appointment.

20. CPA Reviews

20.1 At the time the CPA care plan is produced, the date of the CPA review must be agreed and set, with the service user, which should be within the maximum timescale of **six monthly intervals** for all service users. The planned CPA review must be recorded electronically on CareBase.

20.2 A CPA review takes place in order to review the CPA care plan, evaluate the effectiveness of the interventions contained within the care plan, reassess the service user's needs, consider reassessment of risk factors and update the crisis and contingency plan. For those entitled to Section 117 aftercare (see Appendix 7 on S117), consideration must be given to the continuation or otherwise.

20.3 A CPA review can be called by the service user or anyone else involved in the service user's care, but must take place whenever there is a change of care co-ordinator or when the service user is being discharged from CPA.

20.4 The responsibility for arranging the CPA review lies with the care co-ordinator. The date, time and venue of the review should be negotiated with the service user who must be consulted and agree to the presence of those invited. The care co-ordinator must give adequate notice/invitations (using the Trust's recognised CPA review invitation letter) to all those involved in the care.

20.5 A record of all present at the review and apologies received should be recorded. If key people are unable to attend they should provide an up-to-date report of their involvement, concerns and recommendations.

20.6 A service user's personal details (ie marital status, address, GP, carer, next of kin etc) must be checked at the time of the CPA review to ensure that they are still valid to take account of any changes.

20.7 All attending the meeting (including the service user/carer) should have an opportunity to give their views. A list of recommendations should be drawn up and the new CPA care plan formed. All parties involved in their care must receive a copy of the care plan, even if they were unable to attend the review.

20.8 The planned date for the next CPA review should be agreed and this must be recorded electronically on CareBase.

21. Multi-Disciplinary Professional Meetings

21.1 It may be necessary on occasions to hold a multi-professional meeting to discuss and decide on the management of service users who may present with a complex or difficult case to manage, which could result in unacceptable levels of risk should there be differences of opinion within the multi-professional group.

21.2 Operational Associate Directors must ensure that a multi-professional meeting is convened to deal with any such cases.

22. Carers Assessment Procedure

22.1 Standard Six of the National Service Framework for Mental Health, Caring about Carers, states that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; and
- have their own written care or support plan which is given to them and implemented in discussion with them.

22.2 Carers need to know what to do in a crisis and be assured that prompt action will be taken. Assessing carer's needs and enabling access to appropriate information and support is an integral part of best practice in working with service users and their families and other support networks.

22.3 Carers have the right to an independent social care assessment of their own needs and must be offered this as a matter of course. If this is declined this should be recorded on both the Carer's Assessment/Review Form and electronically on CareBase under patient next of kin details.

22.4 Should the offer of a Carer's Assessment be accepted, the assessment should be undertaken as soon as possible. It is usually appropriate for the person most in contact with the cared for person and family (usually the service user's care co-ordinator or another practitioner from the same CMHT) to facilitate the assessment. Additional support for the carer can also be provided by a friend/advocate.

22.5 When a Carer's Assessment is undertaken, the date and outcome must be logged on CareBase under patient next of kin details. The outcome of a Carer's Assessment or Review falls under one of the following three services:

- Breaks for carers;
- Other specific carers services;
- Information and advice.

22.6 It should be noted that in the case of CAMHS, the needs of carers are sometimes incorporated within the CAMHS CPA Assessment.

23. Inpatient Care and the CPA Process

23.1 **Essence of Care Assessment**- A member of the multi disciplinary team will be responsible for ensuring that an initial assessment, including a physical health assessment using the "Essence of Care Assessment" (see Appendix 9), is carried out on all service users admitted to inpatient units. As part of the physical health assessment, it is mandatory that the service user's BMI (body mass index) is taken and recorded, in addition to their current smoking status.

23.2 **Ward Stay Care Pathway Checklist** - Arrangements for discharge from hospital should be initiated as soon as the service user has been admitted to hospital. The "Ward Stay Care Pathway Checklist" (see Appendix 10) must be completed during the service user's admission. The Ward Stay Care Pathway Checklist and the Essence of Care

Assessment begin the process of discharge planning and will identify the needs of service users and their carers that will require some form of intervention when the service user is discharged.

23.3 **Named Nurse** - The primary or named nurse (often referred to as the key worker) is a registered nurse who has the responsibility, in conjunction with the care co-ordinator, for co-ordinating the care for an inpatient or a day care attendee. In day care settings, this role may also be undertaken by qualified occupational therapists who may take on some or all of the responsibilities and be known as the individual's key worker.

23.4 When a service user is new to the service in an inpatient setting, as there will be no previously assigned care co-ordinator, the named nurse (key worker) will assume the care co-ordinator responsibilities (ie the assessment and the development of the care plan) during the admission period. The named nurse should liaise with the relevant CMHT team leader (or in the case of CAMHS the CAMHS Liaison Team) to identify a **potential** care co-ordinator and this should be organised within 48-72 hours post admission.

23.5 When a service user is known to our service and there is an existing care co-ordinator in the community, during the inpatient episode, the care co-ordination duties will remain the responsibility of the existing care co-ordinator, however, some of the duties may be taken on by the named nurse/key worker who will work collaboratively with the existing care co-ordinator (they must ensure that the care co-ordinator is aware of the admission and liaise closely with them during the service user's stay in hospital).

23.6 **Home leave during inpatient stay -** Whenever home leave is planned prior to discharge, the care co-ordinator should always be informed of this so that appropriate arrangements may be made, as required. For home leave, a clinical/specialist care plan should be completed by the ward.

23.7 **Day leave/Planned absence -** It is the responsibility of the team manager to inform the care co-ordinator of appropriate leave and planned absences from the ward.

24. Discharge from Inpatient Care

24.1 Care co-ordinators must meet face to face with ward staff and the consultant psychiatrist to develop and agree the discharge plan, taking into account the needs of the service user and their family/carer's wishes. It is the responsibility of the care co-ordinator (in conjunction with the ward and others involved in the care package) to oversee all arrangements for discharge.

24.2 Discharge ward meeting/CPA review - Ward staff on the inpatient unit must communicate with care co-ordinators in the community to alert them of discharge from the ward.

24.3 **Discharge care plan/Revised CPA care plan** - On discharge from the inpatient unit, all service users must have a current and coherent discharge care plan that includes any changes in need or circumstances that were not considered or included in their previous care plans. The discharge care plan must include details of follow up.

25. Follow up Post Discharge

(When S117 applies please see section 35 & Appendix 7)

25.1 For service users who have been at high risk of suicide during the period of admission, **a face to face** follow up must be within 48 hours of discharge (please see below for further details).

25.2 For all other service users discharged from the inpatient unit, **a face to face** follow up must be made within 7 days of discharge.

25.3 Follow up must be recorded electronically on the IT clinical record (CareBase).

25.4 In addition to the above face to face follow up, a follow up telephone call must be made within 48 hours of discharge by the ward manager or by a delegated clinical member of staff to all services users discharged. This call **MUST** be recorded electronically on the IT clinical record (CareBase).

Discharge of high risk service users

25.5 The period around discharge from hospital is a time of particularly high risk and therefore effective follow up is paramount. Care plans for service users deemed to have been at a high risk should include more intensive provisions for the first three months after discharge and a specific crisis plan must be put into place.

25.6 Care plans must take into account the heightened risk of suicide in the first three months after discharge and make specific reference to the first week. Service users who have been at high risk of suicide during the period of admission are followed up within **48 hours of discharge** by an agreed member of the clinical team. Assertive outreach teams have been established to prevent loss of contact with vulnerable and high risk patients (*Extract taken from NIMHE Suicide Prevention toolkit*).

26. CRHT

(Please cross refer to the Operational Policy for CRHT for full details)

26.1 The Crisis Resolution and Home Treatment Team (CRHT) has been established to provide a 24 hour service to respond to a crisis in the community/service user's home, which could, by assessment and intervention, avoid inpatient admission. Also this service provides support to service users in their home after an inpatient episode, specifically aimed at reducing the length of the inpatient admission period and to promote recovery.

Existing service user

26.2 When an existing service user is referred to the CRHT Team, it is the responsibility of the CRHT to inform the existing care co-ordinator of their involvement as soon as possible. This is most important because the existing care co-ordinator remains responsible for the care co-ordination. CRHT Team will construct and implement an appropriate care plan in response to the crisis and/or home treatment assessed needs of the service user and ensure the care co-ordinator is kept updated.

26.3 It is good practice to ensure the care co-ordinator is involved in the care planning and reviewing whilst the service user is under the care of CRHT. This ensures an integrated approach and helps prevent confusion in roles and delayed discharges from CRHT.

26.4 CRHT Team must inform the existing care co-ordinator of the service user's discharge from their service, with as much prior warning as possible. The care co-ordinator remains the same unless a CPA review takes place.

New service user

26.5 When a new potential service user is referred to the CRHT Team, an assessment will be carried out and should that person not require further intervention from our service, they should be discharged following assessment (DFA).

26.6 If following assessment, treatment is offered, the assessor will assume care co-ordination until such time as this responsibility is allocated to the another care co-ordinator, as appropriate.

27. Safeguarding Children

(Please refer to the NEMHPT Safeguarding Children Folder for further information)

27.1 The safeguarding of children is integral to the effective assessment and management of risk. The impact of parental mental illness on children and young people can be considerable. The interests of children are paramount, even where the adult service user is the client.

27.2 Where clinicians identify that a child *may* be at risk of significant harm, confidentiality must be breached and a referral made to Social Care and/or the Police.

27.3 Consultation is always available regarding the safeguarding of children either from the Associate Director of Safeguarding Children & Vulnerable Adults on [I/S] or out of hours from the inpatient adolescent unit Longview on [I/S].

28. Vulnerable Adult Protection

(Please refer to the NEMHPT Vulnerable Adult Protection Folder for further information)

28.1 All service users of NEMHPT aged 18 and over, are, by definition vulnerable adults (No Secrets, 2000).

28.2 Where it is identified that an adult service user may be being abused, at risk of significant harm, and in need of protection, consideration should be given to implementing adult protection procedures.

28.3 The service user must be informed about "vulnerable adult protection procedures" and where appropriate an assessment of capacity must occur and be documented; this is particularly important should the service user choose to remain in an abusive situation.

28.4 Consultation is available regarding the protection of vulnerable adults from the Associate Director of Safeguarding Children & Vulnerable Adults on [I/S].

29. Family Group Conference (FGC)

29.1 FGC is a method of involving service users and families in the decision making process. Families are defined within the FGC process as significant people to the service user (eg close family members, friends, neighbours or other member of the community who play a significant role in the service user's life). FGC is essentially a care planning tool based on the belief that service users and families know most about their difficulties. FGC helps the care co-ordinator to build upon existing family, friendship and community networks to facilitate the CPA process. A Family Plan is produced which highlights the service user's objectives and how family members can contribute to the outcome.

