

**EFFECTIVE CARE  
CO-ORDINATION IN  
MENTAL HEALTH  
SERVICES**

**MODERNISING THE  
CARE PROGRAMME  
APPROACH**

**A POLICY BOOKLET**

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# INTRODUCTION

## Context

1. As part of its commitment to a modern, decent and inclusive society, the Government has set out clear proposals to modernise the NHS and Social Services, requiring these agencies to work in partnership to provide integrated services which will improve the quality of life for all citizens.
2. *The Mental Health National Service Framework* sets out the way modern mental health services will be delivered. Services will be much more accessible; intervene more quickly to offer help and support; seek out those who are difficult to engage; involve users and carers in planning developments; use effective care processes; and be delivered in partnership across health and social care as well as other key agencies.
3. Evidence and experience has demonstrated the benefits of well co-ordinated care to those with mental health problems. Mental health service users, particularly those with the most complex and enduring needs, can require help with other aspects of their lives, eg. housing, finance, employment, education and physical health needs. Mental illness places demands on services that no one discipline or agency can meet alone. It is logical that a system of effective care co-ordination is required if all services are to work in harmony to the benefit of the service user.

## Background to the Care Programme Approach (CPA)

4. The Care Programme Approach (CPA) was introduced in 1991 [HC(90)23/LASSL(90)11] to provide a framework for effective mental health care. Its four main elements are:
  - Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
  - The formation of a care plan which identifies the health and social care required from a variety of providers;
  - The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; and
  - Regular review and, where necessary, agreed changes to the care plan.

## The Need for Review

5. The CPA is a model for good practice which remains applicable today. However, a review of the CPA is timely for a number of reasons:
  - *The Mental Health National Service Framework* sets out a challenging agenda for reform. It is right to review the care co-ordination process to ensure that it matches the approach of a modern mental health and social care system;
  - We have been able to learn lessons about the operation of the CPA. Information from research, reviews and inspections is to hand. It is right to take account of this information; and
  - Finally, but of equal importance, is the need to listen to professionals, managers and service users in the mental health system. Professionals have found some aspects of the CPA over-bureaucratic, managers and service users alike have found the lack of consistency confusing. It is they who have been working and living with the CPA for some years now and it is important to take account of their views.

## Aim of this Booklet

6. The purpose of this booklet, therefore, is twofold. Firstly, to confirm the Government's commitment to the CPA as the framework for care co-ordination and resource allocation in mental health care. Secondly, to set out important changes to the CPA which take account of available evidence and experience and which will make the CPA an even more effective and efficient system of care co-ordination.
7. This booklet aims to clarify the role and purpose of the CPA in the context of the provision of modern mental health care. It includes a list of the key changes to the CPA and sets out who is responsible for their implementation.
8. The booklet has four main sections under the following headings:
  - Achieving integration of the CPA and Care Management;
  - Achieving consistency in implementation of the CPA nationally;
  - Achieving a more streamlined process to reduce the burden of bureaucracy; and
  - Achieving a proper focus on the needs of service users.
9. Each section includes detail on, and reasons for, the changes to the CPA. In addition, examples of good practice are highlighted. It is hoped that these examples, and the contact names and addresses given at the back of the booklet, will act as a useful source of reference to assist in achieving the necessary changes.
10. Vignettes are utilised towards the end of the booklet to give the reader examples of the CPA in operation. These illustrations convey a clear message as to where the emphasis of care planning energy should be placed, and describe the difference in application of the CPA for those who have relatively simple needs compared with those who have multiple

needs and require complex care arrangements.

11. The essence of effective care co-ordination is sound professional judgement and practice. The implementation of any care co-ordination process can be no substitute for this. Rather, it is intended to support good professional practice.
12. It is recognised that much work has been invested in the development of CPA procedures and practice across the country. However, research has demonstrated that the effectiveness of implementation and, indeed, commitment to the CPA is variable. It is right, therefore, that a clear policy position on implementation is given and that this builds on the good practice and experience available.
13. A directory of literature and useful contacts is available at the end of the booklet.

### **Effective Care Co-ordination - The CPA as a Whole Systems Approach**

14. All mental health service users have a range of needs which no one treatment service or agency can meet. Having a system which allows a service user access to the most relevant response is essential. The principle is getting people to the right place for the right intervention at the right time.
15. This principle is, of course, particularly important in the case of individuals who need the support of a number of agencies and services and there are some who, as well as their mental health problem, will have a learning disability or a drug/alcohol problem. In all these cases a co-ordinated approach from the relevant agencies is essential to efficient and effective care delivery. No one service or agency is central in such a system. Service users themselves provide the focal point for care planning and delivery.
16. Effective care co-ordination should facilitate access for individual service users to the full range of community supports they need in order to promote their recovery and integration. It is particularly important to provide assistance with housing, education, employment and leisure and to establish appropriate links with criminal justice agencies and the Benefits Agency.

### **Application of the CPA**

17. The CPA remains applicable to all adults of working age in contact with the secondary mental health system (health and social care). The principles of the CPA are relevant to the care and treatment of younger and older people with mental health problems. The transition from child and adolescent services to adult services and from adult services to services for older people is critical and must be managed effectively. Services should have in place clearly identified plans and protocols for meeting the needs of younger and older people moving from one service to another.

