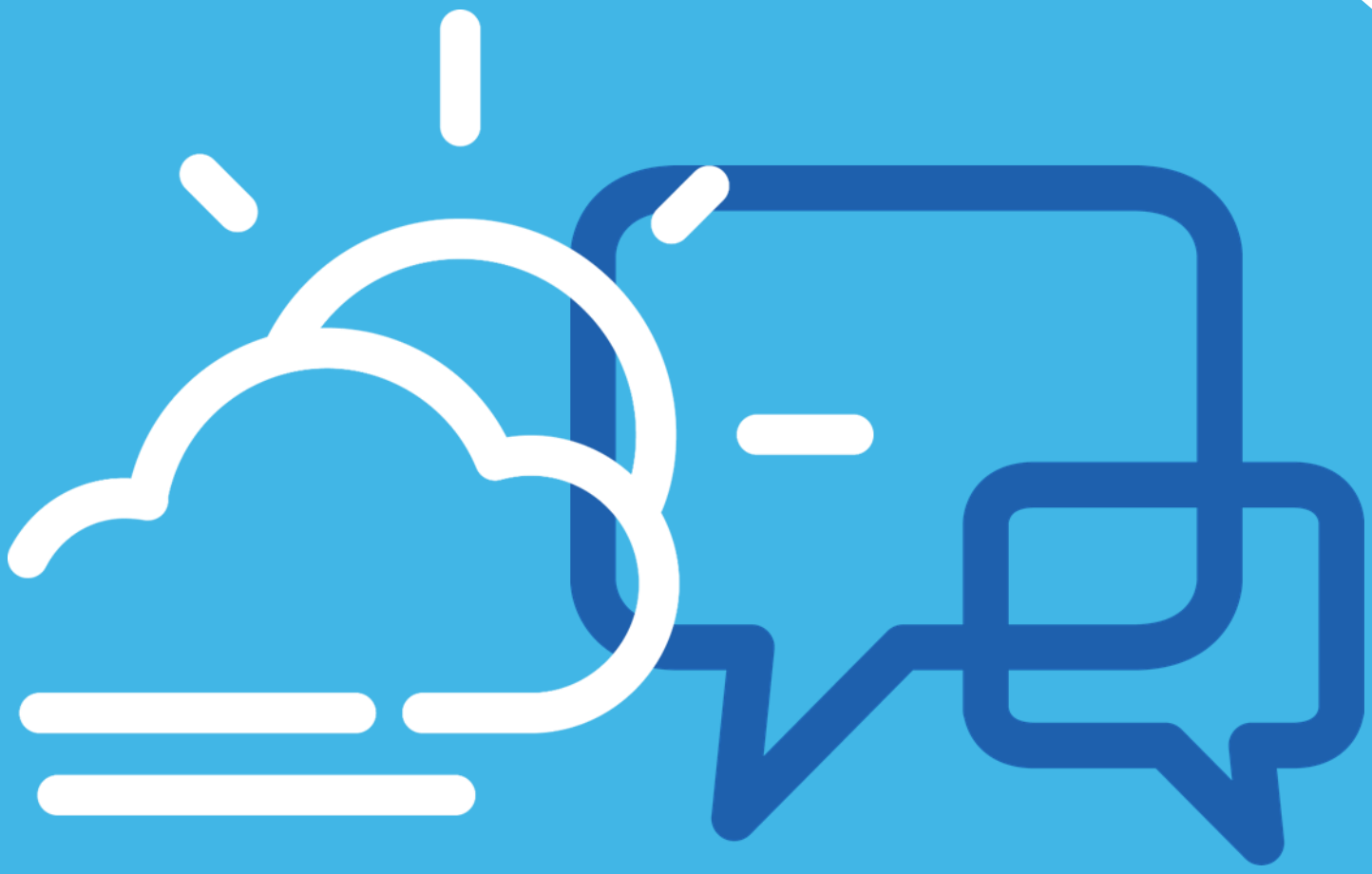
NHS
Greater Manchester Mental Health
NHS Foundation Trust

# Care Programme Approach Policy

Greater Manchester Mental Health NHS Foundation Trust



Improving Lives

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| **Document Name:** | **Care Programme Approach Policy** |
| **Executive Summary:** | The policy sets out the guiding principles of the Care Programme Approach and how this will be delivered within GMMH. The policy harmonises and therefore replaces the previous policies in place in the former GMW and MMHSCT. |
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| **Document Purpose:** | Policy |
| **Target Audience:** | All clinical staff in GMMH |
| **Additional Circulation List:** | All services |
| **Date Ratified:** | 9th April 2019 |
| **Ratified by:** | Risk Management Committee |
| **Consultation:** | All clinical staff in GMMH via SharePoint |
| **Cross Reference:** | This policy should be read in conjunction with related trust policies and procedures including the MCA & DoLS policy<br>MHA Hospital Manager's Hearings Policy<br>Consent to Treatment Policy<br>Community Treatment Order Policy |
| **Superseded Docs** | MMHSCT CPA Policy<br>GMW CPA Policy |
| **Date of Equality Impact Assessment:** | 26th March 2019 |
| **Board Objective Reference:** | We work together<br>1 – to promote recovery by providing high-quality care & delivering excellent outcomes<br>2 – to work with service users & carers to achieve their goals<br>3 – to engage in effective partnership working |
| **CQC Regulation Reference:** | Safe, effective, responsive, effective and well led<br>9 – Person Centred Care<br>10 – Dignity & Respect<br>12 – Safe Care & Treatment<br>13- Safeguarding service users from abuse and improper treatment |
| **Risk Register Reference:** | Not applicable |
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| **Document Status** | This is a controlled document. Whilst this document may be printed, the electronic version posted on the Trust intranet is the controlled copy. |

## Contents

## 1. Introduction

The Care Programme Approach (CPA) was introduced by the Department of Health in April 1991. It required health authorities, in collaboration with social services departments to put in place specified arrangements *'for the care and treatment of mentally ill people in the community'* requiring health and social care authorities to work together. The original guidance was updated by the publication of 'Effective Care Co-ordination in Mental Health' in October 1999 which set out to integrate care management and care programme approach.

