South Essex Partnership NHS
NHS Foundation Trust

Care Programme Approach

Procedural and Professional Handbook for Practitioners

This document has been produced by the CPA Steering Group

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Content

INTRODUCTION

PURPOSE OF THIS HANDBOOK

This handbook has been designed to assist practitioners in understanding the principles of the Care Programme Approach and to act as a guide in following Clinical Policy CLP30 – The Care Programme Approach.

It has been written by the CPA Steering Group which has a multidisciplinary membership from all areas of the Foundation Trust. The guidance is intended to inform service users, carers and workers in the statutory, voluntary and independent sectors about the Care Programme Approach as well as setting out clear expectations for mental health professionals directly involved in its delivery.

The purpose of this handbook is to ensure that service users of this specialist mental health service and their carers, receive comprehensive, well co-ordinated care, which is sensitive to their individual needs

The handbook has been developed for adults of working age in contact with the South Essex Partnership NHS Foundation Trust. The principles of the Care Programme Approach are also relevant to the care and treatment of younger and older people with mental health problems, including persons with a learning disability with a mental health problem.

- Overview of CPA
- Assessment and Care Planning under CPA
- Risk Assessment & the Management of Risk under CPA
- Carer's assessment under CPA
- Review and closure / transfer under CPA

BACKGROUND

The Care Programme Approach was introduced by the Department of Health in 1991 to provide a framework for effective mental health care.

The framework was further updated in 1999 with the publication *'Effective Care Co-Ordination in Mental Health Services: Modernising the Care Programme Approach'* where CPA was revised and integrated with local authority Care Management to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the format for assessment, care planning and review by health and social care professionals in all settings.

Two tiers of CPA were established nationally, Standard and Enhanced, and Key Workers were replaced by care co-ordinators

The Care Programme Approach is applicable to all adults of working age in contact with mental health services, CPA is not dependant on the setting in which care is provided and is just as relevant to people with mental health problems in prisons, in residential care, in nursing homes, in secure units or in hospitals as it is to those living independently in the community. The principles of CPA should be applied when dealing with younger and older people with mental health problems.

It has four main elements:

- Systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services.

- The preparation of a written care plan setting out what help and support will be provided to meet the assessed needs of service users and to assist their care and social inclusion

- The appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate the care plan; and

- Regular review and, where necessary, to agree changes to the care plan.

The Care Programme Approach was introduced in Scotland in 1992 and in Wales in 2004.

The Care Programme Approach is currently being reviewed nationally by the Department of Health and CSIP.

GUIDING PRINCIPLES

SOCIAL INCLUSION

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

Health and social care services have a critical role to play in helping people recover – or hold on to – what they value in life, by facilitating access to advice, support and mainstream opportunities.

In line with the Government's Social Inclusion Agenda, South Essex Partnership NHS Foundation Trust is committed to delivering socially inclusive services through comprehensive assessments which identify service user and carers' strengths. Care plans will place the concept of self-managed care central to the identified aims/outcomes.

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

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

Direct Payments must be offered in lieu of a community care service (the Community Care (Direct Payments) Act 1996; The Health & Social Care Act 2001) to all people eligible for a service under *Fair Access to Care Services (2003)* guidance.

EQUALITY OF OPPORTUNITY & DIVERSITY

It is essential to acknowledge the discrimination that people with mental illness experience and how that discrimination can contribute to their continued mental distress and ill health.

The above is evidenced by the significant number of black people being assessed as being violent by mental health professionals in contrast to white people and the variance in their subsequent behaviour.

It is of particular importance to be aware of the multiple disadvantages faced by people from black communities, woman, sexually diverse people and people who have physical or sensory impairments.

In relation to carers, it is important to be sensitive to different cultures, and particularly appreciate of the role of kinship networks and extended families. It is also important to recognise the impact of age, in particular young carers.

All professionals working within mental health services, in particular care co-ordinators, have a duty to work in what has been called a ‘critical’ way. This involves being sensitive to and continually questioning:

- Their own assumptions
- Peoples interpretation of an individual’s language and behaviour, and
- The impact of discrimination on individuals

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

INFORMATION SHARING AND CONFIDENTIALITY

Sharing information about an individual between partner agencies is vital to the provision of co-ordinated and seamless care to that individual. This in turn will cement partnership working, aid the efficient delivery of care, and, based on valid consent, increase service users' confidence that care is truly co-ordinated.

Please refer to the Trust policies on Sharing Information and the Copying of Letters for detailed guidance.

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

- Consent to share information will be sought at the earliest opportunity and will therefore be completed during the clinical assessment service (CAS) process.

- If consent is given verbally this should be recorded on the service user's case notes.

- All service users should be informed about what information might be shared with other agencies concerned with their well-being.

- All service users should be made aware of the circumstances in which staff will have a duty to disclose information in the public interest. Confidentiality may be overruled in the following circumstances:

    - Where there is an issue of risk to a child, (the welfare of the child is paramount and over-rides any apparently conflicting needs of parent, including confidentiality)

    - Where the service user is incapable of making a decision to his/her mental state (see policy on Mental Capacity)

    - Where the disclosure of information is ordered by a Judge

    - When disclosing information relating to firearms to the police

    - Where a crime has been committed

Normally information should only be provided on a need to know basis, and restricted to that information in which the recipient has a legitimate interest. Therefore this may require taking information from the CPA documentation and writing a brief report for others.

Guidelines set out in the Building Bridges document states “usually it is a good idea if the patient and his or her closest relative are fully involved in his or her care. However if a patient specifically asks that his family and carers are not involved, his or her wishes must be respected unless they have been appointed by a Court to manage his or her affairs, or there is a public interest ground to give them information (e.g. if they are at risk of violence)”.

This of course does not preclude the care co-ordinator or others involved in the person’s care from receiving information from family members / carers or others or in sharing appropriate information, particularly with Carers, in order that they can ensure the service user receives the best care possible.

Under the Mental Health Act 1983, there are circumstances in which a patient’s ‘Nearest Relative’ is entitled to receive information even where the patient objects (e.g. an application for assessment in relation to the patient has been made, or that the patient’s mental disorder has been reclassified)’.

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

When considering the need to share information without the consent of the service user the care co-ordinator should consider the following:

- The relative risk of withholding the information
- Liaison with their manager or colleagues
- Make the decision making process transparent by clearly recording the process in the service user’s case notes

CRITERIA FOR ACCEPTANCE ONTO CPA

The Care Programme Approach applies to all those persons who are in receipt of secondary mental health services. It is the process used to deliver services.

The document Building Bridges published in 1995 provides guidance on the definition of a severe mental illness.