29.2 FGC has proved to be an effective way of care planning for people who suffer from mental ill health and their families. From the initial pilot project FGC has proved to strengthen support networks and improved communication. The process is particularly effective in developing advance directives, or living wills. Service users and families say they are more informed about the nature of the difficulties and are able to provide more effective support. Early warning signs are better identified and addressed, in some cases preventing hospital admissions.

29.3 FGC should be considered as part of the CPA process where a service user and their support networks want to be involved in the decision making process around care and treatment options.

29.4 Please consider FGC on all new patients to our service, admissions to hospital under the Mental Health Act, and when transferring cases from CRHT to the CMHT.

30. Electronic CPA (CareBase)

(For full details on usage of CareBase and any successor system, please refer to the CareBase Operational Policy and Guidelines, the Health and Social Care Records Policy and the Trust Data Quality Policy)

30.1 NEMHPT use CareBase as its primary recording instrument for all service user clinical activity, this includes all the elements of CPA, ensuring the availability of a contemporaneous and comprehensive care record. (The principle of comprehensive data entry will also apply to any successor systems to CareBase).

30.2 It is a mandatory requirement that all NEMHPT employed and seconded clinicians and practitioners record all data and events, including those which relate to CPA. All events must be entered onto CareBase immediately, when possible, but always within two working days of the event taking place. This important action ensures secure access to information by relevant staff 24 hours, 7 days a week which minimises risk to both service users and staff.

30.3 There must be consistency between the electronic record on CareBase and the paper held record in the Health and Social Care case notes (ensuring all entries are named, dated & timed).

30.4 The following components make up the electronic clinical record:

- Master Patient Index (MPI):
  Registration screen for recording service users personal demographic details
- External referral
- Existence and tracking of case notes
- Name of care co-ordinator
- CPA level
- CPA services
- Assessments
- CPA care plan
- Advance directive
- Family plans
- Internal referral
- CPA reviews
- Risk assessment/management
- Physical health
- CPA unmet needs
- Carers assessments
- HoNOS
- Events/Appointments in all care settings
- Discharge from CPA

30.5 All data recorded on CareBase will be used to assess the teams' and the Trust's performance and facilitates the population of the Mental Health Minimum Data Set (MHMDS), as required by the DoH.

31. **Confidentiality**

(Please cross refer to the NHS Confidentiality and Information Sharing Policy which is in line with NHS code of practice)

31.1 The service user will need to be informed at their initial assessment that information that is collected about them may need to be shared with other Trust staff, in particular the rest of the multi disciplinary team involved in providing care or services to them.

31.2 Additionally, on occasion, it may be necessary to share information about service users with health and/or social care professionals outside of the Trust. Only information that is relevant to any particular instance will be shared. It is important that service users are aware of this fact. It should be noted that for older adults there is a Sharing of Information Agreement Form which should be completed with the service user at the time of assessment).

31.3 There are other occasions when it may be necessary to share patient confidential information with agencies external to health and consent from the patient is not always needed to do this. To help service users, carers or relatives understand when this might happen, staff should refer them to the Trust information booklet ("Your health records: How we look after them and who can see them") which are available in information racks across the Trust or from the Customer Care Services Department at Trust Headquarters Stapleford House.

31.4 Should staff require further guidance with reference to information on confidentiality issues, please see Appendix 14 “Trust Policies”. Alternatively you can contact the Customer Care Services Department at Trust Headquarters on [I/S] for advice.

32. Service users who decline involvement with CPA (&S117 Aftercare)

32.1 Should a service user refuse to engage with the services then every effort needs to be made to ascertain the reasons why and address any concerns raised This should be promptly discussed within the CMHT and communicated to the GP.

32.2 An assessment of the risks that the service user presents will be undertaken and plans made accordingly. Where there are serious concerns regarding the safety of the public, liaison with the Police and the Probation Service may also be appropriate in certain circumstances.

32.3 For service users on Section 117, Section 7 or Section 25 of the Mental Health Act, the care co-ordinator, in consultation with the team, will instigate a formal review with all professionals involved. For service users who are not subject to MHA legislation every reasonable effort should be made to maintain contact and re-negotiate a new care plan.

32.4 In all cases, an action plan will be formulated following discussion within the CMHT and where appropriate family members and/or carers should be consulted/informed. The action plan should state how often an attempt to make contact/visit will take place, ie an attempt to offer an outpatient appointment every three months. The action plan will be clearly documented in the service user’s health and social care record. It should be noted that carers are still entitled to an assessment of their needs regardless of the fact that the person they care for has declined services.

33. Transfer of Care between Mental Health Organisations

33.1 The transfer of service users between teams within our Trust must only be carried out once a joint CPA review has taken place and all parties involved are fully informed. A recording of any changes must be made electronically on CareBase.

33.2 For transfer of service user care between Mental Health Organisations, please see **Appendix 6 “Good Practice in the Transfer of Service User Care between Mental Health Districts**”, which is the CPA Association’s recognised good practice guide.

34. Discharge from CPA

34.1 When a service user is discharged from CPA following their CPA Review, this must be recorded electronically on CareBase and their package of care should be completely closed down.

34.2 The service user is discharged from CPA when:

- The service user no longer requires specialist mental health services and is discharged to the care of his/her GP.

- The service user leaves the area and is discharged to the care of services in the new area (see Appendix 6 – CPA Association Good Practice in the Transfer of Service User Care between Mental Health Districts).
- The service user declines further intervention from specialist mental health services and is not at risk of harming themselves or others or at risk of exploitation.
- The service user has lost contact with the service for not less than 6 months and despite every effort, contact has not been resumed (please refer to the Appointments Policy).

35. Aftercare under Section 117 of the MHA (see Appendix 7)

35.1 All service users who fulfil the criteria for S117 will be included, ie those who have been detained in hospital under Sections 3, 37, 47 or 48 of the Mental Health Act (MHA) 1983.

35.2 The purpose of aftercare is to enable a service user to return to their home or community accommodation from hospital and to minimise the chance of them needing any future inpatient hospital care. Service users subject to S117 will not be charged for services which are provided for the purpose of aftercare.

35.3 Such aftercare will be provided until both health and social care services are satisfied that the individual is no longer in need of such services; no specific time limits apply. Although there is a duty to provide this aftercare, there are no powers of compulsion and these service users do have the right to refuse aftercare should they so wish.

35.4 At each CPA review meeting, the appropriateness of Section 117 aftercare continuing must be considered. (NB: The service user does not have to be an enhanced level of CPA when S117 applies).

36. Supervised Discharge

36.1 From April 1996 an amendment to the MHA included a provision for supervision of mentally disordered patients in England and Wales who, on leaving hospital after detention for treatment (under S3, 37, 47 and 48) receive aftercare services under S117.

36.2 Section 25(a) Mental Health Act 1983 – This Section applies to mentally disordered people who have a history of repeatedly failing to comply with treatment plans in the community and as a result have been readmitted to hospital. It allows for certain requirements to be prescribed in their care plan. Only the Responsible Medical Officer (RMO) can make an application for Supervised Discharge, which must be supported by an Approved Social Worker (ASW) and another medical recommendation. It also requires the appointment of a community RMO and community supervisor.

36.3 The Supervised Discharge period is initially for six months, renewable for six months and for periods of one year thereafter. Only the community RMO is responsible for renewing or terminating the Supervised Discharge.

37. Guardianship (Section 7 of the MHA 1983)

37.1 The purpose of Guardianship is to enable a person to receive community care where it cannot be provided without the use of compulsory powers. It provides an authoritative framework with limited constraint in circumstances where a care plan alone is insufficient and can be a useful way of assisting with independent living for people aged 16 and over who meet the criteria (see S7of the MHA). It has also been useful for those who because of their mental disorder may be vulnerable to exploitation, ill treatment or neglect.

37.2 Guardianship offers powers to require the person subject to it to reside at a place specified by the guardian, to require attendance at places and times for the purpose of medical treatment, occupation, education or training and to allow access to the person subject to it to be given at any place where the person is residing, to any registered medical practitioner, approved social worker or person specified. There is no power to compel medical treatment and it does not by itself allow control over a person's property or finances. The guardian can be either the local social services authority or any other person, though the local authority will consider the suitability of any proposed guardian before accepting the application.

37.3 Discussions about the possible use of guardianship should take place with an approved social worker, consultant social work practitioner or associate director, social care and an application would normally commence with an approved social worker's assessment and a case discussion involving the multi-disciplinary team. Applications beyond this stage are then coordinated through the associate director, social care and are considered by the responsible senior manager with delegated authority from ECC for the approval of ECC guardianship applications.

38. Direct Payments and Mental Health

38.1 The aim of direct payments is to promote independence and aid social inclusion. The purpose of a direct payment is to give service users more control over their own lives. It is an alternative to mainstream social care or carer provision.

38.2 A direct payment is a cash payment which enables the flexibility for service users to choose and arrange their own support to assist them in engaging in, for example, employment, education, leisure activities etc, as well support with personal, domestic and daily living needs. It allows service users and professionals to be creative with the type of support that the service user needs. For example, one service user opted not to attend day services and preferred the money that would have been used to fund her in day services, in the form of a direct payment, to fund her taking up horse riding.

38.3 Since April 2003, it has become mandatory for care co-ordinators to offer people, assessed as eligible to need community care services, the opportunity of having all, or part of their support via direct payments. The assessment for direct payments is based on the same eligibility criteria used for assessing any other community care service (eg Fair Access to Care is the national framework for categorising client need into critical, substantial, moderate and low). Once assessed as eligible, the care co-ordinator needs to go to panel to receive approval for the direct payment package.

38.4 Direct payments can be made on a regular basis or for a single purchase depending on need. It can be used flexibly and the service user will decide how the money will be used to meet their assessed need, as detailed in the care plan.

38.5 If the service user requires support to set up the direct payment then there are support services available: The Direct Payment Support Service, Independent Living Advocacy Service and Essex Pass.

38.6 Direct payments can also be made to carers to support them in their caring role; these are non-means tested.

38.7 There are some people who are excluded from receiving direct payments. These are people who are subject to a court order or legislation, including certain sections of the Mental Health Act 1983.

38.8 Should staff require further guidance with reference to direct payments, please contact [I/S], Consultant Social Worker on [I/S].

39. Advocacy

39.1 Service users are entitled to the help of an Advocate through the independent voluntary organisation of the Advocacy Service. Mental health advocacy exists to safeguard the rights of those who use mental health services where they maybe vulnerable.

39.2 Advocacy is taking action to help service users express their views, needs and wishes, secure their rights, represent their interests and obtain services they need. Advocacy promotes social inclusion, equality and social justice,

40. Independent Mental Capacity Advocacy (IMCA) Role

40.1 The IMCA Service was created in the Mental Capacity Act 2005.

40.2 An IMCA is someone appointed to support and represent a person who lacks capacity (possibly because of mental health needs, dementia, learning disability or brain injury), who is also faced with certain decisions about serious medical treatment and long term care moves.

40.3 A person with mental health needs who has no friends or family and who cannot communicate through language will have an IMCA to make representations about their wishes, feelings, beliefs and values.