With the publication of the Mental Health National Service Framework in 1999, mental health policies increasingly focused on personalisation through an emphasis on meeting the wider needs of those with mental illness, addressing equalities, tackling the problems of social inclusion and promoting positive risk management. However, it was clear that more needed to be done to apply good practice consistently across the country and in March 2008, following national consultation, the Department of Health issued best practice guidance on *Refocusing the Care Programme Approach (March 2008)*. This updated guidance highlights good practice, keeping recovery at the heart of the person centred approach. It also sets out how CPA and Non CPA, hereafter known as Standard Care, should be used. The guidance provides a Statement of Values and Principles.

This policy sets out how Greater Manchester Mental Health NHS Foundation Trust (the Trust), together with its local authority partners; Bolton Council, Trafford Council, Manchester City Council and Salford City Council will meet national guidance and Care Quality Commission, (CQC), Health and Social Care Regulations related to the implementation of the Care Programme Approach. The Care Programme Approach (CPA) is endorsed by The Trust's Recovery Strategy, which highlights the need for true collaborative care planning and links to the Triangle of Care.

This Care Programme Approach (CPA) Policy has been updated to reflect best practice and a recovery-focus approach. It provides a framework for the assessment, care, support, planning and review of people referred to secondary care mental health services provided by the Trust. The principles of personalisation, choice and recovery underpin the approach supported by this policy. "*Recovery does not simply mean the absence of symptoms but refers to the process whereby a person gains more control in order to establish a meaningful and fulfilling life" (Kilbride and Pitt (2006).*

Procedural guidance on the CPA for each division will be developed, and will replace the Trust CPA Procedure. Any local variations in procedure must be compatible with this policy and be ratified by the appropriate Trust committee.

### 1.1 Purpose

**Statement of Values and Principles**

**Trust Values**

Greater Manchester Mental Health NHS Foundation Trust shared Values are:

**We Inspire Hope**
**Which means:**

- Having a positive outlook on the future ahead
- Celebrating achievements, no matter how small
- Staying resilient and optimistic
- Enabling people to reach their full potential
- Being a positive role model

**We Work Together**
**Which means:**

- Empowering service users to make informed choices
- Working together to provide seamless services
- Lending a hand to a colleague who needs it
- Setting and maintaining high standards
- Supporting each other to recognise our strengths

**We are Caring and Compassionate**
**Which means:**

- Showing empathy and understanding to all
- Treating service users, their families and each other with kindness
- Doing the little things that make a difference
- Taking time to engage, support, listen and act
- Putting ourselves in your shoes

**We Value and Respect**
**Which means:**

- Seeing the individual in everyone
- Valuing individuality and diversity
- Respecting different people's needs, aspirations and priorities
- Being considerate and respecting each other
- Challenging behaviour that does not fit with our values

**We are open and Honest**
**Which means:**

- Acting with integrity and honesty
- Apologising if we are wrong or if we let you down
- Continually learning to improve
- Doing what we say we will do
- Building a trusting relationship

## 1.2 Scope

### CPA Principles

1. The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

2. Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

3. Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

4. Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

5. Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.

6. Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies not just the planned occasions where people meet for reviews.

Department of Health (2008). Refocusing the Care Programme Approach: Policy & Positive Practice Guidance

## 2. Definitions

**Advance Decision:** A decision to refuse specified treatment made in advance by a person who has capacity to do so, to apply at a future time when that person lacks capacity.

**Care co-ordinator:** The qualified mental health professional who, irrespective of their ordinary professional role, has responsibility for co-ordinating care, keeping in touch with the service user, ensuring the care plan is delivered and reviewed as required.

**Carer:** An individual who provides or intends to provide support to someone with a mental health problem. May be a relative, partner, friend or neighbour, and may or may not live with the person cared for.

**Lead Professional for standard care:** The professional who has lead responsibility for an individual's treatment and care, in their ordinary professional role.

**Recovery: '**Is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are on-going or recurring symptoms or

problems.' *(Sainsbury Centre, 2008)*

**Standard Care:** Treatment and care provided within secondary mental health services, for those whose needs do not require the support of the CPA.

**The Trust:** Greater Manchester Mental Health NHS Foundation Trust.

## 3. Duties

### 3.1 Board/Lead Committee

**Risk Management Strategy Group**

The Risk Management Strategy Group is responsible for approving and monitoring this policy including the receiving of a written chairs reports on the implementation of the policy.

**CPA Steering Group**

The CPA steering group report to Quality Governance Committee via a written Chair's report.

### 3.2 Chief Executive

To ensure arrangements and resources are in place to ensure the provision of CPA within the Trust as outlined within the policy.

### 3.3 Directors

**Director of Operations**

The Director of Operations is the Executive Lead for CPA and must ensure that the Trust has robust CPA policy and procedure. Local arrangements are delegated down to Assistant Director for Social Care.

**Medical Director**

**Director of Nursing**

**Associate Director of Human Resources and Organisational Development**

Ensures that the appropriate training needs analysis for CPA is undertaken and reports are provided on CPA training to the Risk Management Strategy Group.

### 3.4 Head of Operations

**Head of Operations/Associate Medical Director**

Heads of Operations are responsible for ensuring that CPA policy and local CPA

protocols are followed by all Clinical Staff in their Divisions in order to ensure compliance with national guidance and that resources are in place to support this.

Responsibility to appoint a Divisional CPA lead.

