NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

POLICY DOCUMENT

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NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

CARE PROGRAMME APPROACH (CPA) POLICY

Mission Statement

This Policy confirms the Trust's commitment to the Care Programme Approach 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.

1.0 INTRODUCTION

1.1 Aims of CPA Policy

The aims of the CPA policy are to:

- ensure service users and their carers are involved in the planning to meet their health and social care needs and in planning services which support increased social inclusion and recovery;
- make available the option of direct payments to meet social care needs to all those eligible to receive them;
- promote good communication and the effective co-ordination of services between all agencies involved in the care of the service user;
- promote service delivery sensitive to individual needs including those of gender, ethnicity, culture, religion, disability, sexuality and age;
- ensure consistency in the quality of community care by applying CPA to all referrals accepted by the specialist mental health services;
- 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 and primary care, prison health care and voluntary organisations;
- enable staff to work in partnership with carers and carer led organisations and other voluntary and statutory agencies;
- ensure that carers who provide substantial and regular care are assessed and provided with a separate care plan detailing required support.

1.2 Objectives

The requirements of the Care Programme Approach are:

- **Assessment** - Systematic arrangements for assessment of the health and social care needs of service users.
- **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.
- **Care Coordinator** - The appointment of a care co-ordinator.
- **Review** - Regular reviews and, where necessary, agree changes to the care plan.

1.3 Scope of the Policy

- 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.

- 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.

2.0 BACKGROUND

2.1 History

The Care Programme Approach (CPA) was introduced in April 1991 as the cornerstone of the Government's Mental Health Policy. It is designed to provide a framework for effective mental health services to all service users and carers regardless of age, gender, ethnicity, culture, religion, disability or sexual orientation. ***Please note that the term 'service user' will be used throughout this policy to refer to those individuals to whom this policy applies.***

2.2 Key Principles

In accordance with the principles outlined in 'Effective Care Co-ordination in Mental Health Services', the key principles of the CPA policy are to achieve:

- **Integration** through integrating CPA and care management, ensuring each area has a lead officer, and making CPA a framework for care regardless of setting.
- **Consistency** through rationalising the levels of need nationally to two (standard and enhanced) with standard definitions, removing the requirement to maintain a supervision register subject to a robust CPA system.
- **A more streamlined approach** by reducing bureaucracy and supporting sound professional practice, ensuring that there is always a date set for the service user's next review, requiring data to be collected on all service users, and ensuring audit focuses on quality.
- **A proper focus** on risk assessment and management, delivering services appropriate to the needs of service users, and support for service users and their wider family and/or informal carers.

2.3 Development

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.

3.0 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, 25A, 37(4), 117.
- National Health Service and Community Care Act 1990, Section 42.
- Carers Recognition and Services Act 1995.
- Building Bridges Report, 1995.
- The Community Care (Direct Payments) Act 1996 **(superseded by **)**.
- 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.
- 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 Practice Guide March 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).

4.0 OPERATIONAL PROCESS

4.1 Access and Referrals
(Please cross refer to the Appointments Policy and the CareBase Operational Policy, which are available on i-connect)

- Referrals to the Trust are received from GPs, local authority social services, probation services, police service, carers and in some instances, service users may self refer.

- 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.

- The referral allocation process to allocate referrals to an appropriate mental health worker may take place within the Crisis Resolution and Home Treatment Team (CRHT – refer to Section 4.16 on CRHT), or for example at a weekly referral meeting known as "the Single Gate Meeting" held at the Community Mental Health Team (CMHT), or other recognised referral process.

Response Times (please cross refer to the Appointments Policy)

- 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').

- In the case of routine referrals, decisions on the response to a referral must be made within five working days, and in the case of an urgent referral, appropriate action must be taken within a maximum of five working days of receipt.

Choose and Book

- A member of the team will make contact with the prospective service user and offer an appointment. Appointments must be made within the national timeframes, which are set out within the Appointments Policy.

- Service users must be given a choice of appointment and bookings must be either a full booking or partial booking.

4.2 Care Co-ordinator

(For detailed guidance please refer to the CPA Association Handbook 2004)

Role and responsibilities of the Care Co-ordinator

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 the service user understands the care co-ordinator role and knows how to contact them and whom to contact in their absence.

Allocation of a Care Co-ordinator

- The responsibility for ensuring that a care co-ordinator is allocated to a particular case will rest with the **CMHT 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.

- 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.