41. CPA Information across the Trust

41.1 The Trust wide CPA Steering Group meet bi-monthly to discuss CPA issues and share good practice relating to all aspects of CPA, both locally and on a national level. In addition, there are locality CPA groups which interrelate with the Trust wide CPA Steering Group.

41.2 Information on CPA, the CPA Steering Group and who to contact across the Trust is available on the designated CPA page located under Groups on the Trust's internal iconnect site.

42. Audit of the CPA Process

42.1 All teams across the Trust participate in the CPA and health & social care records audit. The audit examines the quality of care provided to service users within the framework of CPA, both in its paper format and electronically.

42.2 Team managers should ensure that any shortfalls found during auditing are addressed immediately with their staff through 1:1 supervision and during that staff member's performance and development review (PDR).

42.3 Audit data is collated centrally by the Trust's CPA/SAP Co-ordinator and is monitored by the Trust wide CPA Steering Group. The audit report is presented to CNST (Clinical Negligence Scheme for Trust) during their annual visit.

43. Staff Induction, CPA Training and Supervision

43.1 All new staff to the Trust will receive an induction to CPA as part of their mandatory Trust induction programme.

43.2 All clinical staff must attend a mandatory one day training course on CPA/Clinical Risk Management every three years. Training courses are held every month in Chelmsford, Colchester and Harlow (course dates and how to book are available on the CPA page on iconnect).

43.3 Team managers will ensure that all members of the team have access to clinical supervision facilities. The nature and extent of supervision will need to be agreed between the team managers and the individual in accordance with Trust policy and guidance on clinical supervision. (Please refer to the Managerial and Supervision Policy for further guidance).

Appendix 1

Glossary of Terms

Abbreviations	Full Title
ASW	Approved Social Worker
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Service
CDAT	Community Drug & Alcohol Team
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
CPA	Care Programme Approach
CPAA	CPA Association
CRHT	Crisis Resolution Home Treatment
CRMO	Community Responsible Medical Officer
FACS	Fair Access to Care Services
FGC	Family Group Conference
GP	General Practitioner
HCP	Health Care Provider
HoNOS	Health of the Nation Outcome Scales
IM&T	Information Management and Technology
IT	Information Technology
MHA	Mental Health Act
NHS	National Health Service
NTA	National Treatment Agency
NEMHPT	North Essex Mental Health Partnership
NSF	National Service Framework
PCT	Primary Care Trust
RMO	Responsible Medical Officer
SAP	Single Assessment Process

The following list provides some examples of terminology frequently used within the Policy:

Care Programme Approach
The Care Programme Approach (CPA) is the cornerstone of the Government's mental health policy, and is designed to support the implementation of the community care in a way which provides well-thought out and properly documented care plans, based on the needs of service users. The Care Programme Approach is a framework within which different professional and agencies can work together in a properly co-ordinated way for the benefit of service users.

CPA Care Co-ordinator
A CPA Care Co-ordinator is the person appointed to be responsible for co-ordinating the care plan for each individual service user and everyone else involved, for monitoring its progress and for staying in regular contact with the service user and everyone else involved. A CPA Care Co-ordinator can come from a variety of different professional backgrounds. It is also the role of the CPA Care Co-ordinator to convene a meeting to review the care plan if circumstances change or if there is any cause for concern about how things are working out.

Service User
Staff use these terms relatively interchangeably across health and social services. The term "client" is usually more commonly used by staff within social services and the voluntary agencies, particularly in reference to someone with social needs. The term "patient" tends to be

used exclusively by health service staff. The term “service user” is increasingly used in order to de-stigmatise individuals. These terms have a particular meaning despite their frequent substitution for each other.

Carer
Sometime the terms formal and informal carers are used, formal referring to those who are paid, whether professionally qualified or not, and informal to those who are members of families or neighbours or friends, who are unpaid. An informal carer is someone who provides regular and important assistance/support to a service user. (A relative who visits weekly, but does not offer any support/assistance, say in carrying out daily living skills, is not a carer; in contrast, a friend who does provide regular support/assistance is also a carer). Carers are now entitled to have their own needs assessed. In situations where a service user is unable to express his or her own needs, the carer might be the most appropriate person to provide information, and to act as the service user’s advocate. The involvement of carers is always subject to the consent of the individual service user.

Someone who looks after another person, usually an adult, who is frail and/or dependent because of physical or mental disabilities, can be described as a carer whether or not they acknowledge this title. An informal carer refers to someone who is not paid to provide care (although they may get a Carers Allowance), and the activities involved are more than might be expected of everyday family relationships. Carers can be anyone – neighbours, friends, or family members providing such support and for who a substitute would be necessary should the carer be unable to continue support.

RMO
Responsible Medical Officer is a term used to describe the Consultant Psychiatrist involved in the care and treatment of service users detained under the Mental Health Act.

CRMO
For those service users whose care is supervised under Section 25a of the Mental Health Act (1983) this role is termed Community Responsible Medical Officer.

CareBase
NEMHPT use CareBase as the clinical IT system to record CPA electronically.

Multi Disciplinary Teams
Each team is comprised of a number of professionals from both health and social services backgrounds and may include:

- consultant psychiatrist;
- other medical personnel i.e. staff grade, senior house officer (SHO);
- psychiatric nurses;
- clinical psychologists;
- occupational therapists;
- mental health social workers (who may also be an ASW);
- senior practitioners;
- cognitive behavioural psychotherapists;
- support workers and STR workers;
- psychiatric nursing assistants;
- accommodation officers.

Appendix 2

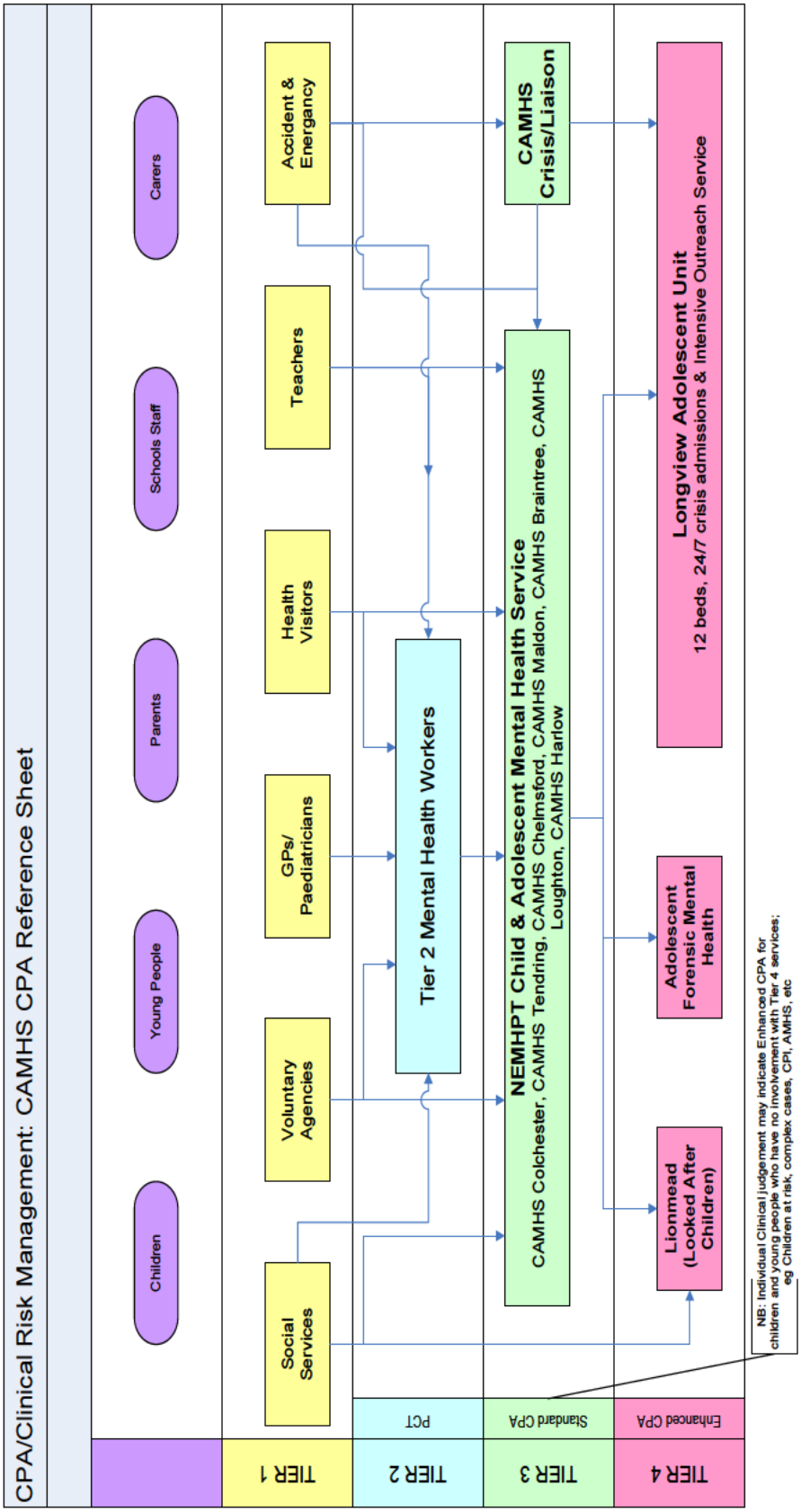
Criteria for Placing on Enhanced CPA

Category	Criteria	Individual Criteria Met (Tick)	Number of criteria in group to meet	Group Criteria met (Tick)
Severe and Enduring Mental Illness (SMI)	• Primary diagnosis of SMI or severe personality disorder		At least two	
	• Significant social dysfunction			
	• Complex and multiple care needs (housing, occupation, finance) requiring inter-agency input			
	• Require long-term support with care co-ordination			
	• Care package needed			
	• Joint working required with tertiary services(s) (rehabilitation, eating disorders, forensic, neuro-rehabilitation)			
	• Early intervention or Crisis Resolution Home Treatment Team input required			
Characteristics	• Passively engaging or negative symptoms		One or more	
	• Poor concordance with medication			
	• Poor collaboration with care plan			
	• Chaotic lifestyle			
	• Self neglect			
	• Dual diagnosis (substance misuse or learning disabilities or personality disorder or mentally disordered offender)			
Inpatient Admission	• Admission to inpatient unit		Either or none	
	• Residential Homes			
Admission History	• Past admission(s)		Any or none	
	• Admissions sometimes compulsory			
	• Subject to S117			
Risk Factors	• Relapse		One or more	
	• Substance misuse			
	• Risk of self harm or suicide			
	• Violence towards others			
	• Informal carers at risk of violence			
	• Self-neglect			
	• Protection of children or vulnerable adults			
	• Social isolation			
	• Vulnerable to exploitation			