### **The CPA and its Application to People with Standard Needs**

18. What has been illustrated so far emphasises the importance of the CPA for the most needy of service users who require a complex care planning response. The key principles of the CPA are applicable to all service users, even those who require only a uni-disciplinary

intervention. They have the right to a thorough assessment of their needs, the development of a care plan and a review of that care by the professionals involved in their care. Indeed, this is good professional practice.

19. It is important to stress, however, that where the service user has standard needs and has contact with only one professional, that professional will in effect be the person who co-ordinates their care and any clinical or practice notes will constitute the care plan and record of review. Service users should be given the opportunity to sign the agreed care plan and then receive a copy. It is not necessary to engage in further bureaucracy for the care of such people. As a minimum, service providers must ensure that central records are maintained on all those in contact with services and that care planning and review take place regularly.

### **Audit**

20. The Government has shown a commitment to the development of quality. Systems should be in place to ensure that the co-ordination of care and treatment is effective. Where agencies are working together, joint auditing processes will need to be established. Any audit of quality will need to include the views of service users, who should be given the opportunity to contribute to the setting of quality standards and measures.

# **THE FUTURE OF THE CPA (SUMMARY OF KEY CHANGES)**

## **ACHIEVING INTEGRATION**

### **Integration of the CPA and Care Management**

21. The CPA will be integrated with Care Management in all areas to form a single care co-ordination approach for adults of working age with mental health problems.

### **Appointment of Lead Officer**

22. Each health and social services mental health provider must jointly identify a Lead Officer with authority to work across all agencies to deliver an integrated approach to the CPA and Care Management.

### **Framework for Care Regardless of Setting**

23. The CPA is not simply "an aftercare arrangement". As a framework for mental health care, the CPA is as applicable to service users in residential settings (including prisons) as to those in the community. Assertive inreach is as relevant as assertive outreach as an underpinning principle of the CPA.

## **ACHIEVING CONSISTENCY**

### **Rationalisation**

24. Two levels of the CPA must be introduced:

- i) Standard; and
- ii) Enhanced.

### **Abolition of Supervision Registers**

25. The requirement to maintain a supervision register will be removed.

### **Change of Name of Key Worker**

26. The Keyworker will be known as the Care Co-ordinator.

## **ACHIEVING A MORE STREAMLINED APPROACH**

### **Reducing Bureaucracy and Supporting Sound Professional Practice**

27. The implementation of the CPA should not place an undue burden on professionals whose prime responsibility is to care for service users; it should facilitate that care.

### **Review of Care Plans**

28. Review and evaluation of care planning should be regarded as ongoing processes and the requirement for a nationally determined review period, ie. six monthly, will be removed. However, at each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer must also be able to ask for a review at any time. Annual audit should ensure that reviews are carried out.

### **Information Requirements**

29. Local service providers should ensure that a system is in place to collect data on all service users, including total numbers in contact with services and the numbers whose care is managed through enhanced and standard CPA.

### **Audit**

30. Local audit should move away from a focus on simply numbers and more towards assessing the quality of CPA implementation, including the quality of care plans, the attainment of treatment goals and, particularly for those with multiple needs, the effectiveness of inter-agency working. The views of service users are an effective indicator of the quality of services and must be included in any audit of service delivery.

## **ACHIEVING A PROPER FOCUS**

### **Risk Assessment and Risk Management**

31. Risk assessment is an essential and on-going part of the CPA process. Care plans for severely mentally ill service users should include urgent follow-up within one week of hospital discharge. Care plans for all those requiring enhanced CPA should include a “what to do in a crisis” and a contingency plan.

### **Care Planning - Delivering Services Appropriate to the Needs of Service Users**

32. Those who use mental health services deserve a framework for care co-ordination which recognises and responds to diversity. The care plan must reflect this diversity through proper attention to the service user’s culture, ethnicity, gender and sexuality.



### **Support for Service Users and their Wider Family**

33. The process of the CPA is clearly intended to deliver care to meet the individual needs of service users. However, those needs often relate not just to their own lives, but also to the lives of their wider family. The CPA should take account of this, in particular the needs of children and carers of people with mental health problems, and must comply with the Carers (Recognition & Services) Act 1995 and the National Service Framework standard on caring for carers.

### **RESPONSIBILITY FOR IMPLEMENTATION**

34. The responsibility for implementation of the changes summarised above rests with the Chief Executive of the Mental Health provider Trust in conjunction with their partner Directors of Social Services. Changes to the CPA need to be built into the overall strategic response to mental health services development, in line with the National Service Framework. Changes in the CPA should have the full support and involvement of all partners in the mental health system, including primary care and health authorities.