- The initial assessor will undertake the role of care co-ordinator until an appropriate care co-ordinator is allocated.

- 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 Care Professionals (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.

- Where a service user receives services on a dual diagnosis basis and delivery of these services is shared with another service, such as the community 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.

- **Note:** An identified care co-ordinator cannot be the name of a professional group or service; it **must** be a named individual.

Change of Care Co-ordinator

- If a change of care co-ordinator is necessary, either within the team or across teams, the current care co-ordinator can only relinquish responsibility through a CPA review (which can be at the service user's request).

- 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.

- At the handover CPA review, the service user's care plan needs to be updated and re-issued to the service user.

- Any disputes as to who the care co-ordinator is must be resolved in the first instance by team managers. Failing a satisfactory resolution, service managers must intervene and resolve regarding appointing a care co-ordinator.

4.3 Primary or Named Nurse (Key Worker)

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.

- When a service user is new to the service in an inpatient setting, as there will be no previously assigned care co-ordinator, the primary nurse will assume all of the care co-ordinator responsibilities for the duration of the admission.

- Where there is an existing care co-ordinator in the community, some of the duties may be taken on by the key worker who will work collaboratively with the existing care co-ordinator, who continues to remain responsible during the inpatient episode. 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.

- In the community, the role of key worker may be undertaken by a support worker, but is not to be considered as the care co-ordinator who must be a clinician.

4.4 CPA Documentation

(Please cross refer to "Appendix 8 - CPA Forms" for full details on the use of CPA documentation)

The following is a list of the current CPA documentation. The use of these revised CPA forms is mandatory and all other/previous CPA documentation should be destroyed:

- Personal Details
- Inpatient Admission
- Referral
- CPA Assessment & Guidelines
- CPA Care Plan
- CPA Clinical/Specialist Care Plan
- CPA Review
- Service User's Self Assessment
- Carer's Assessment

4.5 Assessment

Once it has been decided that a potential service user requires an assessment, a comprehensive assessment of their mental health and social care needs should be carried out by a professionally qualified member of the mental health team.

- Assessments will be conducted in accordance with an agreed multi-disciplinary joint assessment procedure and must also include an assessment of risk.

- It is important to note that the full involvement and participation of the individual (and their carers) in assessment has long been recognised as good practice, however with the implementation of the Community Care Assessment Directions 2004, as set out in the Department of Health's Local Authority Circular LAC(2004)24, the requirement to fully involve the individual (and their carers) is now placed within a legal framework. For example, when assessing older people the requirements of the Single Assessment Process and the National Service Framework should be observed and where necessary joint assessments involving health partners should be completed.

- Assessments for all adults with complex needs should take account of physical, cognitive, behavioural and social care needs in line with Fair Access to Care Services (FACS) guidance. In addition, it is essential to incorporate the needs of children and dependants and to review these needs regularly, making referrals to other agencies as appropriate.

- Assessments may also be undertaken periodically throughout the episode of care should circumstances change (or for access to specialist services within the Trust).

- The CPA Assessment Form should be completed. It must be signed, dated and timed by the assessor and it should be recorded electronically on CareBase.

- If following assessment, the person is deemed not to require further intervention from our service, they should be Discharged Following Assessment (DFA).

4.6 Risk Assessment

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

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.

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

- All key events should now be recorded electronically on CareBase under the Risk Management tool (there is no separate key events sheet, previous CPA 7 form).

- The risk assessment should include an estimation of the degree of risk presented in respect of:
  - aggression/violence;
  - child protection;
  - hazards;
  - neglect;
  - self harm;
  - suicide;
  - vulnerability (this could include advanced directives);
  - adult protection

  and must be recorded electronically on CareBase.

- The outcome of this assessment must form the basis of a risk management plan, which forms part of the care plan.

- 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, ie through admission to an inpatient unit or on discharge, to consider the risk implications to self and others and address accordingly through the care plan.

- Risk assessments must always be signed, dated and timed. A statement of risk must be formulated and where risk is identified there must be a clear risk management plan.

- Risk assessments must be reviewed at each CPA review and a written record made to that effect. 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.

- It is recommended that risk assessment is carried out at least six monthly, irrespective of the stability of the individual's situation.

4.7 Levels of CPA

Please refer to appendix 2 for a definitive guide to standard and enhanced CPA levels.

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

- 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.

- 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;
  - disengage from services.