## 3.5 Managers

### Community Team Managers

Managers are responsible for allocating Care Co-ordinators and for providing;

- Systems that effectively trigger multi-disciplinary discussions and decisions regarding whether a person should be on CPA.
- Regular opportunities for practitioners to discuss assessment and care planning within a multi-disciplinary team and with their line manager via supervision. Ensuring that high risk service users are discussed regularly.
- Opportunities for staff to attend required training as identified within the training needs analysis.
- Relevant interagency agreement to ensure high quality communication and coordination across services.

## 3.6 Employees

### Assistant Director of Social Care (or CPA lead)

The Assistant Director of Social Care is responsible for;

- Co-ordinating the CPA steering group
- Co-ordinating the Directorate CPA Lead Officers
- Liaises with Local Authority Partners on integrating case management arrangements into CPA
- Ensure dissemination of policy.
- Provide or organise training and advice within Divisions.
- Ensure dissemination of lessons learned locally and nationally regarding CPA.

### CPA Care Coordinators

It is the responsibility of CPA care coordinators to ensure they undertake assessment and care planning in line with the CPA policy and to ensure that they have attended the approved training to do so.

### Lead Professionals for standard care

It is the responsibility of identified lead professionals for standard care to undertake assessment and care panning in line with this policy.

## 4. Processes and Procedures

### Refocusing the Care Programme Approach

To meet the requirements of 2008 DH guidance, the term Care Programme Approach (CPA) will be applied only to arrangements for that group of service users having complex care needs. Other service users will be referred to as receiving standard care.

This policy incorporates the requirements of 'Refocusing' into previous CPA guidance, which has not been rescinded or replaced. It underpins any locally agreed protocols.

### Care Programme Approach and Standard Care

In Trust services, the term Care Programme Approach (CPA) will be used to describe the approach used to assess, plan, review, and co-ordinate the range of treatment, care and support needs for people who have complex needs. The term CPA will no longer be used to describe the usual system of provision of secondary mental health services to those with more straightforward needs. Instead they will be referred to as receiving standard care.

All Service Users referred to GMMH services that are operating under CPA are entitled to an assessment of their health and social care needs. Following this assessment, the decision regarding whether the Service User requires the level of treatment and support provided by secondary mental health services will be made. This assessment may result in no support being offered by GMMH and the Service User may be discharged to Primary Care, or signposted to other services.

If people do not need secondary mental health services involvement the referrer, service user and carer/s (as appropriate) should be informed as soon as possible, with recommendations for alternative care where appropriate.

People accepted into secondary services should be assigned to CPA or standard care following assessment that considers their needs and risks. Whilst bureaucracy for those receiving standard care should be minimised, their rights to an assessment of needs, the development of a plan for treatment and care and a review of that care by a lead professional, will remain. The values and principles of personalised mental health within an ethos of recovery apply to all service users.

### The Essential Elements of CPA

The CPA is a delivery system for mental health care with four essential elements.

- A systematic **assessment** of health and social care needs,
- An agreed **Care Plan**
- The appointment of a named **Care Co-ordinator**.
- Regular r**eviews** to reconsider need and change plans as necessary

*CPA is not a process of document management, but rather the essential underpinning framework for assessment, planning, delivery and review of care and ultimately discharge from services*

**Characteristics and Service Responses for CPA and Standard Care**
This section gives lists of characteristics that will assist practitioners in determining if, following initial assessment, the individual's needs require the support of CPA or standard care only.

It must be emphasised that the following characteristics should *not* be used as indicators of eligibility for secondary mental health services. Services should continue to use current local eligibility criteria to make initial decisions on an individual's need for secondary mental health services. The following characteristics should then be employed to decide if, having been accepted as needing secondary mental health services, further support is needed with engagement, co-ordination and risk management under CPA or Standard Care.

**Characteristics of those Requiring CPA**
For individuals needing the support of the Care Programme Approach, characteristics are likely to be:

a) Severe mental disorder (including personality disorder) with a high degree of clinical complexity
b) Current or potential risks including:
    - Suicide, self-harm, harm to others, (including history of offending)
    - Relapse history requiring urgent response
    - Self-neglect/non-concordance with treatment plan
    - Vulnerable adult; adult/child protection issues e.g. financial/sexual exploitation, financial difficulties related to mental illness, dis-inhibition, physical/emotional abuse, cognitive impairment.
c) Current/significant history of severe distress/instability or disengagement.
d) Non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability.
e) Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
f) Currently/recently detained under Mental Health Act or referred to crisis/home treatment team.
g) Significant reliance on Carer(s) or has own significant caring responsibilities.
h) Experiencing disadvantage or difficulty as a result of: parenting responsibilities, physical health problems/disability, unsettled accommodation/housing issues, employment issues when mentally ill, significant impairment of function due to mental illness, ethnicity (e.g. immigration status; language difficulties; religious practices); sexuality or gender issues.

**Characteristics of those requiring Standard Care**
Those requiring standard care will have more straight forward needs and it is likely that:

- They require the support or intervention of one agency or discipline, or have no problems with access to other agencies/support;
- They are more able to self-manage their mental health problems;
- They have an active informal support network;
- On assessment there is little evident risk;
- They are more likely to maintain appropriate contact with services

**Role of the Lead Professional in Standard Care**

'Refocusing the CPA' introduced a new role of lead professional for those who do not need CPA. The lead professional has:

*'The responsibility for facilitating the delivery of care to the service user who has been identified as having straightforward needs'.*

The lead professional will be the qualified practitioner providing treatment or care, and may be a psychiatrist, a psychologist, community psychiatric nurse, occupational therapist or social worker. The Lead Professional has the responsibility for facilitating the delivery of care to a service user who has been identified as requiring Standard Care.

