Devon Partnership NHS
NHS Trust

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# T. Care Programme Approach Policy

# – 2. Appendix 1: Care Programme Approach Operational Policy

# – 7th April 2003

Devon Partnership NHS
NHS Trust

# 2. Appendix 1: Care Programme Approach Operational Policy

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Devon Partnership NHS

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# 2. Appendix 1: Care Programme Approach Operational Policy

## 2.1 Background

This policy was developed to provide guidance to all mental health staff who work with people within the Devon Partnership Trust. The policy sets out a systematic process and procedure for applying the Care Programme Approach within the context of the existing legislation and recent policy changes.

## 2.2 Introduction

The Care Programme Approach (CPA) was introduced in 1991 (1) to provide a framework for effective mental health care. In 1999 further guidance was issued as part of the National Service Framework, entitled 'Modernising the Care Programme Approach (2). Further guidance was received in 2001 under, 'Abolition of the Supervision Register. Department of Health Criteria for Robust CPA' (3) which became known as 'Robust CPA'.

The four main elements of the Care Programme Approach are:

- Systematic arrangements for assessing the health and social needs of people referred into specialist mental health services;
- The formulation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a care coordinator to keep in close touch with the service user and to monitor and coordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.

Under 'Robust CPA', additional specific requirements were made which tightened up procedures and prescribed good practice.

Other important considerations in developing a Trust model of CPA are:-

- The requirements of the Mental Health Act.
- The NHS Plan Implementation Guide.
- Mental Health Policy Implementation Guides on Community Mental Health Teams and Acute Inpatient Care Provision.
- Various risk assessment and management documents.
- Fair Access to Care (FACS).
- Single Assessment Process.
- Electronic CPA.
- The Mental Health Minimum Data Set.
- Standardised Headings for eCPA.
- Regional targets.

The following must be born in mind:-

- Existing paperwork, electronic systems and operational policies.
- The results of the Trust CPA audits on clinical files, risk procedures and service user views.

- CPA training day feedback from the Community Mental Health teams.
- The CPA review group consultation process.
- User-friendly files, paperwork and systems.
- The needs of specialist services and individual professions.
- Integration of CPA and Care Management.

## 2.3 Philosophy / Rationale – Recovery Orientated CPA

Recovery values and concepts represent what service users would like to happen when they ask for help and what their experience has taught them about what helps their recovery. A balance has to be achieved between implementing recovery orientated services and public and staff protection. Various government documents have placed service users and carers at the centre of service design and delivery and 'The Journey to Recovery' from the DoH sets out the government's vision for mental health care.

Broadly speaking:

"Recovery happens when mental health services enable people to find the right help **at the right time, for as long as they need it**

Recovery happens when mental health services provide for **people in the context of their whole lives, not just their illnesses**

Recovery happens when mental health services **protect service user's rights and treat them with respect and equality**

Recovery happens when mental health services **are staffed by people who are compassionate and competent to assist people in their recovery**

Recovery happens when mental health services **enable people with mental illness to take on competent roles**

Recovery happens when mental health services **can prevent people from using them unnecessarily or from staying in them for too long**

Recovery happens when mental health **services can look outward and assist people to find and use other community services supports and resources**" (4)

Recovery focuses on:-

- Hope – believing that change is possible.
- Acceptance – of difficulties and problems as a starting point to moving on.
- Control and empowerment – of symptoms and life.
- Finding meaning – in life and in the experience of mental distress.
- Self-management – finding out what works for each individual.
- Relationships – finding support to help self-management.
- Social inclusion – using normal facilities and non-stigmatising services.

Translated into CPA practice, a recovery perspective is supported by, for example:-

- User and carer led contingency/crisis plans.
- Effective crisis resolution services/early intervention.
- Community alternatives to hospital / early discharge.
- Listening to stories of what 'works' for individuals.
- Developing self-management options.
- Social/educational/employment and community services.
- Involving carers as defined by user.

- Power sharing and user/carer involvement.
- Allowing people to stop being service users.
- User-friendly information.
- Transparency and honesty about confidentiality.

In the Mental Health Foundation, 'Strategies for Living', (5) recommendations concerning CPA are that:-

- "All mental health professionals, providers and policy makers recognise the expertise brought to the mental health field by the experience of mental health service users.
- Care Programme Approach mechanisms include the dissemination of people's personal coping strategies as part of the CPA process.
- Key workers provide people with the opportunity to include their particular strategies for coping as part of their care plan.
- Mental health organisations disseminate information about the range of strategies that people find helpful, in order to assist people find their own strategies and to locate alternative sources of help".

In developing CPA, all the above considerations must be born in mind and sometimes a balance has to be found between the demands of a recovery orientated CPA and the wider considerations of risk, data collection and the safety needs of staff.