The guidance advises that the person should meet one or more of the following criteria:

- Diagnosed as suffering from a form of mental illness (typically, people suffering from schizophrenia or a severe affective disorder, but including dementia).

- Suffers substantial disability or severe social dysfunction as a result of their mental illness, such as an inability to care for themselves independently, sustain relationships or work, or their essential support network is at immediate risk of breaking down which will result in depriving them of their right to live in the community.

- Currently displaying florid symptoms and / or

    - Suffering from a chronic, enduring condition.

    - Have suffered recurring mental health crisis, leading to frequent admissions / interventions.

    - On occasions is a significant risk to their own safety or that of others.

Not all these conditions need to be met for a person to be regarded as seriously mentally ill. For example:

- A person who has a chronic mental illness, but who has not been in regular contact with the services would be regarded as having a serious mental illness.

- An individual who presents for the first time with florid symptoms should be assessed to ascertain if they are suffering from a serious mental illness.

- A person with a very serious phobic disorder which was not necessary chronic, but resulted in very considerable disabilities or social dysfunctioning would also fall into this remit.

- A person can be seriously mentally ill without occasioning significant risk to their own safety or that of others.

LEVELS OF CPA – Standard and Enhanced

The Care Programme Approach is delivered according to two levels of need:

People on Standard CPA are likely to have some or all of the following characteristics:

- They require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline
- They are more able to self manage their mental health problems
- They have an active informal support network
- They pose little danger to themselves or others
- They are more likely to maintain appropriate contact with services

Service users on Standard CPA should have their care reviewed when necessary, **but not less than every twelve months**

People on Enhanced CPA are likely to have some or all of the following characteristics:

- They have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination
- They are only willing to co-operate with one professional or agency but they have multiple care needs
- They may be in contact with a number of agencies and may be subject to Section 117 or 25(A) of the Mental Health Act 1983
- They are likely to require more frequent and intensive interventions, perhaps with medication management
- Combination of severe mental illness and self harm and / or violence and / or self neglect
- They are more likely to have mental health problems co-existing with other problems such as substance misuse
- They are more likely to disengage with services
- They are currently an inpatient in a psychiatric hospital
- They are currently in a residential/nursing home

Those on Enhanced CPA will have a care co-ordinator from the following disciplines:

- Community Psychiatric Nurse
- Social Worker

Service users on Enhanced CPA should have their care reviewed regularly, when necessary and **not less than every six months.**

The decision to which CPA level a service user should be placed upon will be based upon the outcome of the core assessment process or following a review of the care plan.

ROLE OF THE CARE CO-ORDINATOR

The role of the care co-ordinator should usually be taken by the person who is best placed to oversee care planning resource allocation. Care co-ordinator's must be an appropriately qualified mental health professional employed within or seconded into the South Essex Partnership NHS Foundation Trust.

The service user must be allowed a choice of sex of the care co-ordinator, and the service must make all efforts to meet that choice.

Where the service user has standard needs and has contact with only one professional, who ever this may be, the role of the Care Co-ordinator should fall to this professional.

Where the service user has enhanced needs, it is expected that the Care Co-ordinator role would fall to a member of a community team, e.g. Social Worker and / or CPN.

The care co-ordinator will ensure that the identified mental health care needs are fully met. They are responsible for ensuring all involved professionals take part in the discussion and decision making on the following issues:

- The level of CPA required – Standard or Enhanced
- The assessment and management of risk
- The provision of identified services
- Discharge of the service user from secondary mental health services back to the care of his/her GP

All correspondence written about an individual service user must be sent to the named care co-ordinator.

The care co-ordinator's main responsibility is for co-ordinating the care, keeping in touch with the service user, carers and other members of the family, ensuring that the care plan is delivered and ensuring that the plan is reviewed as required.

The role is essentially one of co-ordination and communication; assessment; risk management and care planning.

The responsibilities of the care co-ordinator remain in place whatever the service users setting, especially during the period of in-patient treatment or when the service user is receiving intensive support from specialist services such as the Crisis Resolution & Home Treatment teams or they are placed in a residential/nursing home.

In meeting the above, the care co-ordinator will be required to undertake the following:

FOR THOSE WHO ARE SUBJECT TO STANDARD CPA

- Updating the service user's care plan as required
- Understanding and responding to the specific needs of the service user that may relate to their culture or ethnic background and community.
- Have an overview of any potential risks presented
- Monitoring the delivery of the care plan
- Being available to the service user as their main point of contact
- Making sure that the care plan is reviewed at appropriate intervals
- Monitoring the service users progress against agreed outcomes
- Maintaining regular contact with the service user and their carer(s)
- Informing appropriate individuals when contact is lost, e.g. GP.
- Identification of needs of any carer and the provision of a support plan as appropriate.

FOR THOSE WHO ARE SUBJECT TO ENHANCED CPA:

- A comprehensive assessment of the person's health and social care needs, including an assessment of risk. The assessment must include the needs of any children or vulnerable adults whom are affected by the service users mental illness, and any carer on whom the service user depends in the assessment process.
- Co-ordinating further specialist assessments where necessary.
- Co-ordinating the formulation and updating of the care plan, ensuring that the service user and all those involved understand their responsibilities and agree to them.
- Ensuring that the care plan is sent to all concerned.
- Providing a crisis and contingency plan, key events chart, regularly updated and circulated as appropriate.

- Maintain regular contact with the service user and monitor their progress, whether at home and / or in hospital and / or in receipt of specialist services, e.g. Home Treatment.

- Making sure the right services are in place in the right quantities at the right time.

- If a service user, who remains vulnerable, refuses to take part in the CPA process, all steps should be undertaken to find out why, and continued attempts must be made to engage with them.

- Ensure that the person is registered with a GP and that s/he is involved and informed as necessary.

- Organising and ensuring that reviews of care take place, and that all those involved in the service user's care are told about them, consulted, and informed of any outcomes.

- Ensuring the service user understands the care co-ordinator role, knows how to make contact and who to contact in the care co-ordinator's absence.

- In line with the principles of social inclusion, provide support and assistance with housing; education; employment and leisure.

- Accessing resources as necessary to help the service user, including the purchase of social care services where appropriate via a Direct Payment.

- Ensuring that care plans for service users who are at high risk of suicide include more intensive provision for the first three months after discharge from in-patient care, and specific follow up in the first week after discharge.

- The care co-ordinator may also be required take on other roles such as Guardian or Supervisor under the Mental Health Act 1983.

- Where there is deterioration in the service user's mental health or where problems are arising in the delivery of the care plan, then an urgent review will need to be arranged.