The Lead Professional must provide:

- An assessment of health and social care needs, annually as a minimum. Assessment should consider the ongoing need for Standard Care, the need for CPA or whether their needs can be met in Primary Care.
- A care plan to meet those needs which includes who to contact in a crisis in a suitable format, (a letter will suffice)
- A review date.

**Service Responses for those Service Users needing CPA and Standard Care**

| **Service Users needing CPA** | **Other Service Users Standard Care** |
|---|---|
| **An individual's characteristics**<br><br>*Complex needs; multi-agency input; higher risk* | **An individual's characteristics**<br><br>*More straightforward needs; one agency or no problems with access to other agencies/support; lower risk* |

| What the service users should expect: | What the service users should expect: |
|---|---|
| Support from CPA care coordinator (trained, part of job description, co-ordination support recognised as significant part of caseload) | Support from professional(s) as part of clinical/ practitioner role. Lead professional identified. Service user self-directed care, with support |
| A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks | A relevant assessment of health and social care needs including risk assessment |
| An assessment of social care needs against the National Eligibility Criteria. | |
| Comprehensive formal written care plan: including treatment goals (Inc. monitoring plan, risk and safety/contingency/crisis plans. Written with service users and professionals and a copy given | Clear understanding of how care and treatment will be carried out, by whom, and when (can be a Clinician's letter) |
| On-going review, formal multi-disciplinary, multi-agency review at least every 12 months but likely to be needed more regularly | On-going review as required but at least annually |
| At review, consideration of on-going need for CPA support, step down for Standard care or discharge | On-going consideration of need for move to CPA if risk or circumstances change or discharge |
| Increased need for advocacy support | Self-directed care, with some support if necessary |
| Carers identified and informed of rights to own assessment | Carers identified and informed of rights of own assessment |

## 4.1 CPA Assessment

**SU Assessment**

This is a thorough assessment of health and social care needs, which will involve the service user and carer(s) as central participants in the process. It will also involve the process of gathering information about the service user's previous contact with services and historical mental health issues and a comprehensive assessment of their needs and strengths in the context of the person as a whole. Comprehensive assessment will usually but not invariably be multi-disciplinary. Each assessment will include the need for CPA. National guidance requires the following range of needs and issues to be considered at assessment and re-assessment as part of the CPA process:

- Psychiatric, psychological and social functioning, including impact of medication
- Risks to the individual and others, including previous violence and criminal record
- Needs arising from co-morbidity (e.g. drugs, alcohol misuse)

- Family roles, including parenting issues and other caring roles
- Housing, financial needs and capability
- Employment, education and training needs
- Physical health needs
- Communication, cultural, gender, religious, spiritual and access needs
- Social inclusion and social contact and independence
- The ‘Violence and Abuse Question’.

An assessment is not just a gateway to care and support, it is an intervention to enable people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it. The assessment should enable people to understand their strengths and capabilities, and the support available to them in the community and through other networks and services. The needs assessment will help to collect information about the adult and/or carer and details of their wishes and feeling and their desired outcomes and needs. The assessing professional should facilitate the attendance of an advocate, carer, friend or interpreter as requested or required for the service user.

**Carer’s Assessment**
The Care Act (2014) gives local authorities a responsibility to assess a carer's need for support, where the carer appears to have such needs. This replaced the law which said the carer must be providing "a substantial amount of care on a regular basis" to qualify for an assessment. This means more carers are now able to have an assessment. The local authority will assess whether the carer has needs and what those needs may be. This assessment will consider the impact of caring on the carer. It will also consider the things a carer wants to achieve in their own day-to-day life. It must also consider other important issues, such as whether the carer is able or willing to carry on caring, whether they work or want to work, and whether they want to study or do more socially.

If the service user’s assessment and the carer’s assessment are not to be carried out by the same person, the carer must be advised who will do the assessment. Where professionals do not carry out this assessment themselves they must advise the carer as to who will carry this out, and what is involved. They retain responsibility for the quality and appropriateness of the carer’s assessment and any resulting care plan.

**Assessment of Parent and Child Needs**
Establishing whether a service user is a parent at the initial assessment stage is critical, and must be routine. This will include service users who are temporarily separated from their children. Assessment, including risk assessment, should routinely consider the potential or actual impact of adult mental health problems on parenting, the parent and child relationship, and on the child.

All CPA reviews and discharge planning should consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the child is not living with the service user. Any risk to

children should be assessed not only initially but also on review or as circumstances change, e.g. resumption of contact following a period of inpatient care.

All staff are committed to make paramount the welfare of children within all services provided by the Trust, and the first priority will be the protection of any children identified as at risk, in accordance with the Trust's Safeguarding Children Policy. This will include protection of children in the wider community in some cases, e.g. if a disclosure of historical abuse is made, and the alleged perpetrator may still have access to children.

The impact of parenting on adult mental health should be considered. The strengths that service users may bring to their role as parents, and the importance of the role in their lives, should also be acknowledged. The welfare of dependent children will usually be best served by careful assessment of the needs and strengths adults have as parents, and access to the most appropriate support for those needs, as part of the total care package. However the risks that adults may pose to children in their care, including the risk of neglect, must be carefully assessed and managed, usually in partnership with other agencies.

The situation of children who are carers of parents with a mental health problem must be carefully assessed. The needs of young carers can be overlooked by adult services. Typically they may provide care to a lone parent and they can be at risk of social isolation and bullying, under-achievement, absenteeism from school, and physical and mental ill health.

Assistance to young carers should not reinforce the role of the child or young person as a carer. Their needs will be identified at the service user's assessment but they will be considered as Children in Need and their support will be provided through children's services. They do not have a carer's assessment as such. Staff should seek advice from Local Authority children's services on the assessment of young carers.