**Additional principles governing CPA include:-**

- Partnership with service users and carers.
- Equality of opportunity.
- Anti-discriminatory.
- Multi-disciplinary working.
- Needs led.
- Evidence based.
- Continuity of care / Integrated.
- Transparency.
- Accountability.

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## 2.4 Who The Care Programme Approach Applies To

2.4.1 The Care programme Approach applies for the purposes of this policy to all adults from 16 years accepted and being treated by the specialist mental health services residing within the Trust area.

2.4.2 It applies to "older people with severe mental illness due to schizophrenia or other psychoses. The assessment of their need should be based on the Single Assessment Process (SAP) for older people. SAP, plus critical aspects of CPA, should be applied to other older people with severe functional or organic mental health problems, who, were they younger, would be provided for under CPA." (6)

2.4.3 It also applies to Substance Misuse Services (SMS) for those who meet the criteria for Enhanced CPA. "Under Enhanced CPA, the expectation is that the has severe mental health co-morbidity and is thus subject to the national guidelines for Enhanced CPA. In most cases, the will be under the care of a Community Mental health Team (CMHT) often caring jointly with a substance misuse service for the substance misuser with co-morbidity. Under these circumstances, the responsibility for follow up will be greater than under SCC (Standard Care Coordination) if the client disengages from treatment due to his or her high level of vulnerability or risk. The CMHT should have responsibility for Care Coordination for clients on ECPA with, where appropriate, the substance

misuse service identified as being responsible for elements of the care plan ….. For substance misusers on Enhanced CPA, Care Co-ordination and care programmes should be in accordance with the prevailing mental health guidance and legislation and be the responsibility of a statutory mental health team.” (7)

2.4.4 It applies to people in the **community** and also to those in **inpatient care, day services** and **other residential care, including prisons**.

2.4.5 It does **not** apply to people who are either; not accepted for treatment by the secondary or tertiary services; are referred back to the referring team following assessment or who are formally discharged from treatment to another service.

2.4.6 CPA is divided into two levels: **standard** and **enhanced**.

## 2.5 Enhanced CPA

2.5.1 Applies to people who require a medium / high level of support, **generally from more than one professional or agency**. They are more likely to require frequent/ intensive support or intervention. They may present a higher risk of harm to self or others and may have multiple or complex needs. They may require inpatient assessment or treatment.

2.5.2 Are subject to Section 117(2) or Supervised Discharge under Section 25(a) of the Mental Health Act 1983.

## 2.6 Standard CPA

2.6.1 This applies when a person is receiving low-key support from one member of the mental health team. People on standard CPA will be more able to manage their mental health problems, have an active support network and pose little risk to themselves or others. They are more likely to maintain appropriate and voluntary contact with the service.

## 2.7 CPA Documentation

### 2.7.1 Referrals

2.7.1.1 The **Record of Referral Form (CPA1)** will be completed on **all** new people referred to the service. This information will be registered under eCPA or through the maintenance of a CPA register where eCPA is not operational.

2.7.1.2 The **Record of Referral to Crisis Resolution Team/ ASW (CPA1a)** may be used by Crisis Resolution Teams to reflect specific information required by these teams through urgent, direct referrals.

### 2.7.2 Assessment

2.7.2.1 An **Assessment Form (CPA 2)** will be completed on all people referred into secondary mental health services.

2.7.2.2 A copy of the assessment, or a summary of the assessment, should be sent to the referrer. It is recognised that GPs often prefer a concise report. The last page of the assessment form may be used as a feedback form from the assessment. An adapted

form, **Emergency/Crisis Assessment Form (CPA2a)** may be used by Crisis Resolution Teams, medical staff and ASWs for Mental Health Act assessments.

### 2.7.3 Personal Plan

2.7.3.1 A **Personal Plan (CPA 3)** will be completed with **all** service users, who will sign the plan and retain a copy. In some situations, it may not be possible to obtain a signature.

2.7.3.2 A **Crisis Resolution Personal Plan (CPA 3a)** may be used a) by the Crisis Resolution Teams or b) in other teams where there is rapid change in work with the service user, *supplementary to an existing Personal Plan*.

### 2.7.4 Review

2.7.4.1 The **Review Form (CPA 4)** will be completed on all ongoing service users at a frequency determined by need but no longer than 12 months.

### 2.7.5 Additional Assessments

2.7.5.1 The **Additional Assessment Form (CPA 2b)** is an optional form, which may be used by any person **other than** the care-coordinator to communicate their assessment. Letters are also acceptable.

2.7.5.2 **Notification of Serious Concern Form (CPA 5)** may be completed where there is serious and immediate risk requiring urgent action.