Criteria for Transfer from Enhanced to Standard CPA

Category	Criteria	Individual Criteria Met (Tick)	Number of criteria in group to meet	Group Criteria met (Tick)
Severe and Enduring Mental Illness (SMI)	• Diagnosis of SMI or severe personality disorder stabilised or resolved		At least 5 for standard All 7 for GP	Remain Enhanced Standard GP
	• Social dysfunction improved			
	• More able to manage care needs (housing, occupation, finance)			
	• Require only low-key support or a single worker			
	• Care package not usually needed			
	• Joint working not required with tertiary services			
	• Early intervention or Crisis Resolution Home Treatment Team input not required			
Characteristics	• Likely to remain engaged appropriately		At least 4 for Standard All 6 for GP	Remain Enhanced Standard GP
	• Adequate concordance with any medication			
	• Reasonable collaboration with care plan			
	• Reasonably organised lifestyle			
	• Able to self care			
	• Dual diagnosis (substance misuse or learning disabilities or personality disorder or mentally disordered offender) now well managed			
Admission History	• Admission frequency reduced		2 for either	Enhanced Standard GP
	• Any admissions briefer			
	• Admissions usually informal			
Risk Factors	• Relapse – less probable and likely to seek help		At least 6 for Standard All 9 for GP	Remain Enhanced Standard GP
	• Substance misuse – under reasonable control			
	• Risk of self harm or suicide – sufficiently reduced			
	• Violence towards others – little danger			
	• Informal carers at risk of violence – unlikely			
	• Self-neglect – not anticipated			
	• Protection of children or vulnerable adults – unlikely to be an issue			
	• Social isolation – better networks in place			
	• Vulnerable to exploitation – better protected			
Future Needs	• Specialist monitoring of medication not needed		All 4 for GP	Enhanced Standard GP
	• Administration of Depot by CPN no longer needed			
	• On balance could be managed by GP safely			
	• No longer requires Section 117			

CAMHS CPA Level – Reference Sheet



Appendix 3

Managing Service Users on a Clinical Waiting List

Introduction

This protocol is designed for managing service users who have needs identified under CPA and are awaiting treatment/assessment from another Trust service.

Policy

Following the assessment appointment the assessing clinician (care co-ordinator) will complete the following:

1. CPA assessment.

2. Risk screening.

3. Care referral to the service identified as required for the service user.

4. The assessing clinician's (care co-ordinators) CPA care plan will be completed to include:
   - 4.1 what service they have been referred for;
   - 4.2 name of the care co-ordinator until treatment commences (see 10 below);
   - 4.3 emergency contact details; and
   - 4.4 estimated waiting time or time to review,

5. The CPA care plan will be given to the service user.

6. The GP will be informed of the assessment and the current care plan.

All of the above will be completed using the current electronic clinical record (CareBase).

7. A crisis card will be issued to the service user.

8. The assessing clinician (care co-ordinator) will now complete the initial assessment, but the Care Programme Approach will remain open and the individual remains on CPA.

Role of the Care co-ordinator

9. The care co-ordinator will be appointed in accordance with both the Trust CPA policy and recommendation from National Guidance.

10. The care co-ordinator can be either the initial assessor or the Team Manager of the assessment team.

11. The care co-ordinator will retain the overall responsibility of the following:
    - a) the contact person for the service user on the waiting list and their GP;
    - b) to ensure that the CPA care plan is managed and reviewed in accordance with CPA practice;
    - c) to ensure that the CPA care plan continues to be appropriate and effective for the individual service user.

Appendix 4

1. Mentally Disordered Offenders and CPA

CPA applies to Mentally Disordered Offenders regardless of setting. Where service users are the shared responsibility of Mental Health and the Criminal Justice systems, close liaison and effective communication over care arrangements are essential. Such cases are liable to be complex and to require interagency liaison. Practitioners are advised to refer to relevant NEMHPT policy on information sharing. In addition, reference to the 'Offender mental health care pathways' document, available on the DoH prison health website, is recommended

2. Protocol for Providing Continuity of Psychiatric Care for People entering and Leaving Custody

2.1 The primary responsibility for the treatment and care of people in custody is with the Healthcare Service for Prisoners (HCSP), which provides primary care services to prisoners. For those prisons with secondary care prison mental health in-reach teams, care of mentally disordered offenders assessed as requiring such services will be provided by these teams.

However, regardless of which organisation provides a service, its functions include identifying the need for aftercare on release, which will be provided by local general or forensic services, according to the following protocol. The local service responsible will be determined according to the patient's home address, or if homeless, the district where the offence was committed, or the location of the court initially hearing the case.

Persons Entering Custody

2.2 **Those already known to mental health services -** The responsible consultant and CPA care co-ordinator should ensure that adequate information as to treatment and current care plans are provided to the relevant Primary Health Care Prison Team for that treatment to continue while the patient is in custody. This is likely to indicate the type of aftercare which may be required, and a named contact (e.g. care co-ordinator, consultant or CPA co-ordinator) with whom to make arrangements for release.

2.3 **Persons not in psychiatric care at time of arrest, but such need is identified during the trial process -** While there is no formal guidance on the responsibility of the psychiatrist and criminal justice mental health team preparing court reports, good practice requires that if the report indicates the need for psychiatric interventions, the person preparing the report should ensure that assessment and report is communicated to the relevant primary care prison team. Where that assessment is likely to lead to transfer from prison or a psychiatric disposal at court, the psychiatrist should assist the relevant primary care prison team in facilitating this process.

2.4 Persons in Custody

The nature and composition of mental health services within individual prisons varies according to local arrangements. However, a specialist secondary care psychiatric service should be available in all establishments; either as a multi-disciplinary In-Reach team or by means of a visiting Consultant Psychiatrist and/or mental health practitioner.

- When the primary care prison team identifies a prisoner in need of specialist secondary psychiatric treatment, they will refer to the specialist prison mental health service.

2.5 NEMHPT Clinical Teams' Responsibilities

- The Prison Mental Health In-Reach Team of HMP Chelmsford, as a service of North Essex Mental Health Partnership Trust, is responsible for providing a secondary care service that ensures that appropriate liaison on the care of mentally ill prisoners takes place, in order to ensure continuity of care, particularly around discharge from prison, for those individuals requiring input from NEMHPT mental health services.

- Where a prisoner was cared for within the CPA framework immediately before they entered the prison system, care co-ordinators and the HMP Chelmsford In-Reach team are jointly responsible for ensuring that links are maintained between the service user's care co-ordinator, the HMP Chelmsford Healthcare team and the Trust's In-Reach team during the service user's time in prison. The existing Care Co-ordinator retains this role throughout the period a service user remains in custody.

- On occasions, inmates originating from the North Essex area who are engaged with NEMHPT services will be held in other prisons. It is the responsibility of the identified Care Co-ordinator to maintain links with the patient by means of liaison with the relevant prison primary and / or secondary care team. Particular attention should be given to CPA reviews and planning for release.

2.6 Visits and Care Planning meetings

- The care co-ordinator should alert the In-Reach team and HMP Chelmsford Healthcare team of the individual's sentence or remand to custody as soon as possible. The care co-ordinator should make enquiries with the Court Clerk during the course of court proceedings to determine where the individual is to be held. If it is a prison other than HMP Chelmsford, then that Prison's Healthcare / Mental Health In-reach team should be appraised of relevant health and risk information by the care co-ordinator.

- If the service user is sentenced or remanded for a significant period, the care co-ordinator should visit every three months. Wherever possible Care Planning meetings should occur within the custodial environment with the service user in attendance.

2.7 Release Arrangements

- The care co-ordinator should keep themselves aware of likely release dates in order that they can co-ordinate care on release and should arrange to visit two weeks prior to release.

- For out of area prisoners, the HMP Chelmsford In-Reach team provide a supportive service whilst in HMP Chelmsford, but ultimately care goes back to their respective area on release. The In-Reach team will seek to identify the local mental health team and inform them of relevant health and risk information, making referrals as appropriate.

2.8 Persons in custody requiring transfer to hospital

- In some cases where need is identified, a visiting Consultant will make a decision that an inmate requires transfer to hospital. The Consultant will also make an assessment of risk, which will indicate the level of security that will be required on transfer to hospital.

- The relevant Prison primary care team will refer to the relevant local service providing the level of security that assessment indicates is required, and it is expected that service will accept referral by the Prison primary care team when this has been recommended by a visiting Psychiatrist.

- That service will make such assessment as is necessary to enable the transfer to occur. As a target it is expected that this assessment will be made within ten working days in a local prison, but this may be longer for a more distant prison.

2.9 Onward referral to Forensic Services

On occasions, inmates who are assessed as requiring transfer to hospital will be also be identified as requiring conditions of security of a medium or high secure nature. In such instances, the prison primary care team will contact the relevant Forensic Services, which in the case of patients from the North Essex area will be Runwell Forensic Services. Arrangements for a forensic psychiatric assessment will then be made.

3. Patients referred to forensic service judged to be manageable in local service

- The forensic consultant team will make an assessment on request and will provide a recommendation as to the required level of security. Where this is to be Psychiatric Intensive Care of Low Secure Accommodation, they will contact the relevant local service according to the patient's area of residence.

- In the event of a disagreement as to the level of security required the two consultants will liaise to agree a treatment plan identifying the responsibilities of each service. It is the joint responsibility of the two consultants to agree such a plan.

- In the event of an appropriate bed not being available, the local team's senior clinician will contact the relevant Strategic Health Authority to require authorisation for the use of a PICU or Low Secure bed elsewhere. It is expected that the Health Authority will appoint a single named officer to deal with the case in accordance with local bed management protocols.

- The local team's senior clinician will be responsible for liaison with the accepting unit to facilitate speedy transfer to an appropriate NHS unit.

4. Patients judged to require hospital admission close to release date

- The preceding plan possibly requires two separate NHS teams to assess the patient (forensic and general psychiatry). When there is inadequate time to allow this the ultimate responsibility for arranging aftercare or a bed is with the initial NHS team to see the patient in custody.

- If a bed is not located at the time of release it is expected that the local (General or Forensic) team dealing with the case will advise the HCSP about most appropriate action to take.

Appendix 5

CPA and Substance Misuse Services

1. Substance Misuse Services are overseen nationally by the National Treatment Agency for Substance Misuse, an Independent Special Health Authority. There is a separate National Service Framework for Substance Misuse, and in Essex most services are commissioned separately from Mental Health services by the Essex Drug and Alcohol Action Team.

2. The model of Assessment and Care Management operated by Community Drug and Alcohol teams conforms to the overall requirements of CPA, but differs in a number of important details in order to comply with the requirements for the National Treatment Agency (NTA). There is an agreed Essex wide referral and initial assessment pathway which embraces statutory and non statutory services to ensure provision of seamless services to people with Substance Misuse difficulties.