  - Service users admitted to an inpatient setting under Section will automatically be placed on enhanced CPA.
  - 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);

4.8 Planning the CPA Care Plan

Once the CPA assessment has been completed and the service user has been allocated to either standard or enhanced CPA, in conjunction with the service user (and their carers), the care co-ordinator will develop the CPA Care Plan.

- The CPA care plan should be agreed with the service user and must be expressed in a clear language. It must clearly specify interventions and actions 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 (ie housing, probation, carers), how these will be met and the frequency.

- It must incorporate a plan for the management of risk as identified through the risk assessment process (See 4.6).

- A crisis plan, including relapse indicators and advanced directives should be recorded.

- Any unmet needs should be discussed and recorded on the CPA care plan with an action plan to resolve.

- The CPA care plan could include any of the following:
  - support systems;
  - contact with GP;
  - outpatient appointments;
  - day hospital services;
  - psychological therapies;
  - advocacy;
  - other care provisions.

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

- A copy of the CPA care plan must be printed out and 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.

- A care plan can be provided to an external agency (please refer to the leaflet "Your health records – How we look after them and who can see them". Please refer to Section 4.23 Confidentiality).

4.9 Specialist/Clinical Care Plans

- Within the umbrella of the CPA care plan, specialist /clinical care plans may be compiled by the staff responsible and in agreement with the service user (there could be several care plans, eg day hospital service, drug and alcohol team, CBT etc).

- Clinical/specialist care plans will include:
  - assessed needs;
  - plans/goals;
  - advanced directives, which should be included in the risk assessment (see 4.6)
  - implementation/action required;
  - evaluation date.

- The role of the care co-ordinator is to co-ordinate the various care plans and must ensure that all the care plans are available at the time of the CPA review (see 4.12).

4.10 Care Plan Folder

A care plan folder should be given to all service users on enhanced CPA (but at the discretion of a member of staff, a folder can be given to a service user on standard CPA if it is felt appropriate).

- The care plan folder 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.

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

  - the CPA care plan;
  - clinical 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
  - PALS leaflet.

4.11 Crisis Cards

All service users and/or their carers may be given a crisis card if a member of staff thinks it is appropriate.

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

- 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.

4.12 CPA Review

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 both enhanced and standard service users. This must be recorded electronically on CareBase.

- A review takes place in order to review the care programme approach, evaluate the effectiveness of the interventions contained within the plan, to consider reassessment of risk factors and to reassess the service user's needs.
- The responsibility for arranging the CPA review lies with the care co-ordinator (although a review can be called by the service user or anyone else involved in the service user's care plan).
- Whenever there is a change of care co-ordinator, a CPA review must take place at this time.
- The care co-ordinator should give adequate notice/invitations to all parties involved.

- The service user must be consulted and agree to the presence of those invited.
- Records should be kept of all people present at the review and apologies received.
- If key people are unable to attend they should provide an up-to-date report of their involvement and concerns/recommendations.
- All views should be obtained, including the service user/carer.
- 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.
- A list of recommendations should be drawn up from the review and a new care plan needs to be drawn up.
- The risk assessment, crisis and contingency plan needs to be updated.
- For those on Section 117, consideration must be given to the continuation or otherwise.
- The review form should be signed, dated and timed before circulating to all those present and to those who were not at the review.
- A new date for the next review should be agreed and recorded electronically on CareBase.
- A review must take place when a service user is being discharged from CPA.

4.13 Carers Assessment Procedure

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.

- 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.

- 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 within the assessment documentation (Carer's Assessment/Review Form) and recorded on CareBase under patient next of kin details.

- Should the offer 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 this process by providing the assessment tool for completion. Additional support for the carer can also be provided by a friend/advocate.

- 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.

4.14 Admissions to Inpatient Units

A member of the multi disciplinary team will be responsible for ensuring that an initial assessment, including a physical examination using the Essence of Care Tool (see appendix 9), is carried out on all service users admitted to inpatient units. This assessment begins the process of discharge planning and will identify the needs of both the service user and their carers that will require some form of intervention when the service user is discharged.

New Service Users

Where the service user has not been previously known to the service, then the assessment and development of the care plan should be co-ordinated by the named nurse (key worker). The named nurse should liaise with the relevant CMHT team leader to identify a potential care co-ordinator and this should be organised within 48-72 hours post admission.

Existing Service Users

During an episode of inpatient care, all CPA care co-ordination duties will remain the responsibility of the care co-ordinator. The named nurse therefore 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.