2.7.5.3 **Emergency Discharge from an Inpatient Unit (CPA 6)** will be used in the event of an unplanned or emergency discharge. **IT DOES NOT REPLACE A FORMAL DISCHARGE PLAN OR DISCHARGE LETTER.**

2.7.5.4 The **Advanced Directive Form (CPA 7)** may be completed by any service user who would like to have their specific wishes formally recorded.

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## 2.8 CPA Standards

**A full set of CPA standards is presented in Appendix 1 and covers the following topics relating to the process of CPA:-**

1. General Standards
2. Referral
3. Assessment
4. Personal Plan
5. Review
6. Acute Inpatient admission and discharge
7. Transfer of care (outside of Trust area)
8. Transfer of care (inside of Trust area)
9. Record keeping
10. Holding and sharing of information

## 2.9 Additional Notes Relating To The CPA Standards

2.9.1 Arrangements for high priority referrals will be made before resources are allocated to lower priority work. Team managers will manage and monitor this process according to eligibility criteria agreed through the CMHT Review Implementation Group.

2.9.2 Where possible, decisions regarding the allocation of referrals should be made in a multi-disciplinary forum and should consider service user choice and appropriate matching of need with assessment skills. A pre-allocation meeting may reduce the number of referrals to be allocated. Other criteria such as available team resources or link arrangements will affect this first principle, but should not take precedence.

2.9.3 Allocation should be a managed process making the most effective use of team resources.

2.9.4 Urgent assessments may be carried out by Crisis Resolution Teams, CMHT duty arrangements, out of hours emergency duty teams or through Mental Health Act assessment procedures.

2.9.5 A care coordinator may commission additional assessments.

2.9.6 A care coordinator must be appointed and will usually be the mental health worker with whom the person has the most contact. This will normally take place at a multi-disciplinary meeting and will be the worker most suited to coordinate the service user's needs. Wherever possible, the service user's views should be taken into consideration regarding the choice / gender of the care coordinator.

2.9.7 Where there is more than one team involved, there will be an explicit documented agreement about who will be responsible as care coordinator.

2.9.8 The service user must be informed of any change of care coordinator, as must other involved professionals, carers or significant others. Again, the person's views should be taken into consideration regarding the choice of care coordinator and the decision will be made through a review meeting.

2.9.9 The term 'Personal Plan' replaces the term 'Care Plan' to reflect a greater emphasis on partnership and ownership by the service user.

2.9.10 The contingency plan (page 1 of CPA3) should be used to communicate important information on a 'need to know basis'. It may also contain risk information, which may not have been agreed to be shared with the service user, but is essential for others to know. Any disagreements with the sharing of this information should be recorded.

## 2.10 Risk Assessment And Management

It is recognised that very few situations are risk free and risk cannot be eliminated, only reduced. Positive risk taking is an important part of managing risk and will be more likely to happen if a range of choices is available to service users. A written record of all decisions taken and the reasons is essential. The service user and involved carers should be fully part of the process unless there are justifiable reasons for their exclusion.

### 2.10.1 Risk Assessment

2.10.1.1 **All people** referred to secondary adult mental health services will receive a **screening risk assessment.**

2.10.1.2 If the risk screening reveals areas of concern, the clinician may discuss this with their clinical supervisor. A more **detailed risk assessment** will be completed. This assessment may need to be repeated if circumstances change considerably and should be discussed at review.

### 2.10.2 Risk Management

2.10.2.1 If the concern is significant, the assessor will discuss the situation with their Team Manager either:-

a) routinely during workload management sessions or
b) more urgently by direct contact. If the Team Manager is not available, deputising arrangements should be in place.

2.10.2.2 As part of CPA, a contingency plan will be agreed between the service user and the care coordinator. This should include discussion of risk and, where possible, a risk plan should be mutually agreed and managed on a clinical level. Important information will be part of the statement on Page 1 of the Personal Plan (CPA 3) and may be shared on a 'need to know' basis with others.

2.10.2.3 This may not always be possible in situations where information about risk to others may need to be conveyed in spite of objections by the service user. Sharing of information will conform to CPA standards and service level agreements on confidentiality.

2.10.2.4 For more immediate or serious risk, the clinician should complete a 'Notification of Serious Concern Form' and **discuss with the Team Manager, who will then decide what action will be taken.** This does not preclude any essential action, which may need to be taken by the individual clinician if the immediate circumstances warrant it.

2.10.2.5 All significant information should be gathered and verified before acting on that risk. If possible, a consensus view should be reached among all those involved, reviewing both clinical and management considerations.

