SOUTH ESSEX PARTNERSHIP NHS TRUST

CARE PROGRAMME APPROACH

Controls Assurance Statement

This policy and its associated procedures set out clear guidance for the Care Programme Approach, which will ensure that all risks associated with the Care Programme Approach are minimised.

1.0 Introduction

1.1 The Care Programme Approach applies to all adults of working age (aged 16-64) in contact with specialist mental health services (both health and social care). CPA is not dependent 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.

1.2 This document contains the policy and procedure for the Care Programme Approach (CPA). It has been written by the CPA Steering Group which has multidisciplinary members from all areas of the Partnership Organisation. The procedure 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.

1.3 The CPA forms, guidance documents and audit tools introduced with this policy and procedure provide a more consistent framework for the delivery and monitoring of the Care Programme Approach. But it is important to emphasise that CPA is a framework for good practice and a way of working, not just a new set of documents and forms. **The ability of individual practitioners to communicate clearly with each other, work in partnership with service users and carers and use sound professional judgement and skills are crucial to its success.**

1.4 All mental health workers in adult services, employed by South Essex Partnership Trust, are required to follow this policy and procedure. There will be some variation in the forms used by the Essex Forensic Service and services to older people, but these will be the only exceptions.

2.0 Policy Background

2.1 The Care Programme Approach was first introduced into the National Health Service in 1991 to "provide a network of care in the community" for people with severe mental illness (DOH 1990). It was founded on the belief that better co-ordination of care would prevent people from slipping through the net and finding themselves in the community without enough support.

2.2 By 1999 it was clear to the Government that mental health and social care agencies would have to work in partnership to deliver CPA effectively (DOH 1999). From 2001 CPA has applied to adults with mental health problems in contact with social services as well as to those in contact with the health service, and CPA superseded Care Management, used in social services departments since the early 1990s.

2.3 The Department of Health policy booklet: *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* gives a detailed account of recent changes in CPA (DOH 1999). To avoid unnecessary duplication this policy document does not reproduce the DOH guidance in full. Instead it focuses on local partnership arrangements and agreements that have been reached about the delivery of the Care Programme Approach in South Essex.

2.4 Key changes to the Care Programme Approach are summarised below:

- CPA is now delivered jointly by social services departments and health trusts.
- The Keyworker is now known as the Care Co-ordinator.
- There are only two levels of CPA: Standard and Enhanced.
- There is no set timescale for review (although local standards have been set – Standard CPA must be reviewed at least once every 12 months; Enhanced CPA at least once every 6 months).
- Carers providing regular and substantial care can have their own assessments, care plans and reviews. (Carers also have rights under separate carers legislation).
- Service users, carers and others involved in the Care Programme Approach can request a review at any time and if this request is not granted the reason should be recorded.

3.0 Legislation and guidance

The Care Programme Approach is a key part of a much wider modernising agenda for mental health services. Some of the key documents on the Care Programme Approach, and some related policy documents, are listed below. Most of these are available on the Department of Health website: www.doh.gov.uk. Copies can also be ordered from the DOH publications department: Tel. [I/S]

3.1 Guidance on the Care Programme Approach

Care Programme Approach (HC(90)23/LASSL(90)11) (DOH 1990)
Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet (DOH 1999)
Audit Pack for Monitoring the Care Programme Approach (DOH 2001)

3.2 Related legislation

Mental Health Act 1983
NHS & Community Care Act 1990
Carers (Recognition and Services) Act 1995
Human Rights Act 1998
Data Protection Act 1998
Carers & Disabled Children Act 2000

3.3 Other relevant guidance

Building Bridges (DOH 1995)
Still Building Bridges (DOH 1999)
Mental Health National Service Framework (NSF) (DOH 1999)
Mental Health Act 1983 Code of Practice/Memorandum (DOH 1999)
Fair Access to Care Services (DOH 2001)
Community Care (Direct Payments) Act 1996, Policy and Practice Guidance.
Http://www.doh.gov.uk/scg/ccdp.htm

4.0 An Overview of CPA

4.1 CPA is based on straightforward principles. These can be summarised as:

- Systematic assessment of the health and social care needs of those accepted into specialist health and social care mental health services.
- The preparation of written care plans setting out what help and support will be provided to meet the assessed needs of clients and to assist their recovery.