- If significant new risk factors are identified in the course of delivering the care plan the care co-ordinator must consider calling a review meeting as soon as possible so that this can be discussed with everyone concerned.

STANDARDS

The following standards are expected of all care co-ordinators in relation to those service users on **Enhanced CPA**, and individual cases will be audited to ensure standards are being consistently met in practice.

COMMUNITY

- The care co-ordinator must ensure specific face-to-face follow up takes place within 7 days of a service user's discharge from hospital. Please refer to the 7 Day Follow Up policy (CLP49) for detailed guidance. The community team manager is responsible for ensuring adherence to this policy.

- The care plan must have a record of where and by whom services will be delivered, intended outcomes and timescales.

- Care plans for those on enhanced CPA should be signed by the service user.

- Following discharge from hospital, a review of the care plan must be held within 4 weeks.

- All care plans must have a review date.

- For those on Enhanced CPA a Crisis & Contingency Plan must be completed that clearly sets out what action is required if the service user becomes unwell or their mental health is deteriorating. An individualised record must be made in each of these areas:

    - Things that are likely to trigger a crisis

    - Signs that the service user is becoming unwell

    - Particular difficulties that have arisen in the past

    - Who the service user is most responsive to

    - How to contact that person

    - Previous strategies which have been successful in overcoming crisis.

- All service users must be given a crisis card.

- All care plans must be revised and re-issued after their CPA review.

- A carers assessment must be offered to anyone living with, or caring for, a service user on CPA.

- All service users must be encouraged to complete the CUES (Carers' and Users' Expectations of Services) booklet prior to a CPA review.

- All correspondence to all parties must be copied to the care co-ordinator.

HOSPITAL

- The Community Team will be informed immediately a service user known to the them is admitted.
- The care co-ordinator will remain responsible for the service user's care plan whilst a patient on the Ward.
- The named nurse will discuss the service user's in-patient treatment plan with the care co-ordinator within 3 days of admission.
- All service users will have a one to one session at least weekly with a senior nurse.
- A review meeting will take place as soon after admission as appropriate, within a maximum of 3 weeks.
- All in-patient treatment plans must have a review date.
- All service users will have a risk management plan in place following the risk assessment.
- All service users must be given a crisis card with appropriate emergency contact numbers on discharge from hospital.
- Treatment plans will be based on individual needs, and not contain generalisations.
- A review meeting should be held prior to discharge with the named care co-ordinator.
- All correspondence to all parties must be copied to the care co-ordinator.

OUT- PATIENTS

- A decision on what to do next will be made for every service user who does not attend their appointment.
- Consultants will determine the time between appointments.
- Identified risks will be communicated to other staff involved in their care.
- All service users must be given a crisis card when first assessed in the Out- Patient Department.
- All correspondence to all parties must be copied to the care co-ordinator.

ASSESSMENT

CLINICAL ASSESSMENT SERVICE

The Clinical Assessment Service (CAS) is the gateway to CPA. Its purpose is to provide a clear pathway for GP's and other referrers to access an assessment within secondary mental health services.

The CAS supports patient choice allowing potential service users and GP's the ability to access mutually convenient dates and times for an assessment.

It also provides the practitioner an opportunity to undertake a assessment of an individuals needs and the option of resolving the service user's issue at the time of the assessment, whether this be a medical issue, concerns raised about relationships, housing, employment or finance.

Therefore the CAS will:

Ensure that there is a clear pathway for GP's and other referrers to access an assessment within Secondary Care Mental Health services.

Reduce the numbers of multiple referrals and actively improve the patient experience of assessment and work to ensure the provision of timely outcomes that meet their identified needs.

This service will be provided for routine GP referrals and will not apply for emergency referrals, which will still be processed in the normal way.

ASSESSMENT

The purpose of undertaking a first assessment of a service user's circumstance is to determine whether intervention from secondary mental health services is considered appropriate.

The service user's permission to share information with other agencies should be sought at the start of an episode of care in all cases.

Appropriate arrangements must be made at the earliest opportunity to have an interpreter available for people whose first language is not English and who have difficulty expressing themselves and communicating their needs clearly.

Language Line provides interpreting and translating services (including deaf language interpreting) for people receiving services from the South Essex Partnership NHS Foundation Trust.

Many people experience difficulty in speaking up for themselves and expressing their needs. Service users should be encouraged to have a relative, friend or an advocate with them at any time during the assessment and care planning process.

All practitioners who carry out a first assessment will use the **core assessment document** and will identify whether the needs of the service user fall within Standard or Enhanced levels of need.

The purpose of the core assessment is to gather information about the referred person; their situation and their current mental health needs. This allows a plan to be made for further care and/or where appropriate refer onwards.

Where a Care Programme is not deemed necessary, the service user must be given advice, information or referred to a more appropriate agency for help. It is important to ensure that the referrer and the referred person understand that re-referral to the secondary mental health service is possible if circumstances change or the difficulties cannot be resolved in any other way.

STANDARD CPA

For those service users whose needs are considered to fall within Standard CPA the needs of the service user will be forwarded to the appropriate service within the Trust who will consider the needs identified and will compile a care plan advising how the persons needs are to be met using a letter format.

The Standard care plan will clearly identify itself in the CPA file and will contain the essential components of:

1. Service user name and date of birth
2. Their address

3. A statement outlining the identified needs (health and social care)
4. The service to be provided
5. A review date

It is essential that a copy of the Standard Care Plan is given to the service user, the referrer and any other relevant persons.

ENHANCED CPA

For those service users whose needs fall within Enhanced CPA, the referral, the core assessment and any other relevant documentation will be forwarded to the relevant community team for the allocation of a named care co-ordinator.

Upon the appointment of a named care co-ordinator, the practitioner will complete a comprehensive assessment, risk profile, key events chart and offer an opportunity for the service user to complete a self-assessment if appropriate.

It is essential that the comprehensive assessment and subsequent care plan takes into account the use of a Direct Payment in order to meet the social care needs.

Upon completion of the above assessments, a care plan and a crisis & contingency plan must be completed in partnership with the service user, carer and other persons as necessary.

The co-operation and involvement of service users and their carers at all stages of the Care Programme Approach is essential if individual programmes are to be person centred and thus effective.

The assessment process must be thorough and comprehensive and the practitioner undertaking the assessment must ensure that the service user and carer, where appropriate are central to the process.

An assessment of carers' needs must be offered to carers where a carer has been identified as providing regular and substantial care to a service user whose needs are being assessed by mental health services.

Key areas to be assessed, including prompts, have been included in the comprehensive assessment documentation. If the service user disagrees with any part of their assessment this should be noted and any comments recorded.