2.10.2.6 Options available to the Care Coordinator and Team Manager include:-

- Continuance of routine risk monitoring.
- An urgent risk management conference.
- Additional specialist assessments, e.g. consultant, forensic.
- Sharing of information with other agencies via the Risk Manager, CPA and Mental Health Act Manager or MAPP.
- Informing local Child Protection Team.
- Informing out of hours or crisis resolution teams.
- Completion of a 'notification of serious concern' form.

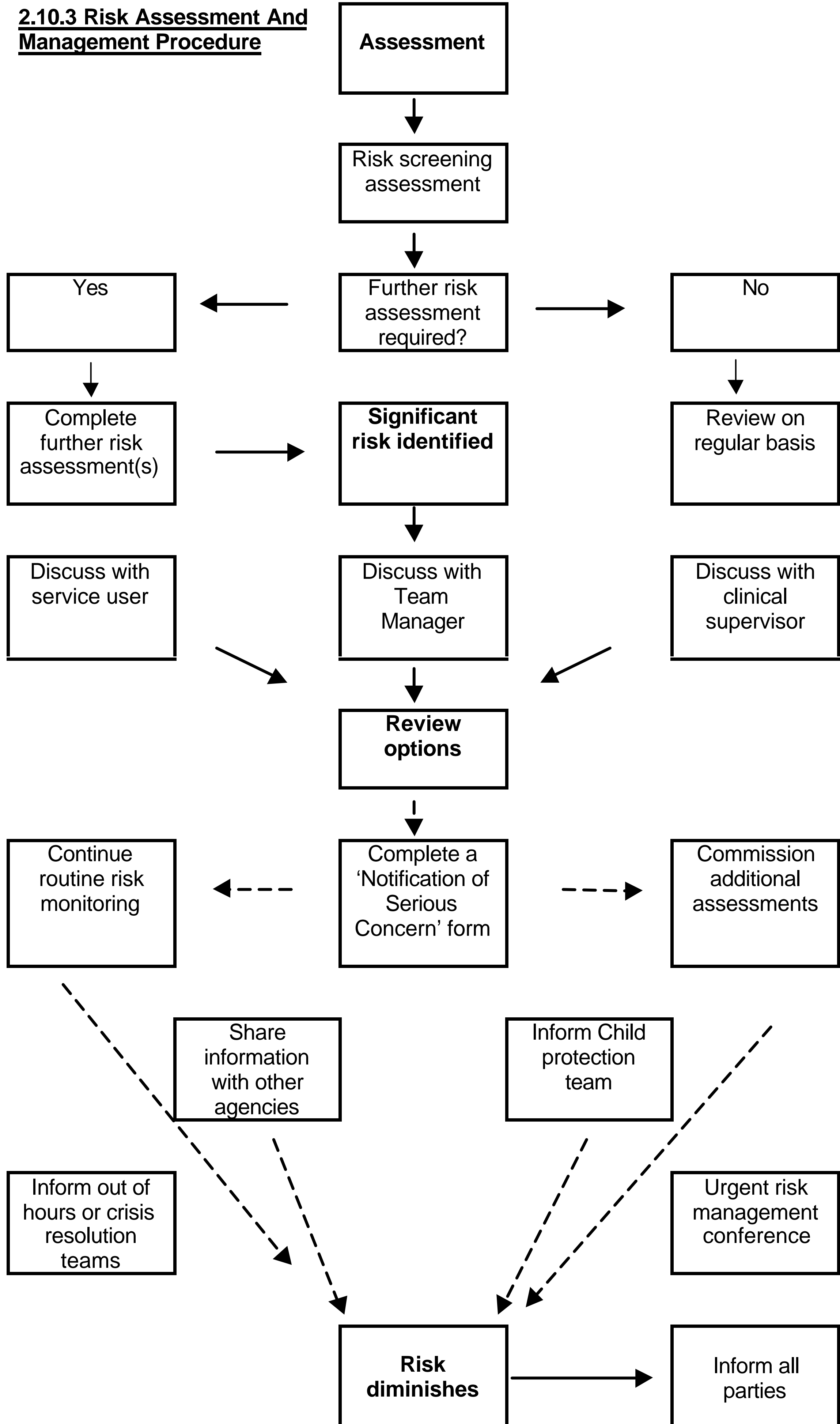
2.10.2.7 The Team Manager must be aware of all service users currently presenting with immediate serious risk within their team and **all clinicians** have a responsibility to inform their Team Manager of service users on their caseloads causing the most concern.

2.10.2.8 The weekly team clinical meeting should share information about and discuss service users currently presenting with most risk.

2.10.2.9 Robust links should be established through Locality Managers with all risk management forums e.g. Vulnerable Adults (At risk) Case conferences including 'No Secrets' Guidance, Multi-Agency Public Protection Meetings (MAPP), Child Protection Strategies meetings and conferences, Probation Service risk management meetings, Anti-social Behaviour Order Consultation meetings (ASBO) and Joint Agency Risk Assessment Processes (JARAP).