- The appointment of Care Co-ordinators to keep in close touch with clients, carers and service providers and to monitor and co-ordinate care.
- Regular review of the progress made towards intended outcomes and, where necessary, agreed changes to care plans.

4.2 **Levels of CPA**

In order to achieve greater clarity and consistency the Department of Health has set two levels of CPA that apply nationally:

Standard CPA
and
Enhanced CPA

4.3 The Department of Health criteria will be used locally to decide which of these two levels should apply. The characteristics of people on **Standard CPA** will include **some of** the following:

- 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.

People on **Enhanced CPA** are likely to have **some 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 (including the Criminal Justice System);
- they are likely to require more frequent and intensive interventions, perhaps with medication management;
- they are more likely to have mental health problems co-existing with other problems such as substance misuse;
- they are more likely to be at risk of harming themselves or others;
- they are more likely to disengage with services.

5.0 The Role of the Care Co-ordinator

5.1 The role of the care co-ordinator should usually be taken by the person who is best placed to oversee care planning and resource allocation. Where the client has standard needs and has contact with only one professional, whoever this may be, the role of care co-ordinator should fall to this professional.

5.2 The care co-ordinator is responsible for:

- keeping in close contact with the client, and for advising the other members of the care team of changes in the circumstances of the client which might require review or modification of the care plan.
- The care co-ordinator is responsible for updating the client's basic care plan and crisis plan.
- The Care Co-ordinator is responsible for ensuring that the client has a comprehensive assessment of their health and social care needs. (In this assessment the needs of any children affected by the clients mental illness must be addressed.)
- It is critical that the care co-ordinator should have the authority to co-ordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency of origin.
- It is also critical that the care co-ordinator can understand and respond to the specific needs of the service user that may relate to their culture or ethic background.

5.3 Both health and social care managers should ensure that the care co-ordinator can combine the CPA care co-ordinator and care manager roles by having:

- Competence in delivering mental health care (including an understanding of mental illness)
- Knowledge of client/family (including awareness of race, culture and gender issues)
- Knowledge of community services and the role of other agencies
- Co-ordination skills and
- Access to resources

5.4 Good caseload management and supervision processes are critical to maintaining effective practice.

5.5 Care plans for clients with severe mental illness who are at high risk of suicide should 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.

5.6 The Care Co-ordinator's responsibilities are:

- to monitor the delivery of the Care Plan
- to act as a consistent point of contact
- to organise CPA meetings
- to make sure that CPA documentation is completed and distributed
- to make sure that the care plan is reviewed at appropriate intervals
- To maintain regular contact with the service user, carer/s and other workers
- to monitor progress made towards intended outcomes

5.7 In the event of deterioration in the client's condition or problems in delivering the care plan, the Care Co-ordinator is responsible for arranging an urgent review. 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.

6.0 Confidentiality, Information Sharing and Complaints

6.1 Clients who come into contact with specialist 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. The leaflets that should be given by workers in the different agencies are listed below:

'*How to Complain, make suggestions or Compliment us'*
'*Information for NHS Patients'*
'Information Sharing Protocol'

6.2 Clients should be offered 'Users Guide to the Care Programme Approach.

6.3 Workers completing CPA forms should ensure that the information they record is accurate, relevant and legible. Records should be kept in a secure place where they are readily available in a crisis or emergency. Copies of CPA Care Plans and Crisis Plans should be sent to others involved in the Care Programme Approach, including carers, on a 'need to know' basis, provided the service user has agreed to this or there is a valid reason for sharing information without their consent. **See Appendix 1** for further guidance on Confidentiality and information sharing.

6.4 The CPA file must follow the client, and must be delivered into hospital in the event of the client being admitted, and follow the client back into the community on discharge. The file should be available for other professionals to contribute to at outpatient consultations and when other assessments have been requested.

6.5 Confidentiality and information sharing; service users' health and social care records should:

- be regarded as confidential and kept in accordance with the law
- be used only for the purpose intended and not for other purposes without the client's authorisation
- not be disclosed elsewhere unless, wherever possible, they have given their explicit and valid consent to such disclosure

6.6 Confidential information, which may be verbal or written, should be handled according to agency policies, procedures and protocols that comply with the principles of the Data Protection Act 1998 (**see Appendix 1**). Under ordinary circumstances information should only be shared with people outside the organisation on a 'need to know' basis, and with the service user's consent. Exceptional circumstances in which it may be appropriate to share confidential information without the service user's consent are outlined in **Appendix 1**.