# ACHIEVING INTEGRATION

## Integration of the CPA and Care Management

35. The CPA is Care Management for those of working age in contact with specialist mental health and social care services. It is essential to work towards an integrated approach across health and social care to minimise the distress and confusion sometimes experienced by people referred to the mental health system and their carers.
36. A seamless service can be achieved through an integrated approach to care co-ordination which provides for:
  - A single point of referral;
  - A unified health and social care assessment process;
  - Co-ordination of the respective roles and responsibilities of each agency in the system; and
  - Access, through a single process, to the support and resources of both health and social care.
37. Systems of self-referral for assessment must be introduced, where they do not already exist. The *Mental Health National Service Framework* sets a standard which requires that those on the CPA should be able to access services 24 hours a day, 365 days a year.
38. Access to services provided by the NHS or Local Authorities is based on an assessment of need. A joint assessment process prevents duplication for the user and carer but, as appropriate, ensures the services allocated from whichever source match need. Most SSDs have developed eligibility for services using descriptions of vulnerability and risk, while many CPA systems define access to service and level of expected monitoring by legal status or diagnosis. The former is a more appropriate method to use to identify the level of need, the risk associated with it and therefore the services and monitoring to be provided within an agreed plan. A single assessment should facilitate access to both health and social services.

## **STRUCTURE OF COMMUNITY BASED SPECIALIST SERVICES – NORTH SOMERSET**

Community resources are divided into three teams, each with a team leader, responsible for allocating appropriate referrals. The teams are as follows:

- Acute and Primary Care team;
- Rehabilitation and Continuing Care Team; and
- Team with small caseloads to work intensively with the less settled, chaotic service users.

New referrals are received at a single point of entry with one assessment to access a Health or Social Service resource. A worker is appointed from the appropriate team to act as point of contact and to see that the Care Programme Approach Care Plan is completed, then implemented and reviewed at appropriate intervals. Reviews may be conducted by the care co-ordinator talking with the service user and contacting, often by telephone, those responsible for the rest of the plan. Reviews, by means of a multi-disciplinary team meeting, only take place where plans are complex, clearly not working or in imminent danger of breakdown. The care co-ordinator could be a Health or Social Services Worker.

*Malcolm Conyers, North Somerset District Council*

*Freda Woolley, Avon & Western Wiltshire Mental Healthcare NHS Trust*

39. Features of a truly integrated system of the CPA and Care Management include:

- A single operational policy;
- Joint training for health and social care staff;
- One lead officer for care co-ordination across health and social care;
- Common and agreed risk assessment and risk management processes;
- A shared information system across health and social care;
- A single complaints procedure;
- Agreement on the allocation of resources and, where possible, devolved budgets;
- A joint serious incident process; and
- One point of access for health and social care assessments and co-ordinated health and social care.

## **INTEGRATION ARRANGEMENTS – NEWHAM**

Over the past year, Newham Community NHS Trust and Newham Social Services have made strenuous efforts to integrate. This has occurred at various levels.

A Joint Management Board, comprising senior management of the Trust and Social Services and members of the Independent Newham Users Forum (INUF) has been appointed with responsibility for managing all community services for adults aged 18 to 65 years.

A Joint Operations Manager, employed by the Trust and Social Services, directly manages all community services and is accountable to the Joint Board.

Joint performance indicators have been developed in conjunction with the Trust, SSD and INUF. These include standards and indicators around the CPA and Care Management. A Joint Service Plan has also been developed and the Board actively monitors its progress and implementation.

CMHTs undertake comprehensive assessments and can access all health and social services. Psychology and Occupational Therapy are provided within the teams. Following assessment, social care can be accessed via the mental health panel (joint Health and SSD).

*George O'Neill, Newham Community NHS Trust*

### **The Role of the Lead Officer**

40. A lead officer with authority to work across all agencies to deliver an integrated approach to the CPA and Care Management must be identified by health and social services. The lead officer's role will require sufficient authority to ensure an integrated approach to care co-ordination across all services and agencies. It is essential that these "lead officers" can put in place a strategy and action plan to deliver on the requirement to integrate the CPA and Care Management. They will also be responsible for ensuring that audit of practice is undertaken and that feedback is provided to practitioners and managers alike. In short the lead officer will be responsible for the strategic oversight and development of the care co-ordination process.

## **CARE MANAGEMENT WITHIN THE CPA – KIRKLEES**

Dewsbury is situated within the North Kirklees area and has a population of 160,000. There has been effective joint working between Health and Social Services since the early 1990s.

The post of CPA/Care Manager was introduced in 1995. The post holder was employed by Social Services following discussion with Health. The brief for the post was to further develop the CPA process and take full responsibility for the monitoring and management of the CPA in line with Social Services Care Management systems. The post holder is responsible for all care purchasing monies including both health and social care.

The CPA is targeted to include people on priority levels who have the greatest need and the highest risk.

The integration of the CPA/Care Management has proved of benefit to users, carers and staff, by:

- Avoiding over bureaucratic problems in the application of systems;
- Facilitating the early allocation of a worker to undertake Community Care Assessments;
- Allowing funding for enhanced care plans to be committed immediately; and
- Providing a central point for communication, well used by other agencies.

*Chris Vickerman, North Kirklees Community Mental Health Services*

### **Primary Care Involvement**

41. Clearly, specialist mental health and social care services have the responsibility to ensure the implementation of the CPA. However, people with mental health problems have the right to access effective primary care support.
42. *HSC1999/038: LAC(99)8 Modernising Mental Health Services: Modernisation Fund for Mental Health Services and Mental Health Grant 1999/2002* has identified additional resources through the Mental Health Grant for the development of social care services for the mentally ill. Part of this allocation is to assist in achieving the integration of the CPA and Care Management, and the development of appropriate partnerships with primary care.