To promote socially inclusive practice the assessment must take into account the service user's racial, cultural, gender and religious needs as well focusing on their strengths and must identify their educational and employment needs, their aspirations and participation in society.

RISK ASSESSMENT AND THE MANAGEMENT OF RISK

Risk assessment is an essential and ongoing part of the Care Programme Approach process. Risk must be clearly documented and reviewed regularly.

The assessment of risk and the management of risk provides the services the structure to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others.

Risk is also dynamic, risks are constantly changing in response to circumstances, in particular treatment and management decisions are likely to influence the risks.

Please refer to the Trust policy on Clinical Risk Assessment CLP28 for detailed guidance.

Assessment of risk is referenced in both the core assessment as well as comprehensive assessment documentation. Where significant risk factors have been identified it would be expected the service user would be placed on to Enhanced CPA and a Risk Profile; a Crisis & Contingency Plan and the Key Events chart will be completed.

Risk includes

- **Self harm**, including accidental harm at home / outside the home, risks associated with alcohol, drug or substance abuse, including any 'likely interaction between medication and substances, degree of dependence / withdrawal problems, deliberate self-harm.

- **Suicide**, including previous attempts, threats, opportunity, means.

- **Violence to others**, including access to potential victims, specific threats made, history of violence to family, staff, to other service users, the general public, specific other people, degree of physical harm caused, history of sexual assault, risk to children & vulnerable adults (non-accidental).

- **Other types of risk** to other people, including risk to children (accidental); arson; risk to staff other than violence; destruction of property.

- **Self neglect**, including inability to care for self and lack of carer support.

- **Exploitation by others/vulnerability to abuse** such as financial, sexual, physical, emotional, racial.

- **Substance Misuse** and how it impacts on the health and wellbeing of the person and those they care for.

In assessing risk the following factors should be considered:

- Detention under the Mental Health Act
- Previous admissions into hospital
- Incidents involving the Criminal Justice system
- Non-compliance with medication
- Reluctance to engage with services
- Failure to attend appointments
- Previous risk taking behaviour
- Substance misuse

In the identification of risk and the management of risk, it is essential to seek information on the service users past behaviour and any previous potential triggers for dangerous behaviour and to consider the information in the context of the service users present circumstances as well as considering what previous strategies have worked.

Information from the service user and other sources, e.g. voluntary agencies, other mental health units and where there are carers have an important role to play and should be consulted, involved and kept informed wherever possible.

The Risk Profile Tool is to be completed in the following circumstances:

- For those service users who meet the criteria for *'Enhanced'* CPA status
- On admission to hospital and / or prior to discharge from hospital
- At the practitioner's discretion; if in doubt, complete the risk profile.
- During the assessment if the outcome score indicates a high risk

The risk profile is a tool to help structure professional judgement, and to record the reasons for decision-making. It does not take the place of normal professional assessment and consideration of other risk factors.

The completion of the Risk Profile Tool will assist in the formulation of a risk management plan. It will also supplement the Crisis & Contingency Plan.

If it appears to a member of staff that a service user is being abused (physically, emotionally, financially or in any other way) by another person, whatever the setting, **the Protection of Vulnerable Adults** (POVA) arrangements must be activated without delay. (See Policy No CLP39).

Similarly if it becomes evident during the assessment that the service user is abusing another vulnerable adult, the Protection of Vulnerable Adult procedures must be activated.

If the service user has parenting or child care responsibilities and family support is required or child protection concerns exist, the practitioner should refer to the **SET Child Protection Handbook** as well as the protocol on joint working between adult mental health and services for children and families.

In such cases it is essential that individual roles and responsibilities are agreed, recorded and clearly communicated to everyone involved.

FOR THOSE PEOPLE WHO ARE ON ENHANCED CPA:

The Crisis & Contingency Plan forms a key element of the care plan and should be based on the service user's individual circumstances. The crisis part of the Crisis & Contingency Plan should set out the action to be taken if the service user becomes unwell or their mental health is deteriorating. To reduce risk the plan should include the following:

- Who the service user is most responsive to
- How to contact that person
- Previous strategies that have been successful in engaging the service user
- Early warning and relapse indicators.

The contingency part of the Crisis & Contingency Plan will outline the arrangements to prevent a crisis developing when, at short notice, either the care co-ordinator is not available, or part of the care plan cannot be provided.

The service user should be given the opportunity of completing an Advance Directive to enable that person to express their views about the most acceptable care and treatment options should he or she become unwell. The Advance Directives Policy (CLP6) should be referred to.

The management of risk must also consider the health and safety of staff or others. When risk to staff or others is identified, visiting in pairs should be considered. The Lone Working Policy (CLP 38) should be referred to.

On occasions when it is not possible to undertake a visit because the second member of staff is not available, the care co-ordinator must discuss this with the Team Manager or other senior clinicians, such as the Consultant Psychiatrist. The Team Manager should make arrangements to visit the service user with the care co-ordinator.

Where a service user is identified as high risk of harm to self or others, the multi-disciplinary team should agree a communication plan in order to ensure

risk is effectively communicated throughout the team. This must include consideration of notifying those people of the potential risks who live in close proximity to the service user, not excluding family members, carers etc.

THE KEY EVENTS RECORDING SHEET

The purpose of the *'Key Events'* recording sheet is to record significant events or incidents in the life of the service user therefore enabling current and future professional staff involved with the management of a service users care plan the opportunity to scan the key historical episodes in a service users care career at a glance, without the need to read through copious volumes of case notes. Therefore the use of this sheet is central to the assessment and management of risk.

The key events chart enables up to 5 episodes to be indexed, dated and summarised on one page. The intention of the key events chart is to highlight any significant episode in which the opinion of those professionals closely involved marks an important episode in the patients / service user's state of health or which may impact on this in the future.

Examples may include:

- Initial referral to mental health services
- Hospital admission dates
- Incidents of violence
- Self harm or neglect
- Divorce
- Court appearances
- Appeal Tribunals
- Death of a significant other

Equally what may be a key or significant event for one patient may not be for another, therefore it is important to retain some flexibility in interpretation.

It is intended that the main person completing this key events chart will be the patients care co-ordinator, however, this need not prevent other professional colleagues, i.e. in-patient staff from making entries.

OUTCOME SCORING

Measuring the outcome of the treatment and care provided within CPA is not a simple task, as many other factors will affect the outcome for the service user. The care co-ordinator has the responsibility of monitoring and reviewing the care provided to the service user and one way of informing this process is by measuring outcomes.