6.7 The service user's consent to share confidential information with other agencies should be requested at the earliest possible opportunity. Service users should be given sufficient information to make an informed choice and the reasons for sharing information should be discussed. It is important to make service users aware that refusal to share information may compromise the quality of the service they receive. Once the service user has reached a decision about whether or not to agree to disclosure of

information outside the lead agency the appropriate form should be completed. Where consent is limited or refused this should be clearly recorded. There is a need to ensure sharing consent is kept up to date**.**

7.0 Assessment and Care Planning

7.1 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 South Essex Partnership Trust

7.2 If there is any uncertainty about how to assist a client or carer with sensory impairments or other special communication needs advice should be sought from a manager / supervisor, a colleague in a relevant discipline or a specialist agency.

7.3 Support from friends, relatives or advocates

Clients should be advised of their right to have a friend, relative, advocate or other person of their choice with them at CPA appointments and meetings. The CUES (Carers & Users Evaluation of Services) booklet should be offered to the client at an early stage in the Assessment process, and always prior to a CPA review. This process allows the client to make sure that things that are important to them in their daily lives are properly considered in the process.

7.4 Eligibility for Assessment

People are referred to specialist mental health services from a number of sources and at referral stage it is important to establish that they are eligible for assessment by the mental health team / practitioner receiving the referral. This decision should be inclusive rather than exclusive and

should take into account the person's whole situation. Factors that exist alongside mental health problems such as disabilities, communication problems, parenting or other caring roles, alcohol or drug use, financial difficulties, housing problems, unemployment and social or cultural isolation can increase needs/vulnerability/risk and should also be taken into account.

7.5 A Screening assessment should be carried out and the outcome of this assessment should determine whether further CPA assessment is required. If a CPA assessment is not carried out information should be given to the referrer about alternative routes into mental health services and other, more appropriate sources of support for the referred person. 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.

7.6 **Admission to hospital**

7.7 On admission to hospital, the initial screening assessment should have been completed by the person making the referral for admission. If this has not been done, it should be completed to provide information for the safe management of care in the first 72 hours in hospital.

7.8 The health and social care assessment must then be completed within the first 72 hours to allow the in-patient service staff to fully meet the clients needs, and anticipate any problems the client may experience on their return home.

7.9 If the client has had no previous contact with the services, the **Named Nurse** will take on the role of the Care Co-ordinator until one is allocated.

8.0 CPA Assessment

8.1 On receipt of a referral in the community, a screening assessment will take place to determine whether the person will go onto CPA.

8.2 If the person is not going to have a care programme, they may be given advice, information or referred to a more appropriate agency for help. They should also be advised that they could be referred again if their needs change or their difficulties persist and cannot be resolved in any other way. This information should also be sent to the referrer wherever possible.

8.3 The Confidentiality and Information Sharing Agreement, Preliminary Risk Screening and Outcome of Assessment should, be completed in all cases to establish with the service user (and where possible their carer/s).

8.4 Following the screening assessment, if the person is accepted for CPA, a full assessment of health and social care need should take place. If the service user disagrees with any part of their assessment this should be noted and any comments recorded.

8.5 If a decision is made **not** to offer care or treatment on the basis of the preliminary assessment the assessed person should be given information about other more appropriate services available to them.

8.6 During the full assessment, the **outcome score** will be completed.

9.0 Risk Assessment, Management and Review

9.1 Assessing, recording and managing risk are core elements of the Care Programme Approach. Risk should be considered at every stage of the process not just when a formal risk assessment is being carried out. In the course of day-to-day contact with the client and carer/s and during more formal meetings it is important to consider:

- Suicide
- Self-harm
- Neglect
- Abuse or exploitation (physical, emotional, sexual, financial, racial)
- Risk to children
- Violence to others
- Sexual offending
- Absconding /withdrawal from treatment.

9.2 The full Risk Assessment process must be completed for all clients who require an enhanced CPA, and for other clients where there are issues of risk currently clinically significant – some risks will be minimal in terms of seriousness, likelihood, or immediacy, and will not require further assessment. This is a tool to help structure clinical judgment, and to record the reasons for decision-making. It does not take the place of normal clinical assessment and further consideration of the risk factors.