A consultant psychiatrist should be directly involved in all clinical decision making (e.g. agreeing leave) for all service users who may pose a threat to children, including parents with delusional beliefs involving the children and/or homicidal thinking prior to completing suicide.

In some cases of homicide committed on children mental health organisations have inappropriately delegated key decision making for patients known to have delusional beliefs about their children (e.g. decisions on granting home leave made by junior medical staff)

**Decision making and documentation**

The outcome of the initial assessment should be communicated to the individual (in a way that they will understand) and the referrer promptly. If it is agreed that the person's needs are best met by a secondary mental health service, a care plan should be collaboratively devised and agreed with the service user and, where appropriate, their carer. A copy of which should be offered and given.

The Trust Standard and Structure of Clinical health Records Procedure states that all healthcare practitioners and staff involved in clinical care are professionally accountable for keeping clear, legible, accurate and contemporaneous clinical records which record all the relevant clinical findings, any decisions made, information given to patients and any treatment prescribed.

Any unmet needs should be identified and escalated through appropriate governance structures.

## 4.2 Standard Care (Non-CPA)

**Standard Care Assessment**
This needs to be an assessment of health and social care needs which will involve the service user and care as central participants in the process. The following range of needs should be assessed as part of the standard care process in the same way this range of needs is considered for CPA:

- Psychiatric, psychological and social functioning and the impact of medication
- Risks to the individual or others
- Needs arising from co morbidity
- Family roles, including parenting and other caring roles
- Housing, financial needs and capability
- Employment, education and training needs
- Physical health needs
- Communication, cultural, gender, religious, spiritual and access needs
- Social inclusion, social contact and independence

**Standard Care Plan**
Following the initial assessment a plan of care should be agreed with the service user and their carer's. This plan can be recorded in any format (including a letter) and must provide the basic information of the planned care and what to do in a crisis. The service user must be offered a copy of their standard care plan. Where appropriate carer's should also be offered a copy of the standard care plan.

**Standard Care Review**
Service users on standard care should expect a review at least every 12 months. More frequent reviews should take place if required. This should include a review within days of discharge from an inpatient mental health unit or transfer from another secondary care mental health service.

Any review must consider all of the person's health and social care needs and involve the service user and their carer's where possible.

**Discharge from Standard Care**
It is not expected that service users will remain on standard care indefinitely. Care planning should be recovery focused and reflect a clear role for secondary care

services.

Discharge from Standard Care should be agreed with the primary care service taking over the care of the service user referencing Shared Care agreements where appropriate.

## 4.3 CPA Review

Assessment and care-planning are ongoing processes for all service users. There must be a formal multi-disciplinary, multi-agency review, led by the care coordinator, at least every twelve months, and more frequently if required.

Whilst it is expected that the care coordinator and service user can agree changes to the care plan informally, any member of the care team, any involved carer, or the service user can request an earlier formal review.

Any review must consider all of the person's assessed health and social care needs, the contributions of the service user and people supporting them, along with those of statutory and non-statutory services involved in the person's care. As more individuals and services are required to meet an individual's needs, the more formal and structured the annual review will need to be.

**In addition to a formal annual review, the CPA care plan should be reviewed where there is a significant change in the individual's circumstances, before discharge from an inpatient mental health unit and where transfer to another secondary care mental health service is taking place.**

**Preparing for the review**
The care coordinator will be responsible for overseeing the arrangements for the annual, and any interim reviews. They will be supported by administration staff in doing this.

In preparing for a review, the views of staff and external services should be sought, and relevant parties should be invited to attend and/ or supply written documentation in support of the review. With the agreement of the service user, any relevant carer or other supportive person, should be included. It is essential that, where the patient has an identified consultant psychiatrist that they are asked to contribute to the formal review and they should be asked to determine whether they consider they need to attend in person, or can otherwise contribute to a review without attending.

It is important to be recognise the individual needs of the service user in considering who should be invited to contribute and how the meeting should be organised (location, timing, and agenda).

The care coordinator will need to meet with the service user, carer or advocate before the formal CPA review to consider with them the following points:

- The purpose of the review – for example, is this a planned annual review, or a more focused review at the point of discharge from inpatient services?
- What progress has been made against items on the current care plan; where

progress has not been made, the care coordinator and the service user need to think about why this has happened. Where goals have been achieved, the care coordinator and service user can reflect on what has gone well, and why, and celebrate success.

- The current needs – a tool such as the MANCAS may be used to structure the review of current needs. As community teams deliver health and social care, this review of current needs must meet the requirements of the Care Act.
- What input the person has had in relation to their physical health and whether arrangements need to be made for them to see their GP, a member of staff from the physical health pathway or another health professional in relation to their physical health needs.
- Any shared care arrangements in place in relation to medication.
- The crisis and contingency plans and whether they need updating.
- Any personal WRAP (wellness and recovery action plan) developed by the service user, any advance directive or other legal statement (e.g. active power of attorney), any DNAR order.
- Any Individualised Budget in place and any Personal Health Budget in place.
- Reviewing the eligibility for social care provision
- Any CTO or other Mental Health Act or Mental Capacity Act provision in place (e.g. Guardianship, DOLS).
- Any involvement of external services, both statutory and non-statutory, for example probation service, social care, education, leaving care services, learning disability services. Where service users live in supported accommodation, the provider should be asked to provide written information in support of the review, and consideration given to asking them to attend the review in person. Where learning disability services are involved, any named keyworker must be asked to attend the CPA review in person.
- Any concerns the service user may have about the review process.
- Whether an advocate is needed.
- The arrangements for the review meeting – who should attend, where/ when.
- How feedback will be obtained from those not attending the meeting.
- Whether the CPA framework is still necessary.
- Whether the s117 aftercare responsibility has now been discharged and the person discharged from aftercare.