43. Everybody, including those with a mental health problem, should have a GP who, alongside other members of the primary care team, will play a key role in maintaining their continuity of care.
44. All primary care groups (PCGs) need to have easy access to information about their individual service users on the CPA, particularly those on the enhanced level. PCGs, in partnership with the secondary mental health system, should maintain and receive regular reports from a shared information system. A copy of the service user's care plan should be given to his/her GP.

### **MANAGEMENT OF STANDARD LEVEL CPA – KINGSTON UPON THAMES**

Most standard level CPA work is picked up and/or managed through Primary Care at GP practices.

Each CMHT has a link CMHN and Social Worker with each GP practice in its locality.

The precise nature of the liaison varies, depending on the GPs' needs: from the CMHN and Social Worker being based in the practice for one session per week, to the CMHN and Social Worker taking all the referrals from the practice for screening, popping in to the practice frequently, and attending Primary Care meetings (but not conducting sessions in the practice).

*Jim Davidson, Kingston and District Community NHS Trust*

### **The CPA, the Criminal Justice System and Information Sharing**

45. A significant number of individuals within the criminal justice system will need the support of the mental health system at some point in their lives. For some people with mental health problems, their first contact with mental health services will come through the criminal justice system. The CPA applies to these people regardless of setting. Where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements, including ongoing risk assessment and management, are essential.
46. Where a service user is not in formal contact with the criminal justice system, but is assessed as being a potential risk to others, careful liaison with the police to manage the risk is necessary. In this context it is important to note that the common law duty of confidence requires that, in the absence of a statutory requirement to share information provided in confidence, such information should only be shared with the informed consent of the individual. This duty is not absolute and can be over-ridden if the holder of the information can justify disclosure as being in the public interest (including a risk to public safety). Further guidance on the operation of the common law is included in the Department of Health publication *HSG (96)18 The Protection and Use of Patient Information*. Decisions to disclose information against the wishes of an individual should be fully documented and the public interest justification clearly stated.

47. Information that is to be shared between different agencies should be governed by strict protocols to ensure that all parties concerned, including the service user, are aware of how information will be used, who will have access to it and how it will be safeguarded. NHS organisations are required, under *HSC 1999/012*, to have in place Guardians of Patient Information tasked with oversight of information sharing protocols and it is recommended that other agencies adopt this model. Protocols enable information to be shared confidently and effectively between staff in agencies providing services within agreed and appropriate parameters.
48. The framework that the CPA provides should be used by all agencies involved in the complex care arrangements necessary for an individual who has mental health problems. It should be supported by probation, police and housing colleagues who will need to be involved in ongoing risk assessment, risk management and review of care arrangements.
49. If service users have to reside in prison and they are known to have longer term and complex mental health needs, the responsible psychiatric team should maintain contact with the individual and make plans for care on the person's release in collaboration with prison and probation staff as appropriate.
50. A number of good examples of liaison schemes at the point of arrest and at court now exist throughout the country.

### **CRIMINAL JUSTICE MENTAL HEALTH LIAISON – LIVERPOOL**

A CMHN led scheme is based in Liverpool Magistrates Court. It aims to assess, support and, where appropriate, divert Mentally Disordered Offenders (MDOs) during their contact with the Criminal Justice System (CJS). It is staffed by 3.5 CMHNs and a secretary, supported by an off site consultant community psychiatrist.

The scheme provides liaison at all stages of the CJS, including point of arrest, at court and in prison. Some MDOs are diverted to hospital soon after arrest, but this represents a very small part of the work of the scheme. On occasion it is necessary to press the CJS to continue proceedings in order to retain the availability of appropriate treatment and disposal options.

The scheme has links with the local forensic psychiatry services, but works closely with CMHTs. It is strengthened by being part of the community service.

The scheme attempts to ensure that care of MDOs in the CJS is as good as that provided in the community. The CMHNs provide inreach to support prison health care staff in caring for prisoners with serious mental health problems. They organise pre-release CPA planning within the prison, involving the CMHT and thus maintaining continuity of care.

*Marion Bullivant, North Mersey Community NHS Trust*

51. The functions of communication and liaison between mental health and criminal justice systems are best managed locally within the setting of a multi-agency co-ordination group.

### **The CPA and the Mental Health Legal Framework**

52. Changes in the legislative framework to support the effective delivery of modern mental health services will arise from the current review of the Mental Health Act. An individual's status under the Mental Health Act can be reviewed at the CPA review meeting. One formal meeting, with the user, should be used to determine all care planning aspects including Mental Health Act status and discharge planning where required. There is no requirement to hold separate meetings, whether the service user is in a hospital or community setting.

### **The CPA - A Framework for Care Regardless of Setting**

53. The CPA should not be considered simply as a framework for aftercare. Ward rounds and discharge meetings, which are more administrative in nature may not provide the best planning area for the CPA. CPA meetings are those which are timetabled around the needs of the service user, and their carers with the right of advocacy. Community-based staff, including children's services staff where issues of child care have a bearing on assessment and care planning, should be involved in hospital discharge planning from an early stage. The CPA provides a framework for care wherever service users are in the system, including residential as well as community settings.
54. The CPA must be utilised to ensure that those with complex needs, in particular, stay in contact with services. This may require the development of assertive inreach approaches into prisons and other settings, as well as assertive outreach for those at risk of losing contact with services altogether.