9.3 Risk management will never eliminate risk, but it provides clinical teams with the structure to anticipate and prepare for foreseeable risk behavior. Risk is also dynamic – risks are constantly changing in response to circumstances; in particular treatment and management decisions are likely to change the risks. Assessment should reflect the most likely outcomes, not necessarily the most serious.

9.4 Risks change with time and the risk assessment needs to be kept under review.

9.5 It is good practice to seek information from the client and other sources e.g. carers, significant others, voluntary agencies, other mental health units when risk is being assessed and risk management strategies are being agreed. Carers also have an important role to play and should be consulted, involved and kept informed wherever possible.

9.6 If there appears to be a risk of abuse of a vulnerable adult then the No Secrets Policy (Thurrock Council) should be initiated.

9.7 If the client has parenting or child care responsibilities and family support is required or child protection concerns exist, the CPA assessor should refer to the 'Blue Book ' guidance on Child Protection and the protocol on joint working between adult mental health services 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.

10.0 CPA in In-patient and Residential

10.1 If the Care Programme Approach applies to someone admitted to hospital or residential care, their Care Co-ordinator should be informed immediately and will usually continue in that role during the course of the admission. Where discharge is likely in the short or medium term, joint working between in-patient and community-based staff should begin as soon as possible so that an appropriate Care Plan / Crisis Plan can be put in place.

10.2 Where a client is admitted to hospital and has not previously been on CPA, the Named Nurse will act as the Care Co-ordinator, until one is appointed by the appropriate CMHT.

10.3 The Care Co-ordinator may decide to review the existing Care Plan or to complete a completely new assessment. It is essential that community-based staff in the area to which the person will eventually be discharged contribute to reviews and meetings at which discharge arrangements are discussed and planned.

10.4 Assessment may be done jointly between in-patient and community staff and in some cases specialist assessments may be undertaken i.e. for forensic services. If a longer stay is likely community-based staff in the area to which the person will eventually be discharged should be invited to contribute to reviews or meetings at which discharge arrangements are being discussed and planned.

10.5 During admissions to in-patient units Named Nurses should develop Care Plans which meet the immediate presenting needs, but this should not be to the exclusion of other health and social care needs. Service users should be asked to sign these wherever possible.

10.6 It is good practice to hold a CPA care planning or review meeting prior to a Hospital Managers' Hearing or a Mental Health Act Review Tribunal. This means that a Care Plan (and where appropriate a Crisis and Contingency Plan) can be put in place should the panel decide to discharge the client from detention.)These plans must be made available to the Hospital Managers or to the Mental Health Review Tribunal as appropriate.

10.7 If a client is detained under the Mental Health Act established procedures and protocols will continue to apply with the exception of those relating to Section 117 of the Mental Health Act 1983 (See **Section 5.7** below).

11.0 Section 117 and Other Legal Requirements

11.1 CPA provides the one route through services for everyone in contact with specialist mental health services, including those subject to Mental Health Act sections and other legal requirements such as Probation Supervision and bail. CPA assessment forms, care plans and review forms should be completed in all of the above cases and the legal status of the individual should be clearly recorded.

11.2 Where a client is subject to Section 117 of the Mental Health Act 1983 separate Section 117 documentation should be completed. The Section 117 Review form should be photocopied onto blue paper before being sent with any revised Care Plans/Crisis Plans to the MHA Administrator of the relevant hospital after the review has taken place.

12.0 Care Planning

12.1 The client should be made aware that they can have a friend, relative or advocate with them when their care is being planned. A Care Co-ordinator should be appointed, this will be a mental health professional employed within the South Essex Partnership and authorised by their employer to perform this role. A decision should also be made about which level of CPA will apply. This decision should reflect the Department of Health criteria for allocation to Standard or Enhanced CPA (See **Section 3**).

12.2 The CPA Care Plan should be prepared and agreed **with** the client. The actions planned should be based on their assessed needs and recorded. Health alerts and other warnings should be clearly stated in the relevant section of the Care Plan. Key information that should be recorded includes details of where, when and by whom services will be delivered

and intended outcomes and timescales. The Care Plan should also give contact details for the Care Co-ordinator, others involved in the Care Programme Approach and out of hours and emergency services. Support received from self-help groups, carers and other services should be included in the Care Plan provided that this has been discussed and agreed with those concerned.