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.

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.

4.15 Discharge from Hospital

Arrangements for discharge from hospital should be initiated as soon as the service user has been admitted to hospital.

- 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 to oversee all arrangements for discharge.

Discharge plan

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

Follow up
(Should S117 apply please see Section 5.1 & Appendix 7)

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

- For service users discharged on enhanced CPA, follow up must be within 3 working days of discharge.

- For service users discharged on standard CPA, follow up must be within 7 working days of discharge.

- For service users on enhanced CPA who are being followed up in the outpatient clinic only, a follow up call must be made and recorded on CareBase by the ward manager or delegated member of staff within 3 working days of discharge.

- Follow up for service users who are not deemed to be at high risk may be face to face contact or telephone contact. Follow up **MUST** be recorded electronically on CareBase.

Discharge of high risk service users

- 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.

- 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*).

4.16 CRHT

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

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 promote recovery.

Existing Service User

- 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

reasonably possible. This is most important because the existing care co-ordinator remains responsible for the care co-ordination. CRHT Team will construct and implement appropriate care plans in response to the crisis and/or home treatment assessed needs of the service user.

- 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.

- 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 (see section 4.12 – CPA Review).

New Service User

- 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).

- 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.

4.17 CPA Procedure for the Young Person (CAMHS)

The CPA process within the Child & Adolescent Mental Health Service (CAMHS) is the same, with a slight modification of the CPA paperwork.

4.18 Safeguarding Children

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

- 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.

- 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.

- Consultation is always available regarding the safeguarding of children either from the Service Manager at Safeguarding Children & Vulnerable Adults on [I/S] or out of hours from Longview on [I/S] .

4.19 Vulnerable Adult Protection

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

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

- 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.

- 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.

- Consultation is available regarding the protection of vulnerable adults from the Service Manager, Safeguarding Children & Vulnerable Adults on [I/S] .

4.20 Family Group Conference

Family Group Conference (FGC) is a method of involving service users and families in the decision making process. Families are defined within the Family Group Conference process as significant people to the service user, ie: close family members, friends, neighbours or other member of the community who play a significant role in the service user's life. The model originated in New Zealand, developed by the Maori people, whose culture fosters empowerment and partnership.

- 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-coordinator to build upon existing family, friendship and community networks to facilitate the CPA process.

- Family Group Conference (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 advanced 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.

- 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.

4.21 Single Assessment Process (SAP)

SAP was introduced in the National Service Framework (NSF) for older people in March 2001.

- It aims to ensure that older people, and those with needs associated with older people, receive appropriate, effective and timely responses to their health and social needs.

- The principles of not duplicating work undertaken by another professional are applicable in relation to SAP. Staff should recognise assessments already undertaken and build on these.

- SAP involves four levels of assessment:

  - **Contact assessment** – starts when an older person first comes into contact with the service; basic information is collated and forms the basis of the referral.

  - **Overview assessment** – this incorporates additional information such as previous medical history, social care needs, strength, abilities and network as well as to identify the needs and care that may be required.
    The overview assessment covers 9 domains/areas of need:
    - user's perspective;
    - clinical background;
    - disease prevention;
    - personal care and physical well being;
    - senses;
    - mental health;
    - relationships;
    - safety;
    - immediate environment and resources.

  - **Specialist assessment** – for use by specialists such as mental health nurses, continence nurses, occupational therapists, psychologists etc.

  - **Comprehensive assessment** – where a variety of professionals work together over a period of time to ensure that the care provided addresses every aspect of the service user's health and social care needs.

- The SAP process will predominantly have commenced prior to referral to secondary mental health services.

- The SAP **specialist assessment** is the mental health assessment and is based on the use of our CPA assessment.

4.22 Electronic CPA (CareBase)

(Please cross refer to the CareBase Operational Policy)

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

- It is a mandatory requirement that all clinicians and practitioners record all data and events, including those which relate to CPA. This important action ensures that 24 hours, 7 days a week secure access to information by relevant staff and population of the mental health minimum data set, as required by the DoH.

- 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).

- The principle of comprehensive data entry will apply to any successor systems to CareBase.

- The following are the electronic CPA requirements that we are expected to meet:
  - Main Patient Index (MPI) Screen recording service users personal demographic details
  - Core CPA details - Name of care coordinator and CPA level
  - CPA Elements including:
    - CPA Services
    - CPA History
    - CPA Reviews
    - Assessments
    - Risk management (including key events)
    - CPA unmet needs
    - Carers Assessments
    - HoNOS
    - Events/Appointments
  - Discharge from CPA
  - Elements required for Mental Health Minimum Data Set.