# ACHIEVING CONSISTENCY

## Rationalisation of the CPA Levels of Need

55. Considerable variation exists across the country in terms of definition and interpretation in the levels of the CPA applied to service users. In order to achieve clarity and consistency it is appropriate that levels of the CPA are defined centrally.
56. Throughout the country services will be required to deliver the CPA according to two levels:
- i) Standard;
  - or
  - ii) Enhanced.
57. The characteristics of people on standard CPA will include some of the following:
- they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;
  - they are more able to self-manage their mental health problems;
  - they have an active informal support network;
  - they pose little danger to themselves or others;
  - they are more likely to maintain appropriate contact with services.
58. People on enhanced CPA are likely to have some of the following characteristics:
- they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;
  - they are only willing to co-operate with one professional or agency but they have multiple care needs;
  - they may be in contact with a number of agencies (including the Criminal Justice System);
  - they are likely to require more frequent and intensive interventions, perhaps with medication management;
  - they are more likely to have mental health problems co-existing with other problems such as substance misuse;

- they are more likely to be at risk of harming themselves or others;
- they are more likely to disengage with services.

### **LEVELS IN CARE PROGRAMME APPROACH – BIRMINGHAM**

Birmingham CPA Policy is jointly agreed by Birmingham Health Authority, Birmingham Social Services Department, Northern Birmingham Mental Health Trust and South Birmingham Mental Health Trust. There is a two level system in operation:

#### **Level 1**

Following an assessment, many people referred to the secondary psychiatric services will have needs identified which can easily be met, organised and delivered, they will not be at risk or present risk and they will not usually have more than one discipline involved in their Care Plan.

#### **Level 2**

People with complex health and social needs will require a higher degree of monitoring of their mental health and co-ordination of their care. The service user may be at risk or present risk or may have a Care Plan that has a high number of components.

Differential criteria for determining access to the two levels is informed by the assessment of risk. Robustness of the care package to offer support and safe management in the community are determining factors. Guidance for characteristics of presenting problems and range/level of services required is included in the Policy.

*Irene Peters, Northern Birmingham Mental Health Trust*

*Liz Parry, South Birmingham Mental Health NHS Trust*

### **Abolition of Supervision Registers**

59. The development of a system where the enhanced level of the CPA identifies and ensures the provision of services to meet the needs of the most vulnerable users means that there no longer remains a need for Supervision Registers. The requirement to maintain Supervision Registers will therefore be abolished from 1 April 2001. However, before a Trust abolishes its Supervision Registers, the Regional Office must be satisfied that robust CPA arrangements are in place.

### **Change of name of keyworker**

60. The key worker will be known as the Care Co-ordinator. They have responsibility for co-ordinating care, keeping in touch with the service user, ensuring that the care plan is delivered and ensuring that the plan is reviewed as required. More detail about the role of the care co-ordinator can be found at paragraphs 81-83.

# ACHIEVING A MORE STREAMLINED APPROACH

## Reducing Bureaucracy and Supporting Sound Professional Practice

61. The burden of additional paperwork, an over-bureaucratic system and the duplication of information gathering have been recognised as major concerns in relation to the implementation of the CPA. In practice, the perceived bureaucratisation of the CPA has arisen as a result of differing management practices around the country. In some areas, the CPA has operated successfully without entailing burdensome paperwork.
62. Robust arrangements for those with the most complex care needs, including assertive outreach for those who are likely to disengage with services, must be in place by April 2001 in order to satisfy the Regional Office that a Trust can abolish its supervision register.
63. For those requiring standard CPA (this might include those who need the support of only one agency or discipline) it is only necessary for professionals to maintain adequate clinical/practice records which record the assessment of the service user's needs, the agreed care plan and the date of the next review of the care plan. Elements of risk and how the care plan manages the identified risk must always be recorded.
64. Good practice dictates a move towards more integrated operational practice. Integrated professional records are an example of such practice. The maintenance of shared records will further reduce unnecessary form filling and bureaucracy, will improve communication and, most importantly, will contribute to a streamlined care process to the advantage of the service user and provider.
65. Another aspect of achieving a streamlined care co-ordination process is to achieve a single system of referral to all aspects of health and social care for people with mental health problems. This approach facilitates a direct route into specialist services, and avoids confusion in searching for the appropriate individual or agency to whom the referral should be made. Once received, the referral can be processed and passed on to the most relevant part of the system.

## Review of Care Plans

66. There is no longer a requirement for a nationally determined review period of six months. Review and evaluation of the service user's care plan should be ongoing. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer must also be able to ask for review at any time. All requests for a review of the care plan must be considered by the care team. If the team decide that a review is not necessary the reasons for this must be recorded. The annual audit of the CPA should check that reviews of the care plan have been carried out.

67. It is particularly important to review a service user's care plan upon discharge from hospital. Hospital discharge is not the point of discharge from care, but a transfer in the location of the delivery of care. Both hospital and community based staff should be trained in discharge and care planning. The implementation of the care plan should be assessed within the first month of discharge.