12.3 Any unmet needs should be recorded on the Care Plan and brought to the attention of the Care Co-ordinator's manager / supervisor. (Performance Management)

12.4 A contingency plan should be discussed and recorded as part of every Care Plan. This sets out what will happen if the Care Co-ordinator is away unexpectedly or part of the Care Plan cannot be delivered. Details (Phone numbers/mobile phone numbers) of anyone who has agreed to provide substitute care in an emergency should be included. Where there are significant risks to the service user or to others it is essential that the Care Co-ordinator's absence does not disrupt the delivery of the care plan. A substitute Care Co-ordinator should always be identified in such cases to ensure continuity of care.

12.5 If a client user disagrees with any part of his or her Care Plan this should be recorded. Clients should be asked to sign their Care Plan and given/sent a copy of it. Carers and other people involved in delivering CPA should also be given copies of the Care Plan wherever possible.

Because of legal requirements relating to confidentiality, information will not usually be shared with other agencies or individuals without the client's consent. Exceptions to this are outlined in Section 4 of this document: *Confidentiality and Information Sharing* and **Appendix 1**. Workers who have any doubts about whether or not information can or should be shared should seek advice from a Responsible Medical Officer / Consultant, manager, supervisor or Data Protection Coordinator. Actions taken and decisions reached should be clearly recorded.

12.6 A review date should be agreed and recorded on the Care Plan. If a Care Plan is put in place for the first time an initial review should be held within six weeks of the start date (four weeks in the case of discharge from hospital or residential care). The Care Co-ordinator should inform clients, carers and others involved in the Care Plan that they can request a review at any time and that if this is refused the reason will be recorded.

13.0 Crisis Planning

13.1 Clients on enhanced CPA will require, as part of their care plans, crisis and contingency plans. These plans form a key element of the care plan and should be based on the individual circumstances of the client. It is good practice where Standard CPA applies to have similar arrangements within the care plan.

13.2 The **Crisis Plan** sets out the action to be taken if the client becomes unwell or their mental health is deteriorating rapidly. To reduce risk the plan, as a minimum, should include the following information:

- things that are likely to trigger a crisis;
- signs that someone is becoming unwell;
- particular difficulties that have arisen in the past
- who the client is most responsive to;
- how to contact that person; and
- previous strategies which have been successful in overcoming crises

13.3 The Crisis Plan has a section in which to record the client's views about the most acceptable care and treatment options should he or she become acutely unwell. The client should be given the opportunity to add further information on continuation sheets or to attach a separate, more comprehensive, Advance Directive.

14.0 CPA Reviews

14.1 Review of the CPA Care Plan should be regarded as a continuous process but from time to time it will be necessary to arrange a more formal review. Everyone concerned with the Care Plan should be contacted in advance of the review date and asked to make a written or verbal contribution if they cannot attend in person. The aim of the review is to consider how well the Care Plan is working, to assess progress made towards intended outcomes, to reconsider risk and to make any adjustments that are needed because of changes in the service user's mental health or circumstances.

14.2 Clients should be consulted about forthcoming reviews and helped to prepare for them. Prior to the review the client should be given a copy of CUES to fill in and bring to the review meeting.

14.3 The client's wishes about the location and timing of the meeting and the number of people attending should be respected wherever possible. The client should be reminded that they can have someone with them to support them. Where appropriate, carers should also be involved in the review and if they are unable to attend in person they should be invited to contribute in some other way.

14.4 The timing of CPA review meetings is subject to a decision by the Care Co-ordinator on how long the proposed actions are intended to be in place and what the goals and expected outcomes to be achieved are.

14.5 The following timescales have been agreed as the **minimum** standard for local service delivery:

- **Standard** - a review must be held at least once a year.
- **Enhanced** - a review must be held at least once every six months.

14.6 At each review meeting the Care Co-ordinator should explicitly monitor the quality and effectiveness of the care, support and treatment that the client is receiving and review needs and risks. Progress made towards outcomes identified in the care plan should be discussed and recorded. Where no progress has been made alternative approaches should be explored. Any changes in the personal circumstances of the client should also be considered, including parenting or other caring responsibilities and informal support received from relatives, neighbours or friends.