2.10.2.10 Training in risk assessment and management should be mandatory with regular updates.

## 2.10.3 Risk Assessment And Management Procedure



## 2.11 Loss Of Contact / Refusal To Maintain Involvement With Service

2.11.1 If a service user fails to attend, every action should be taken to re-establish contact.

2.11.2 Any service user has a right to refuse contact with the service unless there are serious concerns about risk, danger or vulnerability.

2.11.3 The care coordinator will document all action taken in trying to re-establish contact.

2.11.4 If it becomes clear that contact with a service user has been lost or refused and there are serious concerns, a 'Cause for Serious Concern' form will be completed and the procedure outlined in section 7 of this policy will be followed. Consideration should be given to the options outlined in 7.8.

## 2.12 Accessing Social Care

2.12.1 The Partnership Trust, fully complies with the 'Protocol for use of Fair Access to Care Services (FACS) by Staff In Partner Agencies' (8).

2.12.2 Staff who work with adults and offer and/or undertake social care assessments are required to subscribe to the Devon FACS policy, practice guidance and the Eligibility Criteria Checklist in order to access social care services.

2.12.3 Prompts to FACS are included in the Initial Assessment, Personal Plan and Review Forms.

## 2.13 Section 117

A separate policy for the operation of Section 117 (Mental Health Act 1983) is currently being designed. Each area has a current policy, which will remain in force until a new one has been agreed.

## 2.14 Team Manager Responsibilities In Relation To CPA

2.14.1 To ensure that all team members are familiar with, and conform to, the Trust CPA standards.

2.14.2 To oversee that a systematic and comprehensive assessment of health and social care needs is completed on all service users, recording both factual and person-centred information.

2.14.3 To monitor the working of CPA through regular workload management sessions.

2.14.4 To ensure the team has effective communication systems with related teams for the transfer of information routinely and in crisis situations.

2.14.5 To register those service users presenting the most risk at any one time and make decisions with the care coordinator about any necessary action to reduce risk.

2.14.6 To audit all aspects of the working of CPA on a regular basis.

2.14.7 To inform the CPA/MHA manager of any serious shortcomings in the operation or design of the CPA.

## 2.15 Role And Responsibilities Of Care-Coordinators

2.15.1 To coordinate all assessments and develop a Person Plan, which should be a joint statement / plan agreed with the service user and significant others outlining what should happen and when.

2.15.2 To complete a contingency / relapse / crisis plan with each service user on enhanced CPA to relate specific and individual requirements / needs which others involved may need to know should a crisis develop.

2.15.3 To ensure that other key people involved or affected have an opportunity to share their views and opinions. To consider whether a full carer's assessment is required and to commission one if indicated.

2.15.4 To act as a reference point for other professionals, relatives, carers and advocates.

2.15.5 To ensure the person is registered with a GP and that he/she is involved and informed as necessary.

2.15.6 To maintain regular contact with the service user and monitor their progress wherever they may be within the system. If a service user who remains vulnerable refuses to take part in the CPA process, all steps should be made to continue engagement.

2.15.7 To organise reviews at appropriate intervals and ensure that all those involved in the Personal Plan are consulted and involved directly in the review where appropriate.

2.15.8 To explain the CPA process to service users and others involved, making them aware of rights, roles, confidentiality and the limits of confidentiality.

2.15.9 Consider the need for advocacy for the service user, or carer if appropriate, and make them aware of local options.

2.15.10 Remain in contact with the care and treatment of individuals who enter acute inpatient units or the prison system and, if appropriate, prepare an appropriate plan following discharge/release.

2.15.11 Identify unmet needs and communicate these to the CPA and MHA Manager.

2.15.12 Ensure that Fair Access to Care procedures are followed in accessing social care.

2.15.13 Arrange for someone to deputise when absent and to pass on the care coordinator role to someone else if no longer able to fulfil it.

2.15.14 To regularly update the Team Manager about their caseload and in particular, high-risk situations.

2.15.15 To receive regular clinical supervision appropriate to the work being undertaken.

## 2.16 Audit Arrangements

2.16.1 Audit on all aspects of the CPA should be carried out:-

- By Team managers/Locality managers as part of an annual team locality programme addressing specific issues.
- Routinely through workload management sessions.
- By the CPA Audit Group (which must include addressing national and regional priorities.
- Occasionally commissioned by the Service and Research Governance Committee.

## 2.17 Training Implications

2.17.1 All staff involved in CPA should receive appropriate multi-disciplinary training linked to implementation of the revised CPA.