### **Information Requirements**

68. Information systems to support the CPA have four main purposes:
- To assist staff in managing their caseloads;
  - To ensure that key facts about all service users managed within the CPA are available to all professional staff whenever and wherever they need them;
  - To provide statistical information to answer relevant audit questions; and
  - To assist in service planning and improvement.
69. All effective CPA information systems are likely to have a computer at their heart. However, whether this takes the form of a stand-alone system in the CPA co-ordinator's office or a wide area network is less important than the operational arrangements agreed for its use. Systems should be designed to minimise the burden on, and maximise support to clinical staff. For further information see *HSC 1998/168 - Information for Health: An Information Strategy for the Modern NHS*.
70. Annex A sets out further guidance on information requirements.

### **INFORMATION SYSTEMS – STAFFORDSHIRE**

Common information systems may take some time to develop and implement. In the meantime Trusts providing mental health services in Staffordshire (including the Medium Secure Unit, Social Services and the Police), have developed protocols for exchanging information about people needing enhanced CPA.

*Jeremy Boughey, Combined Healthcare NHS Trust*  
*Susie Green, Premier Health Care NHS Trust*  
*Steve Foster, Foundation NHS Trust*

## The CPA and Section 117

71. The CPA is applicable to service users who have been discharged from hospital into the community and are subject to section 117 after-care. Given that the principles of the CPA and after-care are the same, it is recommended that the section 117 register becomes a discrete and identifiable subset of the CPA register.

## Audit

72. Audit and monitoring are essential components of successful implementation of the CPA. The focus for audit should be the 'quality' of the CPA implementation, not just the 'quantity' of people subject to the CPA. CPA co-ordinators have a crucial role in respect of audit and monitoring. The NHS Executive has issued an *Audit Pack for Monitoring the CPA (HSG(96)6)*. The CPA Association (CPAA) has also produced useful standards and an accompanying audit protocol for the CPA. The SSI standards used in the 1997/98 inspections are available as an audit tool for the process of integration.

### AUDIT OF THE CPA – STAFFORDSHIRE

Recognising that service users are the most appropriate people to say whether the CPA met their needs, the CPA Association Audit Tool is designed to be completed by them. It also contains a section in which organisations can review their operational procedures to ensure that they have appropriate support frameworks in place.

In South Staffordshire, a team of MIND advocates has been trained to audit the CPA using the CPA Association Audit Tool. Users are invited by letter, whilst in contact with services, to contribute and if they choose to do so, they can select a venue where they meet with the advocate to complete the audit tool. Results are aggregated and fed back to service users and Trust clinicians so that where necessary, adjustments can be made to services.

This has the advantage of creating an arms-length, user led audit providing feedback to the local Trust, as well as stimulating the use of the advocacy service.

*Jeremy Boughey, Combined Healthcare NHS Trust*  
*Susie Green, Premier Health Care NHS Trust*  
*Steve Foster, Foundation NHS Trust*

## ACHIEVING A PROPER FOCUS

73. The primary purpose of the CPA is to ensure that the needs of all mental health service users are assessed and that appropriate care is delivered to meet those needs.

### **Risk Assessment and Risk Management**

74. Risk assessment is an essential and on-going element of good mental health practice. Risk assessment is not, however, a simple mechanical process of completing a proforma. Risk assessment is an ongoing and essential part of the CPA process. All members of the team, when in contact with service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations.
75. Risk cannot simply be considered an assessment of the danger an individual service user poses to themselves or others. Consideration also needs to be given to the user's social, family and welfare circumstances as well as the need for positive risk-taking. The outcome of such consideration will be one of the determinants of the level of multi-agency involvement.
76. Risk assessment and risk management is at the heart of effective mental health practice and needs to be central to any training developed around the CPA. Staff must also consider the extent to which they might need support from colleagues, other services or agencies, especially when someone's circumstances or behaviour change unexpectedly.

### **Crisis and Contingency Planning**

77. Service users on enhanced CPA will require, as part of their care plans, crisis and contingency plans. These plans form a key element of the care plan and must be based on the individual circumstances of the service user. It is good practice for users on standard CPA to have similar arrangements within their care plans.
78. Contingency planning prevents crises developing by detailing the arrangements to be used where, at short notice, either the care co-ordinator is not available, or part of the care plan cannot be provided. This could be, for example, the sudden absence of the family member who oversees medication, or the absence of a staff member through sickness. The contingency plan should include the information necessary to continue implementing the care plan in the interim, for example, telephone numbers of service providers and the name and contact details of substitutes who have agreed to provide interim support.
79. The *Mental Health National Service Framework* requires that care plans should specify the action to be taken in a crisis for all people on enhanced CPA. Crisis plans should set out the action to be taken based on previous experience if the user becomes very ill or their mental health is rapidly deteriorating.

80. To reduce risk, the plan, as a minimum, should include the following information:

- who the user is most responsive to;
- how to contact that person; and
- previous strategies which have been successful in engaging the service user.

This information must be stated clearly in a separate section of the care plan that should be easily accessible out of normal office hours.

### **Role of the Care Co-ordinator**

81. The role of care co-ordinator should usually be taken by the person who is best placed to oversee care planning and resource allocation. The care co-ordinator is responsible for keeping in close contact with the service user, and for advising the other members of the care team of changes in the circumstances of the service user which might require review or modification of the care plan. Where the user has standard needs and has contact with only one professional, whoever this may be, the role of care co-ordinator should fall to this professional. The care co-ordinator is responsible for updating of the service user's basic care plan and crisis plan.