After this discussion, the care coordinator should be in a position to prepare a draft updated care plan.

**Arranging the review**

The identified administrator, working with the care coordinator (or named nurse if an inpatient), will send out requests for information from involved staff and external services and invitations to attend to those identified as needed to attend by the care

coordinator following discussion with the service user and consideration of the complexity of the review. The patient's GP should be asked to provide written feedback for the review.

The administrator will invite any consultant psychiatrist involved in the care of the patient to decide whether, in their view, they need to attend, or can provide written or other feedback via the care coordinator.

The administrator will make any necessary room bookings and also arrange for interpreters where required. They will also collate information received and ensure that the care coordinator has time to consider it before the review meeting takes place, and that the collated documentation is uploaded to the person's electronic patient record.

**The review**

The review will be chaired by the care coordinator, who will be aware of the needs of the service user and those present, and ensure that opportunities for participation are maximised.

The meeting will briefly consider the previous care plan and what progress has been made in achieving goals before considering the draft care plan and, in particular:

- the identified current needs
- The goals – in straightforward terms – what is the service user hoping to achieve in relation to the current need over the coming twelve months?
- The actions – what steps will be taken to achieve the goals and who will be taking them?

Once the care plan has been agreed and entered in the electronic patient record, the administrator will distribute copies to the service user, to any identified carer with the permission of the service user, to the GP and to anyone attending the meeting (with the permission of the service user). They will also ensure that the preparations for the next formal review are commenced no later than ten months after the completion of the review.

**Reviews on discharge from the ward**

Where people are discharged from inpatient care, consideration must be given as to whether they need to be discharged under the CPA framework, if they are not already subject to CPA. Any decision about this aspect of care should be considered by the multidisciplinary team taking account of current and historical risks. Where a decision is taken to discharge a patient from inpatient care out with the CPA framework, the care documentation should include details of the decision making process and the names of staff involved.

Any review before discharge from inpatient services should, as an ideal, be led by the community care coordinator, attended in person by all key contributors to the care plan and include the user/patient, any advocate, and a carer/relative. If scheduling such a face to face meeting could lead to unacceptable delay in arranging discharge, the care coordinator should seek the input of contributors to the

care plan, including any identified carer, by telephone, and ensure that they know of the discharge plans, and agree to the part they will play. The care coordinator will complete the review having agreed these contributions, and ensure that a copy of the reviewed care plan is given to the service user, to those contributing to the plan, and to the GP. All service users leaving hospital under CPA arrangements must have a copy of their updated care plan.

After-care for all patients admitted to hospital for treatment for mental disorder should be planned within the overall framework of the CPA, whether or not they are subject to Section 117. For Section 117, the Aftercare Plan is the CPA care plan, and its contents are specified in the Code of Practice to Mental Health Act (1983) (as amended).

## 4.4 CPA and the Mental Health Act.

**Community Treatment Orders:**

The Code of Practice for the Mental Health Act Health (2007) states that good care planning and aftercare arrangements in line with the CPA will be essential to the success of Supervised Community Treatment orders, therefore all those discharged from hospital under such orders must have CPA plans and an identified care co-ordinator.

**Guardianship/Section 117:**

A comprehensive Care Plan established on the basis of multi-disciplinary team discussions in accordance with the CPA should accompany any application for Guardianship under section seven of the Mental Health Act (2007). The Care plan should identify services needed and who will provide them, and indicate which of the powers that Guardians have are needed to achieve the plan.

## 4.5 Social Care and eligibility criteria section

Requirements for the assessment for social care services under the Care Act 2014 does not sit separately from CPA. The Local Authorities responsibilities under the requirement of this Act for people with mental illness are delegated to the Trust via section 75 partnership agreements with Councils in Bolton, Salford, Trafford and Manchester and agreed processes are in place. The introduction of CPA in 1991 integrated care management systems in to its processes. The CPA is the care and support process for those people in contact with acute and secondary mental health services. The term care and support function describes the approach used within social care and is a process to help people achieve the outcomes that matter to them in their life and Local Authorities must promote well-being when carrying out any of their care and support functions – the core components have many similarities with the CPA. Ultimately, the provision of integrated health and social care is based on principles of personalised mental health care.

The Care Act 2014 consolidates and modernises the framework of care and support law, new duties for Local Authorities and partners and new rights for service users and carers. The Trust shall wherever possible assist the Councils with the following:

- Assessment for care and support for adults and carers under Care Act 2014. This function and the ongoing case management and review will continue to be undertaken by the Adult and Older Adults CMHTs and Early Intervention in Psychosis Services comprising both Trust and Council staff. Trust staff are able to access Council provision and budgets for purchasing care and support for adults and carers.

- Provision of services, personal budgets or direct payments for any adult or carer eligible for care and support under the Care Act – ensuring that the National Eligibility Criteria (The care and support (eligibility criteria) regulations 2015) is met and applied to all assessed social care needs

- Ensuring timely reviews of need, care and support and eligibility for social care provision takes place

- Continuity of care and ordinary residence issues are addressed

The Care Act 2014 sets out a clear legal framework for how Local Authorities and other partners should protect adults at risk of abuse or neglect. This needs to be incorporated within CPA and risk assessment/management process as does the multi-agency arrangements for children at risk and consideration of the Mental Capacity Act 2005 and DOLS.

The Care Act 2014 refers to the promotion of well-being, which is a broad concept inclusive of dignity, physical, mental health, and emotional well-being, protection from abuse and neglect. The care assessment and planning views a person holistically, seeing and supporting them in their diverse individual context and needs they have including family, parenting, relationships, housing, employment, leisure, education, spirituality, self-management (conducive with CPA process) with the aim of optimising mental and physical health and well-being. When carrying out assessments and devising care plans staff should consider the individual within the context of their family and social circumstances. The promotion of independence and self-determination to help people where possible maintain control over their own support and care is key – and CPA promotes staff working with service users to co-produce the outcomes they want.