2.17.2 Induction of all new staff should involve CPA training.

## 2.18 Confidentiality And Its Limitations

- All staff have an obligation to safeguard the confidentiality of personal information. This is governed by law, contracts of employment and by professional codes of conduct. All staff should be made aware that breach of confidentiality could be a matter for disciplinary action and provides grounds for complaints against them.

- Although it is neither practicable nor necessary to seek an individual's specific consent each time that information needs to be passed on, this is contingent upon individuals having been fully informed of the uses to which information about them may be put.

- Only minimum identifiable information necessary to satisfy a specific purpose should be shared on a strict 'need to know' basis.

- If an individual wishes information about themselves to be withheld from someone or some agency, the individual's wishes should be respected unless there are exceptional circumstances where a breach of confidentiality can be justified. The decision to release information in these circumstances should be made by a senior professional within the agency, in accordance with authority designated by the Caldicott Guardian, in line with local policy, using their professional judgement and accountability; it may be necessary to take legal or other specialist advice.

**Circumstances in which disclosure of information without the service user's permission may be professionally appropriate:**

- Where a child is believed to be at risk of harm (Children Act 1989).
- Where there is evidence of risk of serious harm to the public.
- Where there is evidence of risk of serious harm to self.
- For the prevention, detection or prosecution of serious crime.
- Where the service or individual is instructed to do so by a court (NB. This can involve **all** clinical notes being subpoenaed).
- If the service user gives information about a serious crime, which has been committed, such as a murder, manslaughter, rape, treason or kidnapping (Police and Criminal Evidence Act 1984).

- If a service user gives information about suspected terrorism (Prevention of Terrorism Act 1998).
- Under the Mental Health Act 1983 where a service user objects to their 'nearest relative' being consulted re:-

    - An application for Treatment Order (Section 3) is being considered.
    - An application for assessment and/or treatment in relation to the service user has been made.
    - Under the Mental health (Patients in the Community) Act 1995 where the service user is known to have the propensity to violent or dangerous behaviour.

**(With thanks for permission to use and with acknowledgement to George Askoorum of NHS Direct, from whose work this guidance has been adapted).**

## 2.19 Appendix 2: Standards For CPA

### 2.19.1. General Standards For CPA

**Service users and carers should:**

- Be treated with dignity and respect.
- Be treated as equal partners in planning the response best suited to their needs.
- Be given appropriate information about:

    - The mental health system and what can be expected to happen.
    - Confidentiality and its limitations.
    - Medication and other physical treatments including side effects.
    - Complaints procedures.
    - Current knowledge about the nature, treatment options and possible outcomes relating to specific mental health problems.
    - Legal rights under the Mental Health Act including aftercare (Section 117).
    - Accessing social care provision.
    - Carers right to a separate assessment of their own needs and their responsibilities to the person they are caring for.

- Know who their care coordinator is, how to contact them and who to contact if their care coordinator is not available.
- Be listened to and given time and space to recount their experiences, anxieties and hopes.
- Be offered choices about the services they receive and the people they work with.
- Be fully informed about the reasons for restriction of choice if this becomes necessary.
- Have their concerns respected and acted upon appropriately as soon as possible.
- Expect that files kept on them will contain all relevant information in an orderly and accessible form, should they wish to see them.
- Have any specific cultural, racial, religious, disability and gender needs taken into account.
- Receive copies of all correspondence written about them.

### 2.19.2 Standards For Referral

- Pre-referral discussion should take place wherever possible to ensure that only appropriate referrals are made.
- Even if referrals are targeted to an individual team member, they should go through the same single point of entry to ensure appropriateness and good management.
- All referrals should be to a single point of entry. Even if referrals are targeted to an individual team member they should go through the same process (1).
- On receipt of a referral, an initial screening will take place to determine the degree of urgency of the referral.
- Pre-allocation procedures will be in place to determine the appropriateness of the referral for allocation.
- If referrals are not accepted, the referrer will receive an explanation of the decision with suggestions for a more appropriate referral route.

### 2.19.3 Standards For Assessment

- Everyone who is referred to the specialist mental health services is entitled to receive a systematic and comprehensive health and social care assessment, using all appropriate resources of the multidisciplinary team.
- Assessment is made jointly with the service user, in which the purpose of the assessment is explained to them, the scope and limitations of confidentiality are outlined and where conclusions are shared and negotiated.
- The assessment should be holistic, including a history, physical, psychological, social / work /education/ leisure/financial and spiritual needs.
- The assessment will include both ‘person centred’ and ‘factual’ assessments.
- Assessment should include service user’s strengths, resources and proven coping skills/strategies.
- Other people such as carers, families and significant others should be consulted with the permission/ suggestion of the service user.
- Carers should be made aware that they can request an assessment in their own right to include their own physical and mental health needs.
- Needs should be assessed and recorded even if no services / resources are available to meet those needs.
- Any social care needs requiring funding will assessed according to the Fair Access to Care Services (FACS) procedure.
- Each assessment will include a screening risk assessment indicating whether further risk assessment is required or not.
- A HoNOS assessment will be completed.
- The assessment should include a formulation or summary.
- “Routine assessments should be prompt – 4 weeks maximum, but working towards one week”. (CMHT Implementation Guide).