Outcome measurement provides a means of understanding the progress or otherwise of a service user's health care during a period of time between assessments or reviews. It must be used as follows:

STANDARD CPA

The outcome score measure must be undertaken at the completion of the care plan and subsequent reviews.

ENHANCED CPA

Where a full comprehensive assessment is being completed; whether on commencing a care programme with a community team, or within 7 days of admission to hospital the outcome score measure must be undertaken. It is the care co-ordinator's responsibility to ensure this happens.

Further outcome scores measures must be carried out at reviews of the care plan every six months or more frequently if considered necessary.

CARE PLANNING

CARE PLANNING

A care plan is a record of needs or difficulties, objectives to meet the needs, actions within agreed timescales and responsibilities written in a clear and jargon free way.

Care plans exist for the benefit of the person using the service, and they should be based around their needs, not around the availability of service provision. A care plan is unlikely to succeed unless the service user can fully relate it to their own wants, needs, aspirations and goals.

The Standard care plan will be in a letter format. See page 19 for further detail.

The Enhanced care plan drawn up by the service user and the care co-ordinator may contain a number of separate treatment plans for services provided by other teams or professionals, e.g. in-patient setting or the Crisis Resolution / Home Treatment Team treatment plan; Out-patients or Psychotherapy. The overall care plan must make reference to these other treatment plans.

The Enhanced care plan will identify social care needs that are to be met through social care funding and these will have the Fair Access to Care Services (FACS) criteria shown on the care plan against each relevant need.

Where a need, to be met within the care plan, is in accordance with section 117 the Enhanced care plan will identify that need.

A Care Plan must:

- Be based on a thorough assessment of an individual's health and social care needs.
- It must focus on the service user's strengths and seek to promote their good mental health & rightful place in society.
- Must recognise the diverse needs of people, reflecting their cultural, spiritual and ethnic background as well as their, sex, gender and sexuality.
- Must take into account any risk to the service user, their carer, any worker involved in delivering the care plan and the wider community.

A copy of the care plan must be offered to the service user, and given to all those involved in the care plan.

It is essential that practitioners maximise the extent to which the service user knows and understands their care plan, and agrees with it. The practitioner

must evidence the involvement of the service user in the development of the care plan by securing the service users signature.

If the service user disagrees with any part of their care plan this should be recorded. Service users subject to Enhanced CPA should be asked to sign their care plan and be given a copy of it. Carers and other people involved in delivering elements of the care plan should also be given copies wherever possible.

A review date of the Care Plan should be agreed with the service user and recorded on the care plan.

REVIEWS OF CARE PLANS

The purpose of a review is to consider:

- Any progress the service user has made toward recovery and their move toward independence
- Whether the care plan and its components remain valid and whether it requires amendment
- That services are appropriate and non stigmatising and socially inclusive
- The views of the service user, carer, other professionals
- How the service user has responded to the services being provided
- To consider the risks and the management of the risks to the service user, carer or others.
- To consider discharge from the service or the transfer of Care Co-Ordination responsibilities to another professional or service.
- Whether the level of CPA needs to be amended.

The review should be planned in well in advance and the regularity of the review will depend on the needs of the individual. The format of the review will also depend on the amount of support being offered.

Any person involved in the care plan, including the service user or carer can ask for a review to be held at any time and if this is refused the reason must be recorded in the case file.

For those discharged from hospital and who are subject to the Enhanced level of CPA, it is particularly important to review the implementation of the care plan within the first month of discharge from hospital.

All Service users on Standard CPA, should have their care reviewed when necessary, but not less than once a year. Service Users on Enhanced CPA must have their care reviewed no less than once every six months.

The level of complexity of each case will determine who needs to be present at the CPA review. For those on Standard CPA, the care co-ordinator and the service user may carry out the review together without others present.

For those on Enhanced CPA it may not be practical to have all those individuals involved in the care plan attending a meeting. It is essential that the service user's feelings are taken into account, as large meetings can be intimidating. However the care co-ordinator should ensure the views of others are represented, e.g., the GP could be contacted by either letter or telephone

to be asked for their contribution. The care co-ordinator must be clear about who needs to be involved and who the service user would like to be involved.

The service user's wishes about the location and timing of the meeting and the number of people attending should be respected wherever possible. Where appropriate, carers should also be involved in the review. If they are unable to attend in person they should be invited to contribute in some other way.

It is essential that the care co-ordinator prepares and plans for the review by seeking prior to the review the views of all those involved in the care plan.

Service users should be consulted about forthcoming reviews and helped to prepare for them. Prior to the review for those service users subject to Enhanced CPA should be given a copy of the CUES (Carers & Users Evaluation of Services) booklet to fill in and bring long to the review meeting.

At each review the date of the next care plan review must be set and the service user informed, including all parties involved in the care plan.

Copies of the review documentation must be circulated to all those involved in the care plan, including the service user and where appropriate the carer(s).

At each review the care plan must be revised and copies issued if regardless of whether changes have been made or not.

A copy of the review documentation as well as the outcome scores must be entered onto the Trust database.

Where transfer of care co-ordination responsibilities is required, the care co-ordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team / service.

IN-PATIENT SERVICES

IN-PATIENT TREATMENT EPISODE

If it becomes necessary for a service user to have a period of in-patient care the relevant community team and care co-ordinator will maintain contact with the service user throughout.

To ensure continuity of care and the provision of a full and comprehensive assessment of needs the following must take place within the in-patient area:

- Allocation of a named nurse as per Trust Named Nurse Policy CLP 10
- Documentation for In-patient purposes to completed upon admission and to be continually updated
- In-patient documentation must include continually updated ward based risk assessments and in-patient treatment plans. All appropriate records must be maintained
- Initial assessment and treatment plans must be completed within 72 hours of admission
- The named nurse will make available the opportunity for regular meetings between themselves and the service user to discuss and consider treatment plans and options
- The named nurse will ensure that the service user and if appropriate their relatives and / or carers are involved in all aspects of care from admission to discharge
- The named nurse and care co-ordinators will maintain open communication to facilitate full assessments of need and appropriate treatment plans
- The service user will be given a choice of the sex of the named nurse where possible

INTERFACE BETWEEN HOSPITAL AND THE COMMUNITY

To ensure effective communication and joined up working arrangements between in-patient settings and the community, the following principles must be adhered to:

- The care co-ordinator retains the responsibility for the service user during their period of admission. This includes the period when the Crisis Resolution & Home Treatment services are involved as an alternative to hospital admission

- On admission, ward staff will establish, via the Trust intranet, if the service user is known to services. The ward will immediately advise the relevant community team that the service user has been admitted