4.23 Confidentiality

(Please cross refer to the Trust Confidentiality and Information Sharing Policy)

- 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.

- Additionally, on occasion, it may be necessary to share information about service users with health care professionals outside of the Trust. Only information that is relevant to any particular instance will be shared, but it is important that service users are also aware of this fact.

- There are other occasions when it is necessary to share patient confidential information with agencies external to health and consent for this is not always needed. To help service users understand when this might happen, staff should refer them to the Trust information leaflet ("Your health records: How we look after them and who can see them") which will be given to service users with their CPA Care Plan Folder.

- Should staff require further guidance with reference to information confidentiality issues, please see Section 6.7 of this document where you will find a list of associated Trust policies to help you. Alternatively you can contact the Customer Care Services Department at Trust Headquarters on [I/S] for advice.

4.24 Service Users who decline CPA (& S117 Aftercare)

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

- Refusal of engagement should be promptly discussed within the CMHT and communicated to the GP.

- 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.

- For service users on Section 117 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 with the service user.

- 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. It 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.

4.25 Transfer of Care between Mental Health Organisations

- 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.

- 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.

4.26 Discharge from CPA

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.

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 one year and despite every effort, contact has not been resumed (please refer to the Appointments Policy).

5.0 LEVELS OF PROVISION

5.1 Aftercare – Section 117 (See Appendix 7)

- All service users who fulfil the criteria for S117 will be included, ie those who have been detained in hospital under Sections 3,37,41,47,48 or 49 of the Mental Health Act 1983.

- The purpose of after-care 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.

- 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.

- At each 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).

5.2 Supervised Discharge

- From April 1996 an amendment to the Mental Health Act 1983 included a provision for supervision of mentally disordered patients in England and Wales who, on leaving hospital after detention for treatment (under Sections 3, 37, 45, 47 and 48) receive aftercare services under Section 117.

- 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 Office (RMO) can make an application for Supervised Discharge, which must be supported by an Approved Social Worker (ASW).

- 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.

5.3 Direct Payments and Mental Health

- Direct payments give individuals more control over their own life by providing people with a financial payment instead of the social care or carer services we provide. Individuals have flexibility to look beyond traditional social care or carer services to meet their eligible assessed needs.

- Anyone who is eligible for social care services or carer services can receive a direct payment. (The Health & Social Care Act 2001 establishes direct payments as a mandatory option).

- Direct payments can be used flexibly, and the individual will decide how the money will be used to meet their assessed needs, as detailed in the care plan.

- Direct payments cannot be used to purchase permanent residential care to enable people to purchase and arrange their own services.

- To be eligible to receive a direct payment an individual must be willing, ie can consent to a direct payment and able to manage a direct payment with as much assistance as is necessary.

6.0 MONITORING OF CPA

6.1 CPA Steering Group

The Trust CPA Steering Group meet on a monthly basis to discuss issues relating to all aspects of CPA within the Trust. Its membership consists of:

- Area Director and Lead for CPA
- Service Managers/Lead for CPA in Central, East, West
- Service Manager for CAMHS
- Risk Management
- IT Representative
- CPA/SAP Co-ordinator
- Carer Support Modernisation Manager
- Social Work Lead
- Clinical Governance Representative
- Senior Performance Management Representative
- Communications Representative
- Service User Representative
- Medical Representative

The three areas within the Trust (Central, East and West) hold regular CPA meetings within their respective areas.

6.2 Audit of CPA Process

Each team across the Trust will participate in a CPA audit. The Department of Health's Audit Pack for CPA forms the basis of this audit. This audit assesses the quality of CPA documentation, both in its paper format and electronically. The Trust recognises that the audit of CPA is paramount to ensure the highest quality is maintained. Audit data is collated centrally by The Trust's CPA/SAP Co-ordinator and is presented to the Trust CPA Steering Group, ready for the annual visit from CNST (Clinical Negligence Scheme for Trust).

6.3 Training

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 across the Trust, details of which can be found on the CPA intranet site.

To book a place please contact [I/S] , CPA Secretary, on email: [I/S] or Tel: [I/S]

6.4 Data Collection

The clinical IT system currently used by NEMHPT for electronic data recording and retrieval is known as CareBase.