**National Eligibility Criteria**

This framework was introduced in 2014 to address inconsistencies across the Country about who gets support in order to provide a fairer and more transparent system for the allocation of social care services. The principle behind the National Eligibility Criteria is that there should be one single process to determine eligibility for social care support based on risks to well-being and independence over time. Its aim was to provide a framework for Councils to identify need for social care support in a way that is fair and proportionate to the impact it will have on individuals and the wider community taking into account local budgetary considerations.

Adults needs are only eligible where they meet all 3 of the following conditions and as a consequence of being unable to achieve these outcomes there is or likely to be

a significant impact on the adults well-being and an eligibility determination cannot be made without first carrying out an assessment.

1. Adults needs are arising from or are related to a physical or mental impairment of illness

2. Local Authority must consider whether the adult is “unable” to achieve 2 or more of the outcomes set out in the regulations:

    - Is unable to achieve the outcome without assistance

    - Is able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety

    - Is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health or safety of the adult or of others

    - Is able to achieve the outcome without assistance but takes significantly longer than would normally be expected

3. The Local Authority must consider whether the adults needs and their inability to achieve the outcomes above cause or risk causing a significant impact on their well-being.

The Eligibility Regulations set out a range of outcomes and Local Authorities must consider whether the adult is unable to achieve two or more of these outcomes when making the eligibility determination. The social care assessment is based on the domains below:

- Managing and maintaining nutrition, such as looking at whether adult has access to food and drink and if able to prepare and consume food and drink

- Maintaining personal hygiene, e.g. looking at if individual can wash themselves, do laundry

- Managing toilet needs, e.g. can they access and use a toilet

- Being appropriately clothed, e.g. can they dress themselves, be appropriately dressed

- Being able to make use of the house safely, e.g. move around the home safely, using kitchen facilities, environment

- Maintaining a habitable home environment, e.g. consider condition of adults home, is it clean and maintained to be safe? Do they have means to maintain amenities, e.g. gas, electric etc.

- Developing and maintaining family or other personal relationships, e.g. is adult lonely/isolated

- Accessing and engaging in work training education or volunteering, e.g. consider if adult has opportunity to apply themselves and contribute to society. May include physical access to facilities or support to participate in activities

- Making use of necessary facilities or services in the local community including public transport and recreational facilities or services, e.g. adults ability to get around community, ability to use shops, recreational facilities

- Carrying out any caring responsibilities the adult has for a child, e.g. consider any caring or parenting responsibilities the adult has

The Local Authorities should also consider whether the adult's inability to achieve the outcomes above impacts on the individual's well-being.

Following the assessment and eligibility determination, the service users will have as much influence as possible in determining how they will be supported. Where they need help to manage their arrangements this will be provided as part of their support plan.

Direct payments should be offered to meet assessed outcomes of social care needs except where –

- Service users makes an informed choice to receive a directly provided services

- Where full risk assessment indicates service user or others will be put at substantial risk if care not directly provided

Packages of support should promote the individuals well-being and independence.

## 4.6 CPA and long term settings

The CPA will apply where service users are transferred to residential care commissioned and purchased by the Local Authority or Clinical Commissioning Group, in or out of area, in order to ensure continuity of care. Local Authority care management responsibilities for such placements will be discharged through the framework of the CPA or transfer to the new locality Mental Health services may be indicated when care co-ordination is still required in an out of area placement, but appropriate measures will need to be in place to review the placement as required The principles of the CPA will apply, as appropriate, to the assessment of those admitted to hospital, where they have not previously been known to services.

Where after-care is delivered subject to Section 117 of the Mental Health Act it will be commenced using the CPA. (Refer to relevant local Section 117 policies). When service users supported by the Trust's CPA are admitted to Trust inpatient services this is a change only in the location of care. Local systems should ensure that CPA care plans are shared between hospital and community services

Those in residential settings or in prison should not be lost to the Trust's CPA. Contact will be maintained through regular visits and inclusion of the care co-ordinator in reviews where practicable. Where distance is an issue, liaison may be maintained via telephone, or through requesting regular reports back. The maintenance of links through the care co-ordinator to the home district, and the development of plans for a return home will be of great importance to the person's prospects for continuing recovery and social inclusion.

Where service users are transferred to residential care out of area but commissioned and purchased by the Local Authority or Clinical Commissioning Group, transfer to the new locality Mental Health services may be indicated when care co-ordination is still required, but appropriate measures will need to be in place to review the placement as required.

## 4.7 CPA in Specialist Services

**CPA Arrangements in Specialist Services.**
Where a person not already supported by CPA is admitted, efforts will be made to identify which Trust and Local Authority may be liable to provide aftercare, following normal residency rules, as soon as practicable following admission to hospital. This applies to all patients whether informal or detained. For detained patients, the courts have ruled that under Section 117 Mental Health Act, Health Authorities and Social Services must take reasonable steps to identify appropriate aftercare facilities prior to discharge from hospital. In view of this, an appropriate CPA discharge plan should be discussed as a matter of course with the Trust to which the patient is likely to return, prior to any Mental Health Review Tribunal or Hospital Managers' hearing, capable of being implemented in the event of the patient's discharge (MHA Code of Practice).

Where service users are admitted informally to specialist units for assessment only, their need for on-going CPA support on discharge will be fully considered and there will be appropriate communication of assessed need to home authorities. The requirement to follow up within seven days applies equally to these service users. Plans for treatment and care, linked to the CPA care plan, are needed for periods of inpatient care. Inpatient staff will lead on their development and ensure that recording requirements for the Mental Health Minimum Data Set are met.