- If the service user is known to the Community Team and has an existing care co-ordinator, the Community Team administrator will arrange for the care plan, the crisis and contingency plan, including the risk documentation to be delivered, emailed or faxed to the ward within 24 hours

- The care co-ordinator must liaise with the named nurse / RMO within 3 days of admission to discuss the service users community CPA care plan

- The named nurse and care co-ordinator must agree a date for a care plan review meeting. The date must be agreed within 3 days of admission and for the review date should be set at the earliest opportunity; (within 3 weeks of admission)

- Named nurse / ward must inform the Community Team, if a service user is sent on leave. For planned leave, the care co-ordinator should be involved in the decision and be informed by fax / telephone when leave happens. (Please refer to the Managing Leave for Informal Patients Policy CLP45)

- All service users who are initially accepted into the service through admission into acute in-patient services will be allocated a named nurse within 24 hours of admission

- On admission to hospital, initial nursing and medical assessments will be completed to provide information for an initial in-patient treatment plan for the safe management of care in the first 72 hours in hospital

- If the service user is not known to services. The named nurse will complete a frontsheet and the core assessment documentation immediately, and at least within 1 working day and fax / email it to the relevant community team

- The community team will appoint a care co-ordinator within 7 days of receiving the frontsheet and the core assessment

- The community team will be responsible for assisting the service user with their community needs pending the allocation of a care co-ordinator

- Every effort will be made by the named nurse and the community team to work with the service user to maintain any employment status they may have whilst they are an impatient and on their discharge back to the community

- The named nurse will jointly work with the named care co-ordinator to complete the Comprehensive assessment documentation

- In the case of a service user who is already subject to CPA and who has a care plan, a review of the care plan; crisis and contingency plan is required well in advance of their discharge from the ward

- It is viewed as good practice to hold a care planning or review meeting prior to a Hospital Managers hearing or a Mental Health Act Review Tribunal Hearing so that an effective care plan, a crisis & contingency plan are in place should the hearing decide to discharge the service user from detention. The plans must be made available to the Hospital Managers or to the Mental Health Review Tribunal hearing

- A copy of the care plan must be given to the patient prior to discharge

- All persons discharged from hospital must be seen by their care co-ordinator or a representative from the community team within one week following discharge

- After discharge from hospital the implementation of the care plan must be reviewed within a one-month period

- Care plans for service users with severe mental illness who are at high risk of suicide must include more intensive provision after discharge from in-patient care for the first three months

DISENGAGEMENT, TRANSFER & CLOSURE

SERVICE USERS WHO ARE SUBJECT TO ENHANCED CPA AND FAIL TO MAINTAIN CONTACT WITH SERVICES

Where there are significant concerns about risk, failure to engage with the service user should be discussed immediately within a multi-disciplinary setting. An assessment of the risk that the service user presents to self and/or others, including neglect should be undertaken and an action plan put in place accordingly. These should be communicated to the GP & Consultant.

Where significant risks exist consideration should be given to carrying out a Mental Health Act assessment with a view to compulsory admission to hospital. In cases of high risk, consideration should be given to informing the Police and the Emergency Duty services of the situation at the earliest opportunity.

For those service users who are difficult to engage and unable to benefit from mainstream mental health services, it is essential that discussions take place with the Assertive Outreach Services. The criteria for referring to the Assertive Outreach teams are as follows:

- Subject to Enhanced CPA
- Refusal to engage with services

And to include, one of the following:

- High risk of relapse
- Frequent or prolonged admissions to hospital
- Detention under the Mental Health Act 1983
- Subject to discharge planning under the MHA 1983, e.g., Section 117 aftercare / Section 7 (Guardianship / Section 25 (Supervised Discharge)
- Risk assessment indicates a moderate to high risk to self, others or of self neglect
- Dual Diagnosis
- Poor social functioning

- Risk of homelessness / inability to maintain a tenancy

Liaison with the Assertive Outreach services at the earliest opportunity is viewed as essential.

Persons subject to the Enhanced level of CPA should not be discharged from CPA because of a service user's failure to engage with services. In all cases of failure to maintain contact an action plan should be set out outlining the minimum level of contact, e.g., an attempt by a mental health practitioner to visit once every 2 weeks or the offer of an out-patient appointment every 2 months.

Wide ranging consultation with people involved in the service user's care or support must be undertaken, which might include some or all of the following: team members; GP; carer(s); advocate; family members; relevant housing officers and voluntary sector agencies.

In all cases of disengagement, the care co-ordinator must discuss the situation with the appropriate Consultant Psychiatrist. Where there are significant concerns about risk, failure to engage should be discussed within a review of the care plan, which should include all members of the multi-disciplinary team. This meeting should take place as soon as possible and at least within one week of discussion with the Consultant Psychiatrist.

In all cases of failure to maintain contact a review of the care plan should consider the service users previous behaviour and allow sufficient time to review the service user's previous history and treatments.

TRANSFER OF CARE CO-ORDINATION RESPONSIBILITIES UNDER CPA

To ensure the smooth transfer of care co-ordination responsibilities under CPA from one professional/team/service to another the following standards must be followed:

- For those service users subject to Enhanced CPA. A joint handover meeting between the referring team and the receiving team must be arranged to review the care plan; crisis and contingency plan. It is viewed good practice that where a service user is transferred to another team, this is only undertaken after a 3 month period of relative stability

- The receiving professional/team/service must identify a care co-ordinator as a matter of priority

- The decision to transfer care must be communicated in writing to the service user, their carer and where appropriate their GP

- Adequate time must be allowed to ensure accurate communication of all risks between care co-ordinators

END OF CONTACT WITH MENTAL HEALTH SERVICES

The decision to end contact with services, will usually be made at a review of the care plan meeting. The service user should be given information on how to make contact with services in the future if their needs change.

Wherever possible carers should be consulted about the decision to end contact with the service user. The carer should be given information on how to make contact with services in the future.

The decision to end contact should be communicated to everyone involved in the care plan as soon as possible. CPA documentation should be completed without delay.

Service users and carers should be given a crisis card with details of how to make contact with services again in the future. For those on the Enhanced level of CPA, a direct referral by the service user and / or the carer should be acted upon immediately, rather than them attending the A&E Dept.

Service users should be encouraged to write an Advance Directive giving guidance on how they would prefer to be helped should they need specialist mental health services in the future.

N.B. Should a crisis occur for the service user within six months of closure, the receiving team should make arrangements for supporting the service user rather than returning the service user inappropriately to the GP or the A&E Dept. In anycase if the service user returns for assistance within the six month period they will be accepted back immediately onto the community team's caseload for review and care planning.