14.7 The review should be centred on the needs of the individual client. Particular attention should be paid to whether needs relating to ethnicity, disability, communication difficulties or sexual orientation are being appropriately addressed.

14.8 Any unmet needs identified at the previous meeting and recorded on the care plan should be reviewed to see whether they still apply and whether they can now be met.

14.9 The review process will also establish whether the client needs continuing input from the specialist mental health service. If contact is to continue a decision should be made about whether the current level of CPA is still appropriate or whether this should be changed. This should be discussed with the client (and where appropriate their carer/s) and any decisions taken clearly recorded and communicated to everyone with a legitimate 'need to know'.

14.10 CPA reviews should be recorded. Review of Section 117 of the Mental Health Act 1983 should be completed and endorsed with the signatures that are legally required.

14.11 At each CPA review meeting a date for the next review should be set and clearly recorded.

14.12 At each review the CPA care plan must be revised.

14.13 **CPA Standards**

Standard 1: CPA Care Plans must include specific follow up in the first week following discharge from hospital

Standard 2: CPA Care Plans must have a record of where, when and by whom services will be delivered, intended outcome and timescale.

Standard 3: Care Plans should be signed by the client.

Standard 4: All Care Plans must have a review date.

Standard 5: Following discharge from hospital, a CPA review must be held within 4 weeks.

Standard 6: Crisis Plans must make an individualised record in each of these areas:

- **Things that are likely to trigger a crisis**
- **Signs that he client is becoming unwell**
- **Particular difficulties that have arisen in the past**
- **Who the client is most responsive to**
- **How to contact that person**
- **Previous strategies which have been successful in overcoming crises**

Standard 7: All Clients must be given a Crisis Card when accepted for CPA or on discharge from hospital

Standard 8: A Carers Assessment must be offered to anyone living with, or caring for, a client on CPA.

Standard 9: All clients will be invited to complete a CUES assessment prior to a CPA review.

Standard 10: Care Plans must be revised and re-issued after a CPA review.

15.0 Informal / Family Carers

15.1 Under the Carers (Recognition and Services) Act 1995, the National Service Framework for Adult Mental Health 1999 and the Carers & Disabled Children Act 2000 all individuals who provide 'regular and substantial' care for a person subject to CPA are entitled to:

- an assessment of their social and health needs

- a written care plan, agreed with them, that covers their needs as carers, reviewed at least once a year.

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

15.3 Carers should be given information about the support available to them and how to access it. They should also be told how to make comments, suggestions or complaints about mental health services. Young carers' educational, welfare and developmental needs should always be considered.

15.4 Subject to the consent of the client, or other legal requirements, carers should be given information about the support provided to the person they care for. Much of this information will be contained in their Care Plan. Wherever possible carers should also be given information about medication and other treatments, support arrangements, risk management strategies, and Crisis Plans. Even if the client does not want their carer/s to be actively involved in the Care Programme Approach 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.

15.5 Care Co-ordinators should inform carers that they are entitled to request a review of the CPA Care Plan for the person they support at any time and that any such request should be directed to the Care Co-ordinator in the first instance.

15.6 Someone providing regular and substantial care for someone subject to CPA has a right to an assessment of their physical, caring and mental health needs, *even if the client won't give permission for their carer to be contacted.* The carer has a right to have an assessor from a different team to ensure confidentiality.

16.0 Failure to Maintain Contact

16.1 This procedure applies to clients whose whereabouts and physical and mental well being are known, but who have made it clear that they do not wish to engage with services. It is important to try to establish the reasons for the client's failure to engage or failure to maintain contact with services at the earliest possible opportunity. It is sometimes possible to resolve difficulties or misunderstandings quickly and easily.

16.2 Where Enhanced CPA applies, or there are significant concerns about risk, failure to engage the client should be discussed immediately within the multi-disciplinary team and communicated to the GP and consultant. An assessment of the risk that the client presents to him/her self (including risk of self neglect), or others, should be undertaken and plans put in place accordingly.

16.3 Where significant risks exist consideration should be given to carrying out a Mental Health Act assessment with a view to compulsory admission to hospital. Where there are serious concerns regarding the safety of the public, consideration should also be given to informing the police of the situation at the earliest possible opportunity.

16.4 In all cases of failure to maintain contact an action plan should be set out following discussion within the team and (where appropriate) relatives or other carer(s). Advice given/received and actions taken should be clearly recorded.