- As part of Performance Monitoring arrangements the Trust is sampled for implementation of CPA and the Mental Health Minimum Data Set. Use of CareBase by all clinicians and practitioners to record and store data is **mandatory**.

- The data collection sections, which relate to CPA include:

  - Main Patient Index (MPI) Screen – registration screen for recording service users personal demographic details; this will include sex, marital status, date of birth, address and postcode, GP and ethnicity
  - CPA Services including recording of care co-ordinator and the level of CPA
  - External Referral Screen
  - Internal referrals
  - CPA care plan
  - Risk assessment
  - CPA review
  - Discharge from CPA

- Data recorded on these screens will be used to assess the Trust's performance and therefore must be kept up-to-date. All entries should be entered onto CareBase within two working days.

- For full details on usage of CareBase and any successor system, please refer to the CareBase Operational Policy and Guidelines and the Trust Data Quality Policy.

6.5 Support and Clinical Supervision

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).

6.6 Who to Contact for Information about CPA within NEMHPT:

- **Trust Lead** Andy Mattin: Area Director West
  Tel & email [I/S] [I/S]
- **Trust Wide** [I/S] : CPA/SAP Co-ordinator
  Tel & email [I/S] [I/S]
- **Central** [I/S] Service Manager
  Tel & email [I/S] [I/S]
- **East** [I/S] Service Manager
  Tel & email [I/S] [I/S]
- **West** [I/S] : Service Manager
  Tel & email [I/S] [I/S]
- **CAMHS** [I/S] : Service Manager
  Tel & email: [I/S] [I/S]
- **Carers** [I/S] Carer Support Modernisation Manager
  Tel & email [I/S] [I/S]
- **Trust Intranet (I-Connect) – CPA Section located under Professional Matters**
- **Trust website: www.nemhpt.co.uk**

6.7 Other Relevant Trust Policies and Guidance

- CareBase Operational Policy and Guidelines
- Clinical Risk Management Protocol incorporating Clinical Risk Assessment Tools Handbook
- Appointments Policy
- Choose and Book Policy
- Confidentiality 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

6.8 Useful Websites

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

Appendix 1

Glossary of Terms

Abbreviations	Full Title
ASW	Approved Social Worker
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
NPFIT	National Programme for Information Technology
PCT	Primary Care Trust
RMO	Responsible Medical Officer
SAP	Single Assessment Process
SHO	Senior House Officer

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, 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, 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;
- 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)
Age	•		All Three	
Residence	• North Essex Area (of wider if GP in area)			
GP	• North Essex Area			
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)			
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)
GP	• Registered with a GP		1	
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			

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 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 assessment/assessors Care Plan will be completed to include:
   - 4.1 What service they have been referred for
   - 4.2 Name of the Care Coordinator until treatment commences & any interim Care options
   - 4.3 Emergency contact details
   - 4.4 Estimated waiting time OR time to review

5. The Care Plan will be printed and given to the service user.

All of the above will be completed using the current Electronic Patient Record, (Carebase).

6. The GP will be informed of the assessment outcome and he/she will be responsible for the service users overall care.

7. A crisis card will be issued.

8. The assessing clinician will now discharge/end the assessment Electronic Care Plan BUT the Care Program will remain open and the individual remains on CPA.

Role of the Interim Care Coordinator

9. Interim Care Coordinator will be appointed in accordance with both the Trust CPA policy and recommendation from National Guidance.

10. The Interim Care Coordinator will be the initial assessor or Team Manager of the assessment team.

11. The interim Care Co-ordinator will retain the overall responsibility of the following:
    - a) the contact person for the service user on the waiting list and the clients GP;
    - b) to ensure that the interim Care Plan and the waiting list are managed and reviewed in accordance with CPA practice;
    - c) to ensure that the interim Care Plan continues to be appropriate and effective for the individual client.

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 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 DAT 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

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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 has 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. <u>Unplanned Move</u>

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
Thanks to the CPAA North West Region and the cooperation of the North Western Branch of the ADSS for this guidance.

(November 2004)

Appendix 7

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

Contents

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, 45, 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. 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

[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.

Authorities that NEMHPT and SEPT work with[2], that Local Authorities must waive their 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

[2] Essex County Council, Thurrock Unitary Authority and Southend Unitary Authority

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 112 and 113 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.