SERVICE USER INVOLVEMENT

ADVANCE DIRECTIVES

An Advance Directive is a way of service users making their views known before a crisis, or at such time when they may be unable to make informed choices. Doctors and other workers are obliged to take a person's wishes into account; though they have an over-riding duty to provide treatment that they consider is going to have the maximum therapeutic benefit. An Advance Directive is an aid and not a substitute for open discussion.

An Advance Directive identifies the symptoms that indicate a person is becoming unwell and treatments that help them become well. It will then explain who is most important in their life and who should be contacted and involved in their care during this period of illness.

Service users cannot insist on receiving certain treatments, but can express their opinion about treatment. If detained under the Mental Health Act 1983 and on Sections 2, 3, 37, 38, 47 or 48, treatment may be given without the service user's consent if it is considered to be in their best interests. Please refer to the Trust Policy on Advance Directives (CLP6) for further details.

A database has been set up by the Information Dept for Advance Directives to allow easy and prompt access by professionals as required.

ADVOCACY

Advocacy is communicating on behalf of another person to secure rights, meet needs or support people to make informed choices. Advocacy makes sure a person's voice is heard, that there needs are met and that they get the services they want and need, that they know their rights and have information to make informed choices.

Information about advocacy services should be given to service users soon after referral / admission into hospital / registration onto CPA.

Advocates, whether paid or unpaid, have a role in representing service users or helping them to represent themselves. They should be encouraged to be involved in CPA if service users request and / or need them.

Advocacy involvement may include attendance at Care Planning meetings, assistance to service users in making statements of their needs and in agreeing Care Plans, and attendance at CPA Reviews.

CUES

CUES (Carers & Users Expectation of Services) has been produced in partnership with the following organisations:

- Royal College of Psychiatry
- Royal College of Nursing
- National Schizophrenia fellowship
- Dept of Social Work, University of East Anglia

To promote choice and empowerment, where the criteria for Enhanced level of CPA is met; the CUES booklet must be offered to the person at an early stage in the assessment process, and always prior to a review of their care plan.

This will assist the person in making sure that things important to them in their daily lives are viewed important by all those involved in their care and treatment and to be properly considered during the review of their care plan.

PROVISION OF CRISIS CARDS

All Service Users, regardless of level of CPA or their placement, will be provided with a ‘Crisis Card’ which provides advice on how they could obtain help in a crisis / emergency.

DIRECT PAYMENTS FOR SERVICE USERS

The Community Care (Direct Payments) Act 1996 gave power to Local Authorities to offer Direct Payments to service user. The Health and Social Care Act 2001 made Direct Payments a Duty for Local Authorities to offer this to all people eligible for a service, including Carers, to receive a payment from the Local Authority community care monies and purchase their own care based on an agreed needs led assessment.

Direct Payments is open to people with a physical / sensory disability, learning disability; HIV / Aids or an enduring mental health problem and have been assessed as needing community social care services.

Everyone, to whom Direct Payments are made, has by law, to be considered 'willing and able' to manage them, with assistance if necessary. This means that they must be able to direct both the services they receive and the administration of them. People who receive a Direct Payment are accountable for the way the money is spent.

The aim of a Direct Payment is to give more flexibility on how services are provided. By giving individuals money in lieu of social care services, people are empowered to have more control and choice over their lives about the quality (culturally competent) and delivery of care they receive through the CPA Framework.

Direct Payments for service users can be used to purchase personal assistants in order to meet the social care needs of the service user, but there are many other uses as long as the identified needs are of a social care nature and that they meet the criteria according to Local Authority Fair Access to Care Services (FACS).

For further details please refer to your Local Authority guidelines for Direct Payments or speak to the Consultant Social Work Practitioner.

CARER INVOLVEMENT

SUPPORTING CARER'S UNDER CPA

Carers of people who provide regular and substantial care for a service user on CPA have a right under The Carers (Equal Opportunities) Act 2004; The Carers (Recognition and Services) Act 1995; The Carers and Disabled Children Act 2000, including the National Service Framework for Mental Health to have an assessment of their caring, physical and mental health needs and their ability to continue to care.

A carer may be a relative, friend or neighbour, and may be a sole carer or part of a wider caring network. Any carer providing regular and substantial care to a service user who is subject to the Care Programme Approach must be offered an assessment of their needs in relation to their role as a carer.

The assessment should include

- Current support provided by the carer or others for the service user
- Current support for the carer
- Carer's views

When identifying a carer's needs the following must be considered:

- financial / benefits advice; domestic or personal assistance; respite; the need for a break from the caring role; emotional support; accommodation; social and recreational; employment; life long learning; leisure; health; advocacy; transport and information about the mental health needs of the service user

The Carer's Support Plan should include:

- Information about the mental health needs of the service user for whom they are caring, including information about medication and any side effects.
- Provision of advice on how to cope at critical times.
- How to recognise signs of a relapse and information on what to do and who to contact in a crisis.
- What will be provided to meet their own mental and physical health needs, and how it will be provided.

- How to get information and advice on income, housing, educational and employment matters.

- Arrangements for social support, including access to carer's support groups

- Arrangements to enable a break from caring

The Carers Support Plan must be reviewed on an annual basis.

Wherever possible carers should be consulted during the assessment process of the service user, care planning and at reviews. Generally such consultation will take place with the consent of the service user. However, if there is a significant risk to the service user or to the carer then contact may be made without the service user's agreement.

Carers should also be given information about medication and other treatments; support arrangements; risk management strategies and crisis and contingency plans. Even if the service user does not want their carer(s) to be actively involved in their care programme, it is important for them to know who the care co-ordinator is, where he or she is based and how to access services in a crisis or outside office hours.

It is important to recognise that carers can be of any age. Many children care for their parents who experience mental illness.

FAMILY GROUP CONFERENCE FOR MENTAL HEALTH

Family group conference (FGC) is based on the belief, that service users and families are the people who know most about their difficulties.

FGC for mental health helps the care co-ordinator to build upon existing family, friendship and community networks to provide structured and facilitated support to people with mental health problems, alongside the CPA process.

FGC for mental health has proved very effective in enabling families to communicate and co-operate in ways not possible before, resulting in family plans in the majority of cases. Family plans include advance agreements and co-ordinating the responsibilities of individual family members in the event of a crisis. In this way FGC has effectively tackled problems of social or emotional isolation by connecting the service user back into the family network. In addition family members are able to recognise early warning signs and when the service user might be relapsing.

FGC should be considered as part of a CPA where a service user is part of a family network. For further details contact your Local Authority guidance or alternatively the Essex Consultant Social Work Practitioner.