16.5 This action plan should include the following elements:

- Wide ranging consultation with people involved in the client's care or support, which might include some or all of the following: team members, GP, carer(s), advocate and family member and other relevant housing officers and voluntary sector agencies.

- A formal review during the initial six-month period following the unsuccessful attempt to engage the client.

- A team decision on the minimum level of contact with the client. For example, an attempt to visit by a CPN or Social Worker at least once a fortnight, an offer of an out-patient appointment every two months, and weekly support/monitoring via a third party such as a housing support worker.

16.6 Where there are concerns about extreme risks presented by a particular service user it may be appropriate to consider convening a Public Protection Meeting.

16.7 Where the client is reluctant to accept help it is essential that the Care Co-ordinator records all efforts that are made to maintain contact with the person, including consideration given to using powers under the Mental Health Act.

16.8 In exceptional circumstances contact with the specialist mental health service may be ended where there has been no contact with the client user for at least one year. This step should be fully discussed by the multi-disciplinary team and documented in the service user's file and medical case notes. The team concerned should ensure that the client's GP and formal and informal carer(s) involved in the Care Programme Approach are consulted and informed about this decision and told how to make contact with services in the future if they have concerns. Every attempt should also be made to communicate this decision to the client.

17.0 Transfer of Care

17.1 If a client to whom CPA applies moves out of the area or is referred to another team or service the Care Co-ordinator and his or her colleagues should decide what information should be shared with them. This will depend on the client's circumstances, legal status and any agreements reached about information sharing.

17.2 **Before** responsibility for care is transferred the Care Co-ordinator should ensure that:

- The receiving team/service has identified a Care Co-ordinator.
- Appropriate services have been set up with the receiving team/service to meet the client's needs.
- Sufficient information has been made available to the appropriate professionals in the receiving team/service.
- The decision to transfer care has been communicated in writing to the client, their carer and, where appropriate, their GP.

17.3 Information sharing will usually be subject to the client's agreement although confidentiality can be over-ruled in certain clearly defined circumstances outlined in **Section 4** of this document and **Appendix 1**.

17.4 If a client who is subject to CPA disappears unexpectedly and serious concerns exist about risk to that person, or risk to others, the police and other agencies should be contacted **without delay**. Consideration should also be given to contacting carers and other individuals who need to be informed or who are in a position to help locate the person. In an emergency confidential information can be shared with other people who have a legitimate need to know without the client's consent. If there is any doubt about the appropriate course of action the advice of a Responsible Medical Officer (RMO), Consultant or Senior Manager. Advice given and actions taken should be clearly recorded.

18.0 End of Contact with Specialist Mental Health Services

18.1 The decision to end contact with the specialist mental health service, or to vary the level of CPA, will usually only be made at a CPA review meeting. If the client disagrees with the decision this should be recorded on the CPA review form. If the client agrees they should be given information on how to make contact with services in the future if their needs change. In both cases the client should be invited to record any comments on the review form and to sign it.

18.2 Wherever possible carers should be consulted about the decision to vary the level of CPA or to end contact between the client and the specialist mental health service. If contact is to end carers should be given information on how to get in touch with services in the future if they have concerns.

18.3 The decision to end contact with the specialist mental health service or to vary the level of CPA should be communicated to everyone involved in the Care Plan as soon as possible. Paper and computerised information systems should be updated without delay.

19.0 Training and Quality Assurance

19.1 Team leaders and managers should monitor the delivery of the Care Programme Approach on an on-going basis as part of their supervisory role. They should also identify training and development needs of team members through supervision and appraisal processes.

19.2 Ongoing audit will be used to check compliance with CPA requirements and 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.

19.3 The Department of Health CPA audit format will be used by all CMHTs. Audits will be done in each team on a quarterly basis – one audit per worker per quarter. Findings of these audits will be fed back to individual workers via the supervision process, and aggregated findings published in the Performance Management framework.

19.4 This Care Programme Approach Policy and Procedure will be monitored, reviewed and amended on an ongoing basis.

Please note: specific complaints about service delivery should be made through the formal complaints procedures of the relevant agency.

20.0 Policy reference Information

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The Director responsible for reviewing this policy is

the Director of Adult, Child & Adolescent Mental Health Services