3. The most significant difference between CPA for Adults of Working Age and the NTA process is that substance misuse services are organised offering a tiered delivery of services.
Tier 1 is the general information and advice offered by non specialist agencies and workers.
Tier 2 services In Essex are delivered mainly by the non-statutory sector, but the Trusts teams do provide some services at Tier 2.
Tier 3 services are provided mainly by the Trusts CDAT teams and address the needs of people with complex difficulties, including those who need substitute prescribing, have comorbidity with mental health difficulties, are pregnant, or have other high risk needs.
Tier 4 services are specialist residential or inpatient facilities**,** usually accessed via assessment by Tier 3 services

Assessment
A two tier assessment process is in place; all people in Essex referred to either statutory or non statutory substance misuse services receive an initial Tier 2 assessment to determine the best place from which to receive their services. Tier 2 assessment satisfies all the minimum requirements of CPA, but where individuals are accepted for service by the Trusts CDAT teams a full (Tier 3) assessment will be made, which incorporates all of the wider requirements of CPA together with other aspects required by the Essex DAAT and the NTA.

Documentation
The Trust Substance Misuse CPA documentation differs from that in mental health, in order to fulfil the requirements for single system working in substance misuse services. It does, however fulfil all the requirements for enhanced CPA.

4. Transfer of Clients from CDATs to Mental Health Services

The Tier 3 assessment and care management process conforms in all ways to the requirements of CPA, and where a patient or client is transferred between services it is not necessary to initiate a completely new assessment. A CPA meeting and review will normally be sufficient. This does not prevent further assessment of particular needs or aspects of care as may be appropriate from time to time.

Appendix 6

cpaa
Care Programme Approach Association
Walton Hospital, Whitecotes Lane, Chesterfield. S40 3HW
Tel: [I/S] Fax: [I/S]
Email: cpa.association@chesterfieldpct.nhs.uk

Good Practice in the Transfer of Service User Care between Mental Health Districts

1. Introduction

It is the responsibility of health and social care agencies to collaborate effectively to ensure proper, co-ordinated care is delivered to people with mental health needs. Each district Local Authority Social Services Department and Health Trust jointly operates a Care Programme Approach Policy to ensure a robust systematic framework for the care and treatment of people with mental health needs in line with department of Health Guidance.

Whilst the detail of local CPA policies may differ, the core principles will be the same. A key objective of the CPA is to ensure individuals most in need of care do not slip through the met of service provision. Where service users move from one district to another there is the potential for interruption in the continuity of care and treatment. This has been highlighted in a number of Inquiries in to Serious and Untoward Incidents.

This protocol reflects principles of good practice in transferring service user care between districts.

The following guidelines are proposed to support these principles.

2. Planned Moves

2.1 Service users who move out of one area to another remain the active responsibility of the original authority until a formal hand over can be arranged.

2.2 The decision to transfer responsibility for the care of a service user to another district should take place in a CPA review meeting, unless exceptional circumstances prevent this. The service user should be encouraged to register with a GP in the new area as soon as possible.

2.3 This Review should include consideration of the risks associated with the move, and a judgement made about whether the service user will make contact themselves with services in the new area, or whether this will be carried out by the original Care Co-ordinator.

2.4 Appropriate representatives of the receiving district should be invited to contribute to the Review by attending the meeting or by other means if this is not possible e.g. the proposed new Care Co-ordinator, RMO, Social Services where care management responsibility issues are involved, and Section 117 or other statutory issues, e.g. Guardianship, Section 25, Sex Offender registration or Public Protection.
A timescale for implementing the transfer should be drawn up.

2.5 The transferring Care co-ordinator should ensure that complete and accurate records are made of the discussions surrounding the move, and that the following has been agreed before transfer:

2.5.1 The receiving team / service have identified a new Care co-ordinator who accepts responsibility for them.

2.5.2 Appropriate services have been set up with the receiving team / service to meet the needs before the transfer takes place, where possible.

2.5.3 Effective communication has taken place and detailed information has been made available to the appropriate professionals in the receiving team / service.

2.6 Detailed information should include:

2.6.1 Assessment of need, including risk assessment, clearly identifying the nature, complexity and content of risk.
2.6.2 CPA level.
2.6.3 Legal status.
2.6.4 Care Plan, including crisis and contingency plans, risk management plan where this exists, including indicators of relapse.
2.6.5 The transferring care co-ordinator should document the information has been sent on the patient's file.

2.7 Timescale

The receiving district should acknowledge transfer of Care co-ordinator responsibility within fourteen days of receipt of documentation.

2.8 Informing the Service User and Others

The transferring Care co-ordinator should write to the service user, carer, where appropriate, and GP confirming the transfer and giving contact details of the new receiving Care co-ordinator. Details should be entered on both the transferring and receiving mental health services databases.

2.9 Contingency Arrangements

Arrangements should be in place to ensure a system of rapid transfer back to the original system if the patient moves back to the originating district. In this case, ideally, the original Care co-ordinator and team should resume responsibility for patient care, where possible, based on level of need, risk, availability etc.

The principles of information sharing, and ensuring that arrangements for receiving the service user is in place should be followed by the transferring area.

3. Unplanned Move

3.1 Some service users will move in an unplanned way between districts. Where this is very local, and the original district is aware of this, it should continue working with that patient, if this is possible within service resources, until formal handover arrangements described above, can take place.

3.2 Where the move is at some distance and it would be impracticable for the originating district to do this, then background information should be sent immediately to the new district and discussion should take place between the teams at the earliest opportunity to effect formal handover.

The above should be based on team-based consideration of risk factors relevant to the particular service user concerned, weighing the necessity to pass on information against the user's right to confidentiality. Such deliberation should be appropriately recorded on the user's record for future reference.

4. Service Users who go Missing from Services

4.1 Some service users, for various reasons, may lose touch with services; this may include moving to another district.

4.2 Where a client seems to have gone missing from services there is a duty of care to make all reasonable efforts to locate them to negotiate arrangements for their care and treatment. Actions to achieve this should be clearly recorded.

4.3 The Care co-ordinator should contact other members of the care team, including any Carers and relatives where appropriate, and other known associates to try to locate the client and to offer support and monitor their well-being.

4.4 The Care co-ordinator should initiate a CPA review as soon as the service user loses contact with services to share information and determine action based on an assessment of the risk caused by the person disengaging. Clear recording of this should take place. Use of the National Tracing Service may assist in checking their location via GP registration.

4.5 It will be necessary to take into account the patient's current mental state, previous history, potential and actual risk to self or others, the likelihood that the person has left the local area, and the other available support networks, in order to plan intervention.

4.6 Where a level of risk to the service user or to others is identified, appropriate judgements should be made about the breadth and depth of circulation of personal information within the local and/or non-local areas.

4.7 Local response

4.7.1 The Care co-ordinator, after discussion with their line manager, will make the locally appropriate out of hours mental health and other services e.g. Accident and Emergency, Social Services, aware of the person's details.

4.7.2 Where there is concern that the person may be at risk, or poses a risk, the Police should be contacted with a description of the person and the concerns surrounding their well-being.

4.8 Non-local response

4.8.1 Where it is suspected that a person might be located in another mental health service area, then the Care co-ordinator should consult the manager in his or her own mental health service that acts as the point of contact for distributing and receiving Missing Persons Alerts, and follow the appropriate course of action.

4.8.2 It is expected that each mental health service, in discussion with their SHA, will arrange for there to be a known point of contact in the service for consultation about sending out Missing Persons Alerts to non local areas. This person will agree with the Care co-ordinator, the appropriate level of information and spread of circulation, and assist in identifying points of contacts in other areas.

4.8.3 If a patient is located in a new district the receiving Care co-ordinator should seek advice in their service about making contact with the originating district to cancel the Missing Person's Alert, and should themselves effect a formal hand over of care as described above.

5. Role of the CPA Office or equivalent

The CPA Office, or equivalent, may become involved in the process of relocation or responding to missing persons depending on local arrangements. This may involve, for example, assisting in decision making if the case is problematic, providing advice about points of contact in other mental health services, and processing Missing Persons Alerts.

6. Prisons

Communication of information regarding prisoners with mental health problems should be made in line with this protocol.

7. Review of arrangements

It is proposed that these guidelines are formally reviewed through the national Care Programme Approach Association, the ADSS Principal Officers Group and the Zonal meetings.

Acknowledgements
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(November 2004)

North Essex NHS
Mental Health Partnership
NHS Trust

South Essex Partnership NHS
NHS Trust

Procedure for Section 117
After-care under the Mental Health Act 1983

Issued: March 2004

Reviewed: November 2005

(Please note that the Section 117 procedure is likely to be reviewed during the summer of 2007. Given that this is ahead of the next scheduled review of the CPA Policy, an addendum specifically relating to this section will be made).

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Section 117 : After-Care under the Mental Health Act 1983

The Mental Health Act 1983, Section 117 states:-

"(1) This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under section 37 above, or transferred to a hospital in pursuance of [a hospital direction made under section 45A above or] a transfer direction made under section 47 or 48 above, and then cease to be detained and [(whether or not immediately after so ceasing)] leave hospital.

(2) It shall be the duty of the Primary Care Trust and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the Primary Care Trust or and the local social services authority are satisfied that the person concerned is no longer in need of such services[; but they shall not be so satisfied in the case of a patient who is subject to after-care under supervision at any time while he remains so subject.]

[(2A) It shall be the duty of the Primary Care Trust or to secure that at all times while a patient is subject to after-care under supervision—

(a) a person who is a registered medical practitioner approved for the purposes of section 12 above by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder is in charge of the medical treatment provided for the patient as part of the after-care services provided for him under this section; and

(b) a person professionally concerned with any of the after-care services so provided is supervising him with a view to securing that he receives the after-care services so provided.

(2B) Section 32 above shall apply for the purposes of this section as it applies for the purposes of Part II of this Act.]

(3) In this [section "the [Primary Care Trust or] Health Authority" means the [Primary Care Trust or] Health Authority, and "the local social services authority" means the local social services authority, for the area] in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained."

1.0 Introduction

Section 117 of the Mental Health Act 1983 (MHA) places upon Health Authorities and Local Authorities a statutory duty to work together to provide after-care services for all patients who leave hospital having been detained in hospital under a treatment section of the MHA (i.e. Sections 3, 37, 47 and 48). The duty to provide aftercare includes patients who are subject to these sections and who have been given Section 17 leave (Code of Practice 27.3). The duty also applies to people who have been detained under the relevant Sections but then remain as a voluntary patient before leaving hospital. This duty is not to be interpreted only in general terms i.e. through the county-wide provision of services for mentally ill people in general, but individually i.e. the after-care needs of each individual to whom Section 117 applies must be considered and met. People subject to Section 117 may be managed by other specialisms whilst the Mental Health services will provide consultancy and specialist advice. Health Authorities should now be understood to mean Primary Care Trusts (PCTs) or Care Trusts who have taken over most of the funding and commissioning responsibilities of Health Authorities. (Refer to paragraphs 6-9 below.) "Aftercare services" are not defined in the Act. There is

discretion with regard to the appropriateness of the provision to meet individual need AND to prevent readmission to hospital in the foreseeable future (see 4.3).

2.0 Implementation of Section 117

2.1 In practice since all mental health services, within the two Partnership Trusts, are provided within the framework of the Care Programme Approach (CPA), it is through CPA that after-care under Section 117 is provided.