82. It is critical that the care co-ordinator should have the authority to co-ordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency of origin. It is also critical that the care co-ordinator can understand and respond to the specific needs of the service user that may relate to their cultural or ethnic background.

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

- competence in delivering mental health care (including an understanding of mental illness);
- knowledge of service user/family (including awareness of race, culture and gender issues);
- knowledge of community services and the role of other agencies;
- co-ordination skills; and
- access to resources.



## **ROLE OF THE CPA CARE CO-ORDINATOR – NORTHUMBERLAND**

### **Joint Arrangements**

Provision is made for appropriate health or social services professionals (eg social workers or CMHNS), to take on the role of care co-ordinator. Authority is given to these professionals to access Health or Social Services provision on the strength of their single assessment, eg negotiate with social services community care budget holder or health day care or day hospital provision.

### **Qualification and Training**

Professionals have the appropriate level of experience, qualification and training to match the complexity of need of the service user. Systems are in place to ensure that referrals are allocated appropriately.

All persons undertaking the role of care co-ordinator undergo joint training to prepare them for this. This training enables the care co-ordinator to identify if and when more specialised or in-depth assessments are required and how to arrange these, eg for family work or behavioural therapy.

*Chris Lozinski, Northumberland Mental Health NHS Trust*

### **Caseload Management and Clinical Supervision**

84. Good caseload management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that staff in care co-ordinator roles are maintaining caseloads of suitable sizes with individuals who have active needs and that support and clinical supervision is provided.
85. Care plans for service users with severe mental illness who are at high risk of suicide should include more intensive provision for the first three months after discharge from in-patient care, and specific follow-up in the first week after discharge.

### **Care Planning – Delivering Services Appropriate to the Needs of Service Users**

86. An individual service user's care plan must be based on a thorough assessment of their health and social care needs. This assessment will involve the user and the carer, where appropriate, as central participants in the process. The service user must be given full information about the CPA process and a copy of the agreed care plan which must:
  - identify the interventions and anticipated outcomes;
  - record all the actions necessary to achieve the agreed goals;
  - in the event of disagreement, include the reasons;
  - give an estimated timescale by which the outcomes or goals will be achieved or reviewed;

- detail the contributions of all the agencies involved; and
  - include appropriate crisis and contingency plans.
87. Care plans should focus on users' strengths and seek to promote their recovery. Recognising, reinforcing and promoting service user strengths at an individual, family and social level should be an explicit aspect of the care plan. Care plans should recognise the diverse needs of service users, reflecting their cultural and ethnic background as well as their gender and sexuality, and should include action and outcomes in all the aspects of an individual's life where support is required, eg. psychological, physical and social functioning. The Mental Health National Service Framework sets out further information about the assessment and care planning process.

### **Providing Support for the Service User and their Wider Family**

88. The needs of service users often relate not just to their own lives but to the lives of the wider family. The assessment of an individual user's needs should take account of this and must comply with the Carers (Recognition & Services) Act 1995. The Mental Health National Service Framework includes a standard which requires that all individuals who provide regular and substantial care for a person on the CPA should:
- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; and
  - have their own written care plan which is given to them and implemented in discussion with them.

## Information Requirements

1. Records on the information system should comprise at least the following:
  - Service user's details;
  - Details of overall periods of mental health care; and
  - Details of the CPA reviews.
2. Some likely data items for each type of record are set out at paragraph 5. Records which have been superseded should be archived, not over-written, to allow service user histories to be analysed for audit purposes.
3. Data will be gathered from several sources:
  - The single point of referral;
  - Care reviews; and
  - Care co-ordinators and other staff managing their caseload.
 The responsibility for ensuring that data is updated lies with the care co-ordinator.
4. Data held on the CPA constitutes health records. Extensive confidentiality and data protection guidance thus applies and should be rigorously followed. An up to date summary of this is found in *HSG (96)18: LASSL(96)5 The Protection and Use of Patient Information*.
5. Likely data items include:

### Patient Record:

name;  
 address including postcode;  
 NHS number;  
 social Services ID number;  
 name of GP;  
 date of birth;  
 gender;  
 housing status;  
 employment status;  
 ethnicity;  
 number of dependent children;  
 known aliases; and  
 a history summary, where possible.

### Care Record:

Dates of referral and termination of overall period of care; source of referral; and method of termination.

Care Review Record:

name and details of principal carer;  
responsible care team;  
identified problems - could include outcome measure eg HoNOS rating;  
diagnosis including indicators of severe mental illness;  
identified risks to self or others;  
date care plan and assessment explained to and agreed by service user;  
agreed care plan components (including planned frequency of contact);  
crisis plan details;  
CPA level;  
details of carer's support plan;  
care management details including assessed needs;  
legal status;  
care co-ordinator; and  
date of this, and next planned review.

## VIGNETTES/CASE ILLUSTRATIONS

### Case 1

Sally is 25 years old and has been known to her local mental health service since her mid teens. She has had a troubled relationship with her family, and episodes of severe distress follow contact with her mother, who has an alcohol problem. She copes by lacerating herself, and has had frequent, brief, in-patient admissions at times of crisis. She has recently started to disclose that she suffered sexual abuse as a child. She will not speak to male staff.