Appendix 8

CPA Forms

- All CPA documentation will now be known by the name of the form rather than being numbered.
- It is essential that all information on the CPA forms corresponds with that recorded electronically on CareBase.
- All CPA forms 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.

The CPA documentation consists of:

Personal Details Form

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. The service user's handwritten form should be placed at the front of the case notes underneath the CareBase print off.

Inpatient Admission Form

The CPA Inpatient Admission form is a new form and 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 Form

The CPA Referral form should be used for both new external referrals to CPA (ie from the GP) and for internal referrals within our mental health service (ie when referring to the day hospital or psychology etc). The completion of this form may take place electronically on CareBase or in the paper format.

CPA Assessment Form

The CPA Assessment should be recorded on this form, using the Assessment Guidelines. As many sheets can be used as necessary. It should be noted that it is mandatory for the Assessor to sign, date and time their assessment. The contents of this form should be entered electronically onto CareBase, including one of the following outcomes:

Standard CPA
Enhanced CPA
Discharged following Assessment (DFA)

CPA Care Plan

The CPA Care Plan form should be completed once the CPA Assessment has been completed and the service user has been allocated to either standard or enhanced CPA (it should be noted that there is only one CPA Care Plan to be used for service users on both standard and enhanced CPA). The CPA Care Plan includes the Assessed Need, the intervention/action to be taken and states by whom and the frequency. The crisis plan and contingency risk management plan should be completed. The form also includes an "unmet needs" box to record any service needs not being met. 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 form should be completed within the umbrella of the CPA Care Plan by specialist/clinical staff who may be offering a service to the service user (eg day hospital service, drug and alcohol team, CBT etc). All information should be recorded electronically on CareBase.

CPA Review Form

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 (it should be noted that there is only one CPA Review form to be used for service users on both standard and enhanced CPA). 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 Form

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 users' CPA Care Co-ordinator, or by another professional and should be recorded on the Carers Assessment/Review For. Carers who are assessed are not subject to CPA unless they too have a severe mental illness and have been assessed in their own right. The offer of a Carers Assessment and the date the assessment took place must be recorded electronically on CareBase.

Appendix 9

Essence of Care

Assessment of Service User's Physical Condition
Please complete this form for every service user on admission or as soon as possible afterward.

Name of Service User……..…… ……

Date of Admission …….. CareBase Number……

Area of Care	Yes	No	If NO, how is this reflected in the Care Plan?
Please ✓			
1. Nutrition Service user has three meals and six drinks per day			
2. Personal hygiene Service user is able to maintain their personal hygiene			
3. Oral hygiene Service user is able to maintain own oral hygiene			
4. Continence and bladder and bowel care Service user has no problem with bladder or bowel function			
5. Pressure ulcers a) Service user 's skin condition is good and no pressure ulcer risk is apparent			
b) Service user is fully mobile either unaided or with appropriate aid(s)			
6. Self-care Service user's ability to make choices and take appropriate action to maintain health and well being has been assessed			
7. Communication Service user's is able to communicate effectively either unaided or with appropriate aid(s)			
8. Safety Risk assessment undertaken			
9. Record Keeping The care plan contains evidence of the service user/carer's involvement in care planning			

Signature(s) of Assessing Nurse(s)……..…… ……

Name:……..……..……

Designation:……....

Essence of Care Guidance Notes

Each team is encouraged to discuss the benchmarking factors that apply to them. The patient-focused outcome will be achieved when accountable practitioners or professionals ensure that practice reflects the benchmarks of best practice and all carers are committed to the delivery of quality care.

It is acknowledged that not all benchmarks and/or factors will be relevant to every clinical area. However, successful implementation of the system demands that assessment underpins care planning. The process of assessment of physical care skills is a feature in the relevant benchmarks and will promote a holistic approach to care delivery.

Use of the Essence of Care Framework will ensure that all aspects of physical care are assessed and treatment planned according to the individual needs of each service user.

Guidance on specific treatments required to meet the service user's physical care needs can be sought from the "Manual of Clinical Nursing Procedures" published by the Royal Marsden, a copy of which has been made available to each clinical team. Other appropriate sources can be accessed to enable practitioners to evidence the basis for treatment choices.

On completion of the "Essence of Care Assessment" more detailed assessment of areas of care that need addressing should be undertaken.

The service user's notes should contain the "Essence of Care" assessment sheet accompanied by the relevant further assessments, e.g. continence, nutrition. All service users should have a fully completed mental health assessment and assessment of risk to self or others.