2.2 Patients entitled to statutory after-care under Section 117 should have their needs assessed and clarified as part of the CPA process. "Before a decision is taken to discharge or grant leave to a patient, it is the responsibility of the RMO to ensure, in consultation with other professionals concerned, that the patient's needs for health and social care are fully assessed and the care plan addresses them. If the patient is being given leave for only a short period a less comprehensive review may suffice but the arrangements for the patient's care should still be properly recorded (Code of Practice 27.5)." The needs assessment and any discussion and/or agreements should be written up fully in the patient's notes. Their needs should be considered at CPA Care Planning meetings as would be the care needs of any other patient. The differences should be that: -

2.2.1 contributors to the CPA process should be aware of the patient's Section 117 status and the additional statutory duty to provide aftercare services that this entails.

2.2.2 all the patient's needs should be considered carefully identifying which needs should be met as a means to prevent further admissions to hospital and those which should be met as part of any previous care package that will not affect their continued living in the community.

2.2.3 the CPA Care Plan should therefore indicate very clearly which services are being provided under Section117.

2.2.4 any care package for a patient, including residential and non-residential services, should be drawn up in awareness of Section 117 rights and responsibilities.

3.0 Charging for Services

3.1 The major difference between patients subject to Section 117 and others is that the statutory duty to provide after care to patients on Section 117 means it is not lawful[1] to charge for services provided to them as part of an aftercare package designed to support the patient in the community AND prevent readmission to hospital in the foreseeable future due to mental disorder and associated problems.

3.2 Whilst this does not directly affect NHS provision within the Partnership Trusts, since NHS services are provided free at the point of use, it does make a significant difference to the services the Trusts manage on behalf of Local Authorities whose services can be charged for, subject to means tests. It must be clear then, and is accepted by the Local Authorities that NEMHPT and SEPT work with[2], that Local Authorities must waive their

[1] See HSC 2000/003 LAC (2000) 3 Point 2. issued 10th Feb. 2000. This considers a legal judgement involving four local authorities, later upheld at the Court of Appeal and again in the House of Lords, clarifying the unlawfulness of charging for residential services for Section 117 patients and indicating that there is a 'strong implication' that other services may not be charged for.
[2] Essex County Council, Thurrock Unitary Authority and Southend Unitary Authority

normal charges for any services patients are receiving under S117 for as long as the service continues to be provided under Section 117 (see below 4). This should be taken to apply to both residential and non-residential services.

3.3. The full implications for charging arrangements within Local Authorities and the Department for Work and Pensions are necessarily outside of the scope of this procedure and are a matter for the charging authority. However the following should be noted:

3.3.1 Care co-ordinators involved in a CPA package for a Section 117 patient should, where any Local Authority commissioned or provided services are involved (whether or not these services are arranged/ managed by the Trusts) ensure that the Local Authority Finance Department is aware of the patient's legal status and that after-care services cannot be charged for.

3.3.2 The Trusts' Patients Welfare Officers and care co-ordinator, or equivalent, where involved, should ensure that the application of Section 117 to a patient is written on claim forms sent to the local Benefits Agency when any claim for means-tested benefits is made.

3.3.3 Even though someone is eligible for Section 117 aftercare there may be occasions when they are charged for a service if they are no longer assessed as needing it e.g. someone who is assessed as no longer needing residential care but who refuses to move from it could be charged. (In this situation the residential care would no longer be provided as a S117 aftercare service).

3.3.4 The provision of after-care services under Section 117 should not be confused with providing for the essentials of life, such as food, clothes, accommodation, heating etc. These remain the responsibility of the individual except in the very special cases where accommodation, heating etc., are provided as part of a residential placement and are an inseparable part of the placement.

4.0 Review of Section 117 aftercare services

4.1 Section 117 makes it a duty for Health Authorities (now PCT/ Care Trusts) and Local Authorities to jointly provide after care services for patients who have been subject to a treatment section (as defined in 1.0 earlier), and to continue to provide aftercare services for as long as the patient is in need of them. Once the person is no longer in need of any aftercare services they can be discharged from Section 117 and their exemption from any charges will therefore cease to apply. (For guidance on "patient is in need" see 4.3. below). It will also be possible to determine on review that the patient is no longer in need of some, rather than all, the S117 aftercare services being received as part of an aftercare package. In this case it must be made clear to the service user at review which services will no longer be provided under S117, whether they are eligible and meet priority criteria for provision of these services under other legislation, and any charging implications for the services continued under legislation other than S117.

4.2 Discharge from Section 117 is therefore of importance. Decisions about discharge should be individual ones based on the circumstances of a particular case and will normally be taken as part of the CPA process.

4.2.1 It follows that the Care co-ordinator under CPA will have a particular responsibility for considering the need for continuation of services under S117 and the question of discharge from Section 117 and bringing it to the attention of the multi-disciplinary team at CPA reviews. The actual decision to discharge from CPA will normally be made by the full multi-disciplinary team.

4.3 There may be occasions when patients continue to receive services under CPA but because of a substantial improvement in and stabilisation of their mental health no longer receive services under Section 117 (a service can continue to be provided under a different legislative framework but the person is no longer “in need” under S117). Examples where this may apply include when all of the following are met:-

- The patient has become stabilised in the community, and they continue to receive a level of support from the Partnership and other Local Authority services in accordance with services they received before detention in hospital under section 3.
- This has continued for a reasonable period of time – any decision to discharge S117 should not be implemented for at least 8 weeks after becoming established in the community.
- There is no foreseeable need for readmission bearing in mind the reasons for the original admission to hospital.

On this basis it may be concluded that the provision of a service which is likely by then to be a greatly reduced level of service such as depot medication/periodic attendance at psychiatric outpatient clinics has ceased to be after-care as such i.e. that the service is no longer to follow-up hospital care and prevent readmission in the foreseeable future but has become continuing community care without reference to the need for readmission to hospital.

4.4. Any such decision to discharge a patient from service provision under Section 117 must be:-

- Discussed fully with the patient, carer and nearest relative so that their views are taken into account in a CPA review.
- Jointly agreed by the multi-disciplinary team, including the responsible Consultant and signed off by the CPA care co-ordinator. The CPA care Co-ordinator has the authority to sign off both the health and social care duties and obligations under Section 117.
- Recorded in writing, including the names of those taking the decision and the reasons for the decision.
- Recorded on CPA documentation and in the clinical notes including not just the decision but the reasons for the decision.
- Communicated verbally and in writing to the patient, as part of the CPA process.
- Followed up with the patient with information and explanation about how it will affect their right to care/benefits and any implications in respect of charging for any services which might continue to be received but not under S117.

4.5. Someone discharged from Section 117 can only come back under its provision if they are re-admitted to hospital under a treatment section of the MHA.

4.6. No one can be discharged from Section 117 if they are still subject to Section 25 (Supervised Discharge).

4.7. No one can be discharged from CPA if there are continuing assessed needs under Section 117.

5.0 Register of Section 117 Patients

5.1 A Register of Section 117 patients will be kept by the Trusts and this will form a sub-set of the electronically recorded data maintained on CPA. This means that the Mental Health Minimum Data Set for CPA will always identify whether a patient is subject to Section 117.

5.2 Entry to the Section 117 Register will, therefore, be through the CPA Care Plan.

5.3 Removal from the Section 117 Register will be through the CPA Review Form (*see 4.0 above*).

5.4 Audits of CPA documentation will be carried out regularly. This will include whether Section 117 status is recorded appropriately and that the care plan clearly shows which services are provided under S117 and which are not.

6.0 Local Authority Responsibilities

6.1 So far as local authorities are concerned, s117(3) provides that:

"local social services authority" means the local social services authority for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained"

It is important to note that neither s.117 or the MHA provide for a system of dispute resolution between social services authorities, in default of agreement, as is provided for under the National Assistance Act 1948 (resolution by Secretary of State – see para. 24 of LAC 93(7)) where responsibility for payment is an issue. Though this guidance deals principally with the National Assistance Act 1948 and specifically refers to the statutory regime under that Act it is good practice that local authorities take account of it when considering residence questions under s.117.

6.2 In the context of s.117, LAC93(7) states:

"Authorities should note in particular that the provision of services for individuals requiring social services should not be delayed because of uncertainty about which authority is responsible and that when an individual does not appear to have any settled residence, it is the responsibility of the authority of the moment to provide any residential care required to meet their needs."

6.3 A similar same point is made at Part 1 para.3 of the same guidance

"If there is a dispute about the ordinary residence of a person in need of services it should be debated after the care assessment and any provision of service".

6.4 Paragraphs 12 and 13 deal with the then law on "ordinary residence". Paragraphs 22 to 24 deal with section 117 MHA. Reference is made at para.24 to AMA.ACC Guidance from October 1989. Paragraph 24 goes on to state:

"For effective application, it is also implicit in the care programme approach that health and social services authorities are able to co-operate and agree an appropriate provision."

6.5 Following the case of R v Mental Health Review Tribunal ex parte Hall [1999] guidance was issued under LAC 2000(3) in February 2000. The relevant parts of the guidance are set out below.

The guidance provides:

"5. This judgment concerns a restricted patient who was granted a deferred conditional discharge by the Mental Health Review Tribunal (MHRT). One of the conditions set by the Tribunal was that the patient should not return to where he lived before admission to hospital. The judgment confirmed that the health and social services authorities where the patient was resident at the time of admission to hospital have legal responsibility for providing after-care under section 117.

6. If the patient has no current residence when admitted to hospital, the authorities for the area where the patient must reside as part of his/her conditional discharge have responsibility for providing after-care under section 117(3).

Implications of Judgment

7. A patient who was resident in an area before admission to hospital does not cease to be resident there because of his/her detention under the Act. If a patient with ordinary residence in one area is sent to another area on discharge, it is the responsibility of the health and social services authorities in the area where the patient was resident before admission to make the necessary arrangements under section 117. However, where a patient does not have a current residence, the responsibility for providing after-care under section 117 falls to the health and social services authorities covering the area to which the person is sent on discharge. When a patient is conditionally discharged, the Tribunal may send the patient to an area by imposing a residence condition.
Points for Action

8. Guidance in the revised Mental Health Code of Practice makes clear that where section 117 applies and there is to be a hearing of the MHRT, the "responsible authorities" should prepare an after-care plan under section 117 and submit this to the Tribunal.

9. Where a patient is discharged to an area different from that where he/she was resident at the time of admission, the "responsible authorities" may need to purchase services in that area. They should inform the health and social services authorities in the receiving area of the arrangements made for the patient's after-care.

10. LAC 93 (7) on "Ordinary Residence" provides guidance to local authorities on ordinary residence. Guidance for Health is provided in a booklet "Establishing the Responsible Commissioner" (Oct 2003).