### 2.19.4 Standards For Personal Plans

- All service users accepted into the secondary mental health services will have a personal plan.
- The level of CPA should be clearly stated.
- Everyone involved in the personal plan should be in broad agreement about the aims of the plan and any disagreements recorded.
- The plan should be written in clear, respectful and jargon-free language.
- Personal plans should always contain a contingency / crisis plan which has been discussed and, where possible, agreed with the service user and any appropriate others.
- All information relating to assessed risk should be recorded.
- Areas for service development should be recorded.

- The personal plan should be communicated to all appropriate parties on a 'need to know' basis and with the full understanding and consent of the service user wherever possible.
- The service user should sign the personal plan if appropriate. If he/she does not wish to, this should be recorded on the plan.
- The service user will receive a copy of the personal plan.
- The care coordinator will sign the personal plan.
- Personal plans should be recorded on the appropriate joint agency CPA form.
- Goals should be stated with; responsibility for action, time scales and anticipated outcomes.

### 2.19.5 Standards For Reviews

- The format and timing and setting of the review will be appropriate to the needs of the individual.
- The purpose of the review should be recorded.
- In the case of a review meeting, people involved in the personal plan should be invited to contribute. If they are unable to attend, this should be recorded and relevant comments written on the review form.
- In the case of a less formal review, the opinions of other involved people should be sought and recorded.
- A HoNOS re-assessment will be completed.
- Transfer and discharge information will be recorded.
- The outcome of the review will be recorded and a copy of the review form will be sent to all relevant parties.
- The service user will sign the review form.
- The care coordinator will sign the review form.

### 2.19.6 Standards For Acute Inpatient Admissions

- Unless unavoidable, all admissions should be planned. All people being considered for admission should be referred to crisis resolution / community teams / ASW for assessment and consideration of community alternatives to hospital.
- A copy of the community Personal Plan should be received by the inpatient team on admission or within 72 hours at a weekend, electronically or manually.
- All newly admitted patients not previously known to the service will have a community care coordinator appointed within a week of their needs being assessed, who will register them under CPA.
- Community care coordinators, GP, carers (where appropriate) and other appropriate staff will be informed by the ward of admission, leave arrangements or discharge on the same day or within 72 hours at a weekend, electronically or manually.
- Any specific risk factors will be communicated on admission and discharge to those taking on responsibility for care.

### 2.19.7 Standards For Acute Inpatient Discharge

- The community care coordinator or delegated crisis resolution worker, the consultant and the named nurse and the service user will begin to discuss discharge options as soon as possible and within 10 days.
- Care coordinators will remain fully involved with inpatients on their caseload and take responsibility for convening the discharge meeting.
- A clear statement of responsibilities should be agreed, recorded and disseminated.
- Service users should have influence over who attends their discharge meeting.

- Consideration should be given (in consultation with the Locality Manager) to informing other members of the public or multi-agency groups under existing protocols of a discharge where personal safety may be affected or high risk is indicated.
- All discharge letters to GPs will be copied to the care coordinator, service user and carer if appropriate.
- No patient should be discharged without a community care coordinator and without arrangements being in place for their care unless valid reasons are recorded.
- The care coordinator or delegated crisis resolution worker will have face to face contact with the service user within seven days of discharge from hospital.
- A specifically identifiable discharge meeting will take place involving the care coordinator, service user, carer (if appropriate), inpatient and appropriate others prior to discharge.
- Where there is an unplanned discharge, a CPA 6 form (emergency discharge) will be completed, a formal discharge letter completed and a post discharge meeting (if indicated) will take place.
- All discharge paperwork should be clearly and easily identified in the file.

### 2.19.8 Standards For Transfer of Care (Out Of Area)

- Where possible, a transfer should be part of a planned process allowing time for a new care co-ordinator to be appointed and a handover completed.
- Transfer of patients to another CMHT should involve a joint CPA meeting for handover where possible.
- Disengagement should not occur before the new team has established a relationship.
- The care coordinator should try to ensure that the service user registers with a GP in the new area.
- Consultants should liaise with their counterpart in the new area prior to transfer of care and begin handover to the new consultant within three months.
- Transfers should follow a full review.
- Any ongoing social care services should be discussed with the new care coordinator. If agreed, responsibility for funding is transferred to the new area after three months.
- Where a service user moves from residential accommodation in one area to residential accommodation in another area, the placement will normally continue to be funded by the originating Social Services Authority.
- Care co-ordinators must consider the transfer of legal responsibilities where a service user is subject to the Mental Health Act (e.g. social supervision, guardianship, Section 117 after care).