The term “Family” is used here loosely. It can mean people who are important to a service user, e.g. friends and neighbours.

DIRECT PAYMENTS FOR CARERS

Direct Payments now extend to carers. In identifying a carer's needs it is important to determine the carer's situation. The provision of a Direct Payment in meeting their needs must be offered if it is of a social care nature and they so request it.

Examples of Carers Direct payments have ranged from driving lesson's for a carer to the provision of complimentary therapies through vouchers.

For further details please refer to your Local Authority guidelines for Direct Payments or speak to the Consultant Social Work Practitioner.

PURCHASE OF HEALTH AND SOCIAL CARE SERVICES

The NHS and Community Care Act 1990, gave Local Authorities the lead responsibility for assessment and care management of those people with social care needs. With the introduction of the Care Programme Approach, it has been agreed that CPA is now the lead process for assessing need, care planning and co-ordination of care for those people with enduring mental health difficulties, for all agencies.

Where services need to be purchased in order to a meet an identified need and where they relate to social care, the Care Co-Ordinator regardless of their discipline should refer to the Care Management Purchasing procedures for each Local Authority.

Any care that is to be purchased whether on behalf of or through a Direct Payment must meet the criteria according to Fair Access to Care Services. (FACS).

LOCAL AUTHORITY NATIONAL ELIGIBILITY FRAMEWORK, 'FAIR ACCESS TO CARE SERVICES' GUIDANCE

LOW BAND

Level of risk – no presenting risk to health and safety

Practice guidance – support within this banding will improve the quality of life, support and maintain independence, assist and support the carer in their caring role to maintain their quality of life

MODERATE BAND

Level of risk – no immediate risk to health and safety

Practice guidance – support within this banding will improve the quality of life, maintain independence, assist and support the carer in their caring role to maintain their quality of life

SUBSTANTIAL BAND

Level of risk – relates to physical and / or psychological harm which has, or is likely to occur, and that without action will lead to a critical band need

Practice guidance - relates to situations where without intervention there will be serious harm or injury to the service user and without action will lead to risks becoming critical

CRITICAL BAND

Level of risk – in this band the level of risk relates to serious physical and / or psychological harm which has, or is likely to occur without action being taken

Practice guidance – relates to the most serious of situations where without intervention there will be death, serious harm or injury to the service user

Most people on Standard CPA will be expected to fall within either the 'low band' or 'medium band' using Social Services Eligibility criteria under *'Fair Access to Care'* guidance.

Conversely, most people on Enhanced CPA will be expected to fall within the 'substantial' or 'critical' bands.

Since the threshold at which these criteria are set may vary between different local authorities (Essex; Southend & Thurrock) it is important that practitioners familiarise themselves with the relevant eligibility criteria.

NURSING NEEDS ASSESSMENTS

Where a service user is being assessed for Continuing Care they must be assessed by a suitably trained nurse or doctor in order to ascertain their health needs. This assessment will be submitted to a Continuing Care Panel managed by the Primary Care Trust but with input from Social Care.

In order to assist with this assessment a Mental Health Nursing Needs (MHNN) assessment will be undertaken by a suitably qualified nurse within a ward setting or by a suitably qualified CPN when in the community.

Where the assessment indicates the person does not meet the criteria for Continuing Care a Registered Nursing Contribution to Care (RNCC) assessment will be undertaken by a nurse nominated by the local Primary Care Trust (PCT). This assessment will identify if the service user qualifies for banded funding toward the cost of their care in a home.

It is necessary for all service users, who require residential or nursing care, to go through this process before they are presented to any social care purchasing panel.

SECTION 117 of the MHA 1983 STATUTORY AFTERCARE

The Care Programme Approach is applicable to all service users who have been discharged from hospital subject to Section 117 after care.

Service users subject to section 117 cannot be charged for services which are provided for the purpose of statutory aftercare.

All patients who are detained in hospital under Section 3, 37, 47 and 48 of the 1983 Mental Health Act are subject to Section 117. This includes patients who have been formally detained, become informal for the remainder of their admission. The care arrangements for service users who are subject to Section 117 after care will fall within the Enhanced level of CPA.

Essex Social Care has, in partnership with SEPT and NEMHPT produced guidance on the management of statutory aftercare (Section117). It is recognised that service users who are subject to section 117 may not always require services to maintain them in the community and/or to prevent readmission to hospital. Therefore there may be occasions when section 117 may be discharged whilst other services continue to be provided for a service user. A review of a person's care plan under the CPA is the correct setting for this decision to be made.

Guidance and the procedure to be followed is available in a separate publication from Essex, Thurrock and Southend Social Care Services via CMHT managers.

GOVERNANCE

WORKLOAD MANAGEMENT AND CLINICAL SUPERVISION

Good workload management and the provision of clinical supervision are viewed as critical to maintaining effective practice and compliance with the CPA process. A workload consists of a caseload of service users and carers, combined with other duties and responsibilities, e.g. supervising, training.

Clinical supervision is viewed as an essential requirement in accordance with both the Partnership Trust and the Local Authority Policies.

It is the responsibility of the Manager and/or Clinical Leader to ensure, and be able to demonstrate, that staff undertaking care co-ordinator responsibilities are maintaining workloads, including caseloads, of suitable sizes. It is important that the caseload is made up of service users who have active needs, and that support and clinical supervision is provided to the care co-ordinator.

The Team Manager must be cognisant with all allocated work and be aware of the competence and limitations of each care co-ordinator in their team.

Through regular supervision the care co-ordinator will account for the action they have taken with each of their allocated “cases” and ensure that targets (e.g. reviews, care plans and outcome scores) have been achieved.

TRAINING AND QUALITY ASSURANCE

Ongoing audit will be used to check compliance with CPA requirements and to assess the quality of the CPA process. Access to information for audit purposes will be subject to the Data Protection Act and agency guidelines on confidentiality.

Team managers and supervisors should monitor the delivery of the care Programme Approach on an on-going basis as part of their supervisory role. They should identify training and development needs of team members through supervision and appraisal arrangements.

The Department of Health CPA audit format will be used in hospital and community services, on an annual basis.

Individual Team / Ward managers are expected to complete audits on the key standards on a regular basis, of at least one case per worker per month and a tool for on-going service improvement.

Findings of these audits will be fed back to individual workers via the supervision process, and aggregated findings published in the Performance Management framework.

It is expected that each team or service will provide one nominated lead. This person will undertake training on a regular basis for the team or service and will cascade this information to the team or service.

All newly appointed care co-ordinators must attend CPA training as part of their induction process.

FURTHER INFORMATION

REFERENCES

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