Practical application

6.6 The facts of individual case always need to be considered but the following questions are useful so far as local authority responsibilities are concerned:

a) Was the client resident in the area of a social services authority prior to admission to hospital? If they were, residence in hospital will not have prevented this authority retaining responsibility and it will retain it, even if the client is placed outside the local authority's area, until the "receiving" authority accepts responsibility.

b) As noted above there is no formal mechanism for deciding the point at which responsibility under s.117 will pass to the "receiving authority" though the fact that a person can be regarded as "ordinarily resident" in the receiving area will be a relevant consideration.

c) Alternatively, was the client lacking a residence anywhere at the time they entered hospital, in which case, according to Scott Baker J in *Hall,* the "local authority of the moment" needs to be identified and may, in the initial period at least, be responsible rather than the "receiving authority", if different.

7.0 Partnership Trust Responsibilities

7.1 Local Authorities are jointly responsible with Health Authorities (now PCTs/ Care Trusts) for the provision of aftercare services under Section 117. This is managed by the North and South Essex Partnership Trusts in close liaison with the Essex PCTs and Essex, Southend and Thurrock Social Services.

7.2 Partnership Trusts and other Local Authority services therefore need to ensure that all of their Practitioners, as necessary, are available and willing to participate in CPA/Section 117 care planning meetings.

7.3 Partnership Trusts and other Local Authority services also need to ensure that any services identified as necessary for a particular patient on Section 117 are provided when those services are within the remit of the PCT and Local Authority to commission.

7.4 Partnership Trusts on behalf of local authorities need to provide an adequate mechanism so that patients who have right under Section 117 are not charged for services for as long as the Section 117 is deemed to be in place.

7.5 Decisions to end the Section 117 status of services for a particular patient are joint Health and Social Care decisions and the procedure included in section 4 must be followed.

8.0 Co-operation with Voluntary Agencies

8.1 Section 117 specifies the duty of Health Authorities (now PCTs/ Care Trusts) and Local Authorities to provide after care services under Section 117 in co-operation with relevant voluntary agencies.

8.2 The voluntary sector therefore have a responsibility to co-operate with the provision of services where they fall within the agreed remit for a particular voluntary organisation.

8.3 It may be that particular services for which the Health Authority (PCT) or Local Authority has responsibility are in practice contracted for with a voluntary organisation. These services could therefore be provided under Section 117 by the Voluntary Sector.

9.0 Strategic Health Authority Responsibilities

9.1 The Strategic Health Authority needs to satisfy itself that Trusts and PCTs/ Care Trusts providing mental health services discharge the responsibilities identified for them in this procedure. It needs to monitor that Section 117 is working for the patients under its responsibility and that local services have mechanisms for:-

- Identifying patients subject to Section 117
- Setting up CPA/Section 117 care planning meetings to develop care packages for all such patients.
- Setting up similar meetings to review the progress of care and to discharge patients from S117 status for services when they no longer meet the criteria for Section 117.

10.0 Section 117 and Care Programme Approach (CPA)

10.1 This procedure throughout is based on the principle that the responsibilities of the Partnership Trusts under Section 117 can be discharged through the correct application of the CPA.

10.2 Section 117 discharge planning meetings will therefore be the same as CPA care planning meetings though the special legal status of the meeting and the additional responsibility to attend will be highlighted.

10.3 Section 117 Care Plans will be the same as CPA Care Plans though the Section 117 status of the patient will be stated on the form.

10.4 Review of the progress of care under Section 117 will be carried out at CPA Review meetings.

10.5 Decisions to discharge patients from Section 117 status or from some services under S117 will be made at CPA Review meetings.

10.6 A register of Section 117 patients will be kept up-to-date by each Trust and this will be a sub-set of Carebase or TotalCare, the CPA information systems.

11.0 Section 117 Information to Patients

11.1 It is implicit in this procedure that patients will be made aware of their Section 117 status and the rights resulting from it. This will be communicated to them at CPA meetings during the CPA planning process.

11.2 The Appendix to this procedure has a leaflet which will be given to patients as appropriate to inform them of their rights specifically. It will be sent to patients by the MHA Administrator when patients are discharged from Section 3, 37, 47 or 48.

SUPPORTING CPA DOCUMENTATION

- All CPA documentation is known by the name of the form and not a number.

- It is essential that all information recorded manually on the CPA documentation corresponds with that recorded electronically on CareBase.

- All CPA documentation must be signed, dated and timed.

- All CPA documentation should be held on the service user's health and social care records and filed under the CPA divider at the front of the file.

- It should be noted that the CPA documentation for CAMHS is slightly different to that for adults, and consists of the following documentation:
  - CPA Personal Details (CAMHS)
  - CPA Referral (CAMHS)
  - CPA Assessment (CAMHS)
  - CPA Care Plan (CAMHS)
  - CPA Clinical/Specialist Care Plan (CAMHS)
  - CPA Review (CAMHS)

The CPA documentation consists of:

CPA Personal Details

The CPA Personal Details form is designed to collect demographic details and data collection from the service user and is completed by the service user. Once the form is received, all information should be entered into CareBase and a personal details form printed off and placed on the front of the service user's health and social care record. The service user's handwritten form should be placed underneath the electronic print-out. It is essential that all staff involved with the service user check on a regular basis that the personal details are up-to-date. When changes occur, these should be amended on CareBase and an up-to-date personal details form printed out and placed at the front of the health and social care record.

CPA Inpatient Admission

The CPA Inpatient Admission form should be completed at the time of admission. The first two pages of this form are the same as the Personal Details Form (above) and if the service user is known to our service, information should be cross-checked to see if it is still valid. If the service user is new to our service, the form should be completed with them at the time of admission. All information should be entered on CareBase.

CPA Referral

The CPA Referral should be used for both new external referrals to CPA (ie from the GP) and for all internal referrals within our mental health service (ie when referring to the day hospital or psychology etc).

CPA Assessment

The CPA Assessment should be conducted by following the CPA Assessment Guidelines. The Assessment must be signed, dated and timed by the Assessor and should be entered electronically onto the CPA Assessment module on CareBase.

CPA Care Plan

The CPA Care Plan should be compiled once the CPA Assessment has been completed. The CPA Care Plan includes the assessed need, the intervention/action to be taken, by whom and the frequency. As much detail, including names and telephone numbers should be included on the Care Plan. The crisis plan and contingency risk plan form part of the CPA Care Plan and must be completed at this time. Any unmet needs should be recorded on the CPA Care Plan. The service user should sign and receive a copy of their CPA Care Plan. All information should be recorded electronically on CareBase.

CPA Clinical/Specialist Care Plan

The CPA Clinical/Specialist Care Plan should be completed within the umbrella of the CPA Care Plan by any staff who are providing a service to the service user (ie. day hospital service, drug and alcohol team, CBT etc). All information should be recorded electronically on CareBase.

CPA Review

The CPA Review form should be completed at a CPA Review every six months where progress made for each item of the CPA Care Plan should be recorded The date of the next planned review must be recorded. Personal details (ie marital status, GP, carer, next of kin etc) must be checked at the time of review to ensure that they are still valid to take account of any changes. All information must be entered electronically onto CareBase.

CPA Service User Self Assessment

The Service User Self Assessment form is a form that service users may like to use to record their views about their needs/care plan in advance of any future review meetings. This form is solely for the service user's use and is **not a mandatory form to use**, thus the content of which does not need to be entered electronically on CareBase.

Carers Assessment/Review Form

Every person who provides regular and substantial care to a person who has a mental illness should be offered an assessment of their own needs in relation to their role as a carer. This assessment may be undertaken by the service user's CPA Care Co-ordinator. Carers who are assessed are not subject to CPA unless they too have a mental illness and have been assessed in their own right. The offer of a Carers Assessment, whether this was accepted or declined, the date the assessment took place and the assessment itself must be recorded electronically on CareBase.

Appendix 9

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

ESSENCE OF CARE ASSESSMENT

This form must be completed for every patient on initial assessment

Name of Patient ……..……..……

Date of Admission ……..…… CB Number …… NHS Number ……..

Unit/Ward ……

Area of Care Please ✓	**Yes**	**No**	**If No, how is this reflected in the Care Plan?**
Health Promotion: Patient is able to make decisions on ways to improve or maintain their health and well being			
Safety: Risk assessment undertaken and information shared with other practitioners/ agencies or Trust as indicated			
Privacy & Dignity: Patient 's privacy and dignity is maintained at all times			
Self-care: Patient is able to take responsibility for their own health and well being			
Personal hygiene: Patient is able to maintain their own personal hygiene			
Oral hygiene: Patient is able to maintain their own oral hygiene			
Nutrition: Patient has at least three adequate meals and six drinks per day			
Continence and bladder and bowel care: Patient has no problem with bladder or bowel function			
Pressure ulcers: Patient 's skin condition is good and no pressure ulcer risk is apparent			
Communication: Patient is able to communicate their needs effectively			
Record Keeping: Patient involved in the development of their care plan and has retained a signed copy			

Comments *(If necessary, continue on a separate page)*

Signature of Assessor …… Print Name ……

Designation ……Date ……...

Appendix 10

WARD STAY CARE PATHWAY CHECKLIST

Ward Name	
CareBase No.	
DoB	
Admission Date	
Discharge Date	

Service User Name:	

Introduction

This document is to help ensure all Service Users follow the correct steps on the Ward Stay Care Pathway. It allows a brief documentation of what has happened but also is there to help guide the process. When complete it gives a brief summary and is not a replacement for clinical notes. It is based on best practice principles and CPA policy.

Within the CPA process **ALL** Service Users should have a planned CPA review before discharge. Exceptions apply where the Service User may take their own discharge. However, there is still an obligation to ensure that any risks identified are addressed.

Discharge planning for every Service User should start at the point of admission or as soon as it is practical to do so. Keep the discharge plans as a focus for discussion throughout the Service User's hospitalisation. This will reinforce the idea that the Service User's hospitalisation is temporary and that discharge is the eventual goal.

The following is a **CARE PATHWAY** which Must Be Adhered to for **every Service User** admitted to the inpatient area.

Subject	**Section(s)**	**Content**
Admission to Hospital	**1-3**	Registration
Within 24 Hrs of Admission	**4-6**	Support & Referrals
During first 48hrs	**7-9**	Initial Planning
During Ward Stay (Including RISK)	**10-23**	Risk, Coordination, CPA
CPA Review Prior to Discharge	**24-29**	Medication, Transport, Care Planning
FOLLOW UP	**30**	Details for 48hr & 7 Day
Day of Discharge	**31-33**	Fitness, GP notification
Optional Notes/Comments		

ON ADMISSION TO HOSPITAL

1	Are there any emergency social problems created by the admission? If YES, has telephone referral been made to Social Services Yes ☐ No ☐	Y/N	Comments	Date & Initials
2	Is the service user registered with a GP? If no advise, the service user how to register.			
3 ✯	Were the service users BMI and smoking status recorded on CareBase? If not record immediately from ward listing on CareBase			

WITHIN 24 Hrs of ADMISSION

4	Does the service user have support services at home? eg meals on wheels etc If YES Ensure two-way contact is put in place – Exchange of information.	Y/N	Comments	Date & initials
5	Is a referral needed to CMHT? If YES, refer using the appropriate format, e.g. CareBase care referral			
6 ✯	Has the service user got an identified CPA care co-ordinator? If YES, who and contact number.			