### 2.19.9 Standards For Transfer Of Care (Within The Trust)

- The above standards apply except when a service user moves out of a team area on a temporary arrangement, when the original team will retain responsibility.
- If the change is more permanent, the care co-coordinator and the consultant (if involved) will liaise with the new service, ideally at a review meeting.

### 2.19.10 Discharge From CPA

- Discharge from enhanced CPA may only happen at a review or through workload management with a Team Manager.

### 2.19.11 Re-referrals

- If a person is re-referred or re-refers themselves following discharge from a caseload, the person receiving the referral should consult the Team Manager rather than automatically, as the previous care co-ordinator, take the case on.

- However, it is recognised that good practice may, but may not necessarily, indicate involvement from the person who is most familiar with the service user.

## 2.19.12 Standards For Record Keeping

- Trust CPA documentation and the Trust file format must be used as standard.
- Records should be kept of all contacts with the service user and with significant others in relation to the care that the patient receives.
- There should be a single, integrated, sequential, written record for each service user.
- All records should conform with conform with the Mental health Minimum Data Set.
- All documentation should be signed and dated. Black ink must be used and writing must be legible. Hard copies should be printed out from eCPA and signed as correct.
- Assessments completed under the Mental Health Act should be handed to the hospital on admission and should be placed on file whether or not an admission has been completed.
- Service users have the right to access files through existing Access to Records procedures.

## 2.19.13 Standards Relating To Holding And Sharing Of Information

- "Staff should only have access to personal information on a need to know basis, in order to perform their duties …relevant clinical and professional details should be available to all those, but only those, involved in the care of the individual." (Manual for Caldicott Guardians; Governing the Receipt and Disclosure of Patient/Client Information, para. 21).
- Each agency will ensure that they have mechanisms in place to enable them to address the issues of physical security, security awareness and training, including safe haven requirements and security management.
- "Each agency will take all reasonable care and safeguards to protect the physical security of information technology and the data contained within it". (Manual for Caldicott Guardians).
- "All personal files and confidential information must be kept in secure, environmentally controlled locations when unattended, e.g. in locked storage cabinets, secure protected computer systems etc. Keys to lockable storage cabinets should be held only by staff who require regular access to the information they contain. Keys must be held in a secure place." (Manual for Caldicott Guardians).
- Sharing of information for the purposes defined should be done by a telephone call back system, secure fax method or other locally agreed process, until a more secure method is developed, i.e., electronic transfer.

The above standards have been gleaned from various documents, which affect CPA. Sources include:-

- Department of Health HC(90)23/LASSL(90)11.
- Department of Health. Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach – A Policy Booklet. October 1999.
- Abolition of the supervision register, department of health criteria for robust CPA (2001).
- The Care Programme Approach Association (CPAA) CPA Handbook.
- The Mental Health Foundation 'Strategies for Living' (2000) Chapter 5.
- Department of Health Mental Health Policy Implementation Guide on CMHTs. June 2002.
- Department of Health ' The Single assessment Process – Care Management for Older People with Serious Mental Health Problems' 2002.
- Models of Care for substance misuse treatment.
- Department of Health Mental Health Policy Implementation Guide on Adult Inpatient Care Provision 2002.
- Manual for Caldicott Guardians; Governing the Receipt and Disclosure of Patient/Client Information.

- Draft 'Protocol for use of Fair Access to Care Services (FACS) by Staff In Partner Agencies' Jennie Stephens July 24th 2002.

## *2.20 References*

*(1) Dept of Health HC(90)23/LASSL(90)11.*
*(2) Dept of Health. Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach – A Policy Booklet. October 1999.*
*(3) Abolition of the supervision register, department of health criteria for robust CPA (2001)*
*(4) Blueprint for Mental Health Services in New Zealand (Dec 1998).*
*(5) The Mental Health Foundation 'Strategies for Living' (2000) Chapter 5.*
*(6) Department of Health ' The Single assessment Process – Care Management for Older People with Serious Mental Health Problems' 2002. www.doh.gov.uk/scg/sap/sapandcpa.htm)*
*(7) Models of Care for substance misuse treatment. P32. http://www.nta.nhs.uk/publications/modelsofcarefull.pdf*
*(8) 'Protocol for use of Fair Access to Care Services (FACS) by Staff In Partner Agencies' Jennie Stephens July 24th 2002.*