The Trust's approach overall will be to ensure that home Trusts and local authorities are strongly encouraged and facilitated in forging and maintaining links with service users whilst they are in inpatient care far from home. This recognises the importance to the individual's prospects for recovery and social inclusion on discharge of preserving links to local services.

Home authorities will be asked how they intend to meet their co-ordination responsibilities for those in supra -district inpatient facilities. If no satisfactory arrangements are notified to the Trust within a twenty eight-day period, the Trust will make formal representations requesting them.

**Specialist services, Outpatients**
Specialist Services also conduct outpatient specialist assessments and interventions. Most of these services will only accept referrals from secondary mental health services and require there to be a care coordinator involved responsible for CPA

Some of these specialist services work in partnership with criminal justice agencies, managing offenders who do not suffer from a serious mental illness and are therefore not subject to CPA (even though they may be complex & high risk offenders). The service will ensure that there are crisis management plans in place for these cases

## 4.8 CPA 48 Hour, 72 hour and 7 day follow up

The GMMH Policy on 48 Hour, 72 hour and 7 Day Follow up is currently being drafted. Once ratified & issued this will provide further direction regarding follow up.

## 4.9 Carers

A key component to the CPA process is to recognise the importance of the service users family, carers, friend and wider social networks and how these can influence the service users experience and recovery outcomes.

A fundamental aspect of the Care Coordinators role is to explore ***who the key and meaningful people*** are who support the service user and ensure they are involved with the service users care and treatment i.e. invite them to reviews, ensure they receive copies of care plans and involve them with relevant decision making. The consent of the service user must be sought and recorded in the legal tile on Paris. If consent is not given, family, carers and friends can still be listened to and signposted for support. Consent must be re-visited with the service user (when appropriate). These nominated key and meaningful people are entitled to a Carer's Assessment (regardless of the frequency or type of care provided, whether they live with the person receiving care or not and no matter what their financial needs are). A Carer Assessment will assist the carer (family member or friend) to understand what services and support would be helpful in their current caring role. It should cover what care they are providing, the impact of this on their own physical and mental health, work and family commitments.

A Carer Assessment is the opportunity for the carer to talk through issues, possibly for the first time, which can be a positive experience in itself. The Care Act (2014) requires that the impact of caring on a carer's outside interests (work, study, leisure) must be considered in this assessment. Following assessment, carers must be offered their own written care plan related to their support needs that must be discussed and implemented in collaboration with them. If the service user and carer both agree, a combined assessment of both their needs can be done at the same time. Depending on local pathways, Carer assessments are either carried out by a Care Coordinator or Carer Support Worker or signposted to the local Carer Centre.

### 4.10 Accessible Information Standard.

**Communication needs**
The CPA process and any related documentation must meet the NHS England Accessible Information Standard. The standard applies to service users and carers who have communication needs in relation to a disability, impairment or sensory loss e.g. blind, deaf, deaf-blind and/or have a learning disability. If any communication needs are identified, the Care-Coordinator needs to identify what format the service user or carer requires when receiving CPA related information or supporting them during the process e.g. large font letters, easy read, British Sign language interpretation for deaf people, Braille etc. Please see Accessible Information Standard policy.

Service users whose first language is not English should have communication support arranged in accordance with the Trust's Interpreters Policy.

### 4.11 Quality Assurance and Equality Impact Assessment

**Equality and Diversity**
The Trust delivers health and social care to a diverse population. Assessments, care plans and reviews should take account of the needs of service users in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs. The CPA process should be personalised and recognise any specific needs the service user or carer may have in relation to their protected characteristics.

See monitoring section below.

## 5. Training Requirements

- Role of the care co-ordinator
- CPA policy
- CPA and the MHA

## 6. Monitoring

| Minimum Requirement | Frequency | Process for monitoring | Evidence | Responsible Individual(s) | Response Committee(s) |
|---|---|---|---|---|---|
| CPA Policy | 3 yearly | IPDR | Attendance | Care Co-Ordinator | CPA Forum |
| Role of the Care Co-Ordinator | 2 yearly | IPDR | Attendance | Care Co-coordinator | CPA Forum |
| MHA | Annual | IPDR | Attendance | Care Co-ordinator | CPA Forum |

## 7. Resource/Implementation Issues

- Training

## 8. Risk Issues

- Failure to train all staff on the new policy may result in failure to comply to new policy agreements in some elements of the Trust

## 9. Requirements, Supporting Documents and References

### 9.1 Requirements

| | |
|---|---|
| **Board Objective Reference:** | We work together<br>1 – to promote recovery by providing high-quality care & delivering excellent outcomes<br>2 – to work with service users & carers to achieve their goals<br>3 – to engage in effective partnership working |
| **CQC Regulation Reference:** | Safe, effective, responsive, effective and well led<br>9 – Person Centred Care<br>10 – Dignity & Respect<br>12 – Safe Care & Treatment<br>13- Safeguarding service users from abuse and improper treatment |
| **Other requirements:** | Related legislation including the Care Act (2014) |

### 9.2 Supporting Documents

This policy should be read in conjunction with related trust policies and procedures including the

- MCA & DoLS policy
- MHA Hospital Manager's Hearings Policy
- Consent to Treatment Policy
- Community Treatment Order Policy

### 9.3 References


- Department of Health (1999). Effective care co-ordination in mental health services: modernising the care programme approach. Jan 1999. Crown Copyright.
- Department of Health (2008). Refocusing the Care Programme Approach: Policy & Positive Practice Guidance, March 2008. Crown Copyright.


## 10. Subject Expert and Feedback

Any queries or suggestions regarding this policy should be directed to the author in the first instance.

## 11. Review

This policy will be reviewed annually with the next review due January 2020 in anticipation of national changes to CPA.