✯ performance measure

DURING FIRST 48hrs

7 ✯	Has the service user been assessed by the ward doctor? If NO – When is this to take place?	Y/N	Comments	Date & initials
8	Has there been a date set for an initial CPA meeting to draw up the care plan in discussion with the service user, carer and other professionals? If NO – book ASAP			
9	Does the service user live alone? If YES – Are the any risks/needs identified?			

✯ performance measure

DURING WARD STAY (Including RISK)

10 ✯	Does the service user have a carer? If YES – Has a carer's assessment been offered/completed?	Y/N	Comments	Date & initials
11	Is the service user competent with administering own medication? If NO – What help is in place on discharge from Hospital?			
12	Has written advice been given to the service user, eg advice re medication use? If NO – Who will attend to this?			
13	During admission has the service user been compliant with medication/ treatment plan? If NO – What measures need to be taken to encourage compliance on discharge?			

14	Please briefly indicate any risks identified or known during ward stay e.g. Neglect, aggression, drug use, suicide, vulnerability, self harm etc If YES – What are the risks involved? Who will address these?	Y/N	Comments	Date & initials
15	Is the service user at risk of falls?			
16	Is there a history of abuse? If YES has there been a professionals meeting?			
17	Have any physical needs been addressed?			
18	Are there any behavioural difficulties associated with dementia? Eg wandering			
19	Is the service user's home environment habitable, any hazards, access problems, available food, available heating, benefits, finance etc.			
20	Has the service user met his/her care coordinator?			
21	Will the service user be discharged to his/her own address?			
22	Is the accommodation permanent or temporary?			
23	Does the service user understand their condition and care plan?			

CPA REVIEW PRIOR TO DISCHARGE

24	Has the discharge arrangements been confirmed with the service user and the carers by the MDT? If NO – The CPA discharge planning process has not been carried out to an acceptable standard – who will immediately address this?	Y/N	Comments	Date & initials
25 ✯	Has a copy of the care plan been given to the service user?			
26	Has medication been ordered? Has medication been explained to the service user? If NO – Who will do these and when?			
27	How is the service user to be transported on discharge? Has arrangements been made and by whom? Is it necessary for someone to greet the service user at home What are the transport arrangements? Named person to greet the service user at home.			
28	Are there any Outpatients or Community appointment to be made? ☐ Given to Service User ☐ To be Posted			
29 ✯	Does Section 117 apply to this service user? Is this recorded in the files?			

✯ performance measure

FOLLOW UP

30 ✯	**Most service users are discharged on Enhanced CPA** Who will make the 48hr telephone contact? Who will do the Face to Face follow up and when?	Y/No	Comments	Dates & initials

✯ performance measure

DAY OF DICHARGE **Date:**

31	Is the service user clinically fit for Discharge? Medical statement to confirm findings.	Y/N	Comments	Date & initials
32	Information to the GP ☐ Posted ☐ Faxed ☐ Emailed			
33	Has the care coordinator and person responsible for follow up been informed?			

Optional Notes/Comments

Appendix 11

The Ten Essential Shared Capabilities for Mental Health Practice
The National Institute of Mental Health in England/Sainsbury Centre for Mental Health 2005

1. **Working in Partnership -** Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

2. **Respecting Diversity -** Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. **Practicing Ethically -** Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. **Challenging Inequality -** Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in communities they come from.

5. **Promoting Recovery -** Working in partnership to provide care and treatment that enable service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying People's Needs and Strengths -** Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

7. **Providing Service User Centred Care -** Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

8. **Making a difference -** Facilitating access to and delivering the best quality, evidence based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

9. **Promoting Safety and Positive Risk Taking -** Empowering the person to decide the level of risk they are prepared to take with their health and safety and positive risk taking including assessing and dealing with possible risks for service users, carers, family members and the wider public.

10. **Personal Development and Learning -** Keeping up to date with changes in practice and participating in lifelong learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

SINGLE ASSESSMENT PROCESS (SAP)

1.0 Introduction

The Single Assessment Process (SAP) forms part of the Government agenda for modernisation of Health and Social Care Services. Specifically, it is introduced through the National Service Framework (NSF) for Older People Standard Two.

1.1 Aims of the Single Assessment Process

- Older adults are placed at the heart of assessment and care planning, and these processes are timely and in proportion to individuals' needs.
- Care plans of service delivery are routinely produced and service users receive a copy.
- Professionals contribute to assessments in the most effective way.
- Information is collected, stored and shared as effectively as possible.
- Professional and agencies do not duplication each other's assessments.

2.0 Background

2.1 The National Service Framework (NSF) for Older People

The Government recognises that older adults use the NHS more than any other group and the NSF for older people set out an action plan to improve health and social care services for older adults, whether they live at home, in residential care or are being cared for in hospital.

2.2 Standard 2 – Person Centred Care

Standard 2 of the NSF for older people is the standard that includes detail of the Single Assessment Process. It is the development of 'Person Centred Care'. The aim of Standard 2 is "*to ensure that older adults are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals regardless of health and social care boundaries".* This requires professionals to:

- listen to older adults;
- respect their privacy and dignity;
- recognise individual differences and specific needs including cultural and religious differences;
- enable older adults to make informed choices, involving them in all decisions about their needs and care;
- provide co-ordinated and integrated service responses;

3.0 Four Levels of Assessment

The Department of Health guidance sets out four levels of assessment. A person will not enter the Single Assessment Process (SAP) if their needs are of a straight forward nature, eg specific minor ailments, are short term or requiring only say the intervention of one agency.

SAP comprises four types of assessment:

- Contact assessment
- Overview assessment
- Specialist assessment
- Comprehensive assessment

The four types of assessment are not progressive – it is not expected that older adults will move through the stages in an orderly fashion. The important thing is that all older adults should receive good assessment matched to their individual circumstances.

3.1 Contact Assessment

This is a first contact initial assessment where significant needs are first described or suspected. At this stage basis personal information is collected and the presenting, as well as wider health and social care issues, are established or explored. (NB: it does not refer to every contact between, say a GP and an older person coming to their surgery).

3.2 Overview Assessment

This is completed by a competent, trained practitioner where a wider ranging broader assessment is needed. During this stage, areas such as medical background, personal care and physical wellbeing, senses and mental health are explored, looking at all areas of need:

- **User's perspective** (problems and issues in the user's own words, user's expectations and motivation).
- **Clinical background** (history of medical problems, history of falls, medication use).
- **Disease preventions** (history of blood pressure monitoring, nutrition, vaccination history, drinking and smoking history, exercise patter, history of cervical and breast screening).
- **Personal Care and physical well-being** (personal hygiene, including washing, bathing, toileting and grooming, dressing, pain, oral health, foot-care, tissue viability, mobility, continence, sleeping patterns).
- **Senses** (sight, hearing, communication).
- **Mental health** (cognition including dementia, mental health including depression).
- **Relationships** (social contacts, relationships and involvement, caring arrangements).
- **Safety** (abuse or neglect, other aspects of personal safety, public safety).
- **Immediate environment and resources** (care of the home, accommodation, finances, access to local facilities and services)

It provides an indication that staff have recognised the older person has a need for a more rounded multi-disciplinary assessment. An overview assessment considers all domains (although not all domains have to be recorded). In completing an overview assessment a practitioner will consider if further specialist assessments are required.

Front line health or social care staff from a range of disciplines who currently undertake assessments, (for example community nurses, social workers, occupational therapists or physiotherapists) should carry out an overview assessment.

3.3 Specialist Assessment

Specialist assessments are those carried out by individuals within their own field of expertise and offers a way of exploring specific needs. Specialist assessments may be identified as being required from either a contact or overview assessment.

The specialist assessment is the most likely assessment to be undertaken by staff within the Trust. When the specialist assessment is carried out by a member of NEMHPT, the CPA process should be followed (ie the CPA Assessment, the Risk Assessment, the CPA Care Plan and the regular review of the Care Plan). As the provider of our specialist assessment, NEMHPT will have to deliver the outcome as set out in our assessment and the care as stated in our CPA Care Plan).

3.4 Comprehensive Assessment

A comprehensive assessment is an assessment of an older person that addresses all the areas of need (see 3.2 Overview Assessment) and is made up of all the various specialist assessments undertaken, involving a range of professionals or specialist teams with the relevant skills and knowledge.

Appendix 13

Bibliography and Useful Websites

Law and Guidance

- National Health Services Act 1977, Sections 3(1) and 21, Schedule 8, para 2(1).
- Mental Health Act 1983, Section 2, 3, 4, 7, 25A, 37(4), 117.
- Sex Discrimination Act 1975 and 1986
- NHS and Community Care Act 1990, Section 42 & 47.
- Carers Recognition and Services Act 1995.
- Building Bridges Report, 1995.
- The Community Care (Direct Payments) Act 1996.
- National Service Framework for Mental Health 1999.
- Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach, 1999.
- Carers and Disabled Children's Act 2000.
- The NHS Plan 2000.
- No Secrets (DoH) 2000.
- Race Relations(Amendment) Act 2000
- Health & Social Care Act 2001.
- National Service Framework for Older People 2001.
- Fair Access to Care Services; Guidance on Eligibility Criteria for Adult Social Care: May 2002.
- Fair Access to Care Services (FACS) guidance 2003.
- Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003**.**
- Community Care, Services for Carers and Children's Services (Direct Payments) Guidance, England 2003.
- Clinical Negligence Scheme for Trusts (CNST) Standard 8.
- Local Authority Circular: LAC (2004)24 The Community Care Assessment Directions 2004.
- National Service Framework for Children, Young People & Maternity Services (Standard 9) 2004.
- Carers (Equal Opportunities) Act 2004.
- Children Acts (1989 & 2004).
- Disability Discrimination Act 2005
- Mental Capacity Act 2005
- Equality Act 2006
- Commissioning Guidance for vocational services
- Commission Guidance for day services

Useful Websites

- Trust Site www.nemhpt.co.uk
- CPA Association www.cpaa.org.uk
- Carers www.carers.gov.uk
- Department of Health www.doh.gov.uk
- Essex County Council direct payments www.essexcc.gov.uk/directpayments

Appendix 14

Relevant Trust Policies and Guidance

- CareBase Operational Policy and Guidelines
- Clinical Risk Management Protocol incorporating Clinical Risk Assessment Tools Handbook
- Appointments Policy
- Confidentiality and Information Sharing Policy
- Health & Social Care Records Policy
- Access to Health Records Policy
- Your health records: How we look after them and who can see them Leaflet
- Supervision Policy
- Data Quality Policy
- Ethnicity Policy
- Safeguarding Children Folder
- Vulnerable Adult Protection Folder
- Direct Payments Policy and Practice Guidance
- Advance Directives Policy
- Access to Health and Social Care Records Policy and Procedures
- Mental Health North Essex Employment Commissioning Strategy
- North Essex Employment Strategy
- Carers Strategy