#### *Comment*

Sally may benefit from intensive support under enhanced CPA. Her care co-ordinator might come from any discipline, but it is important that the care co-ordinator should be female.

### Case 2

Sharon recently had her second baby daughter. Unfortunately she has developed a mental health problem which is similar to that which happened on the birth of her first child. Sharon has become quite unwell and will require a short stay in hospital, but will soon be in a position to be supported at home where she lives with her partner. Sharon's extended family lives some distance away. Sharon and her partner live in a single bedroom flat and have had some difficulty in keeping up with the rent for this accommodation of late.

#### *Comment*

Clearly Sharon has a number of care and treatment needs which need to be handled together in a co-ordinated way. The support of social care, housing, health and primary care agencies would be essential to meet Sharon's and her family's needs. Sharon should be supported on enhanced level CPA until such time that her care needs reduce.

### Case 3

Robert recently left prison. He is known to have a history of serious mental health problems. Unfortunately, he has a co-existing alcohol and substance misuse problem which compounds his mental state. When Robert drinks to excess he can become verbally and physically aggressive. A number of assessments have shown that he has had thoughts of taking his own life and occasionally harming others. Robert remains subject to a probation order.

### *Comment*

Robert's history and current care and treatment needs demand intensive support and monitoring. The involvement of the criminal justice system, probation service, health and social care requires an effective co-ordination process to be in place. Robert should be on enhanced CPA.

### **Case 4**

Helen is referred to the community mental health team because of a recent bereavement. She is obviously low but on assessment does not show any signs of suicidal thought. She is clear that the loss of her partner only re-inforces the need to focus on her young children's future, but feels the need to talk to others about her experiences. The community mental health team decides that Helen would not benefit from further engagement with specialist mental health services, but would be helped by a local bereavement support group and a referral is made. Helen is also reassured that she can make contact again if she needs to.

### *Comment*

Helen does not need to be subject to the CPA under circumstances where she no longer requires contact with specialist mental health services.

### **Case 5**

Andrew caused discipline problems at primary school and was known to the police from the age of 10. At 14 he was placed in a local authority secure unit where he became increasingly aggressive and frequently absconded. He abuses drugs and alcohol and now, aged 16, he has become withdrawn and has been complaining of hearing voices. He believes that the Director of Social Services is trying to kill him. He faces court proceedings relating to theft and bail offences. He has been referred to the CMHT.

### *Comment*

After a period of assessment it becomes clear that Andrew needs a complex and intensive long term care package, provided by a range of agencies working together in co-ordinated way. He will be subject to enhanced CPA, which will take into account his range of needs:

- for robust supported accommodation which can cope with his turbulent behaviour and which can meet his adolescent developmental needs;
- for monitoring of his mental state and for supervision of medication;
- for help to minimise the harm to his physical and mental health arising from his drug and alcohol habits;
- for education and meaningful activity; and
- for his need for appropriate responses to his offending.

There are a range of predictable problems, such as episodes of worsened psychosis, which are likely to arise, and contingency plans must be made to allow for timely intervention.

## **Case 6**

Alison is thirty-five. She suffers severe mood swings, and has been admitted to her local mental health unit under the Mental Health Act on five occasions. When she has been depressed Alison has taken dangerous overdoses. When elated she overspends and places herself in dangerous situations with strangers. During periods of better mental health she is heavily involved in running a charity shop and is well regarded by neighbours and her friends at church.

### ***Comment***

Alison is at long term risk and should be cared for under enhanced CPA. Her community network will willingly provide the best quality care for her, supported by a CMHN. The success of this depends on the provision of rapid access to the community mental health team for Alison and her carers when the need arises. An important part of the care plan is an understanding of Alison's circumstances and her particular subtle early signs of relapse.

## **Case 7**

James is a 48 year old married man who suspects he is about to be made redundant. He has developed panic attacks for the first time in his life. He is suffering from stomach pain, caused by a recent increase in his alcohol consumption. He is frightened that he is going to die and consults his General Practitioner.

### ***Comment***

James is likely to benefit from advice about his drinking, about the nature of his anxiety symptoms and about the relationship between the panic attacks and his fear of redundancy. Good self-help literature may resolve his symptoms, and if this fails further advice about self referral to a local voluntary sector group is likely to be helpful. He does not require care under the CPA, but his GP may need support to become confident in assessing and helping service users like James.

## **Case 8**

Simon developed a serious mental health problem during his twenties. For two years he was in close contact with the mental health services, during which time he was briefly an in-patient. He was admitted to the day hospital twice, and saw a psychiatrist and an Occupational Therapist regularly. He and his family benefited from an early psychosocial intervention and were helped to understand his mental illness. Increasingly they were able to cope with his persistent symptoms. Eventually he returned to his employment as a cook.

### ***Comment***

Simon was initially cared for under enhanced CPA, but later was moved to standard CPA. 6 months after he returned to work it was agreed that his GP would monitor his medication and that the CMHT would become involved only if the need arose. Simon, his family and his GP were given a telephone contact for same day re-assessment by the CMHT.

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## Resource Directory

1. HSG(96)6: An Audit Pack for Monitoring the CPA
2. HSG(95)56: Building Bridges - A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people
3. Care Programme Approach and Supervision - Operational Guidance (Nuffield Institute)
4. Care Programme Approach and Supervision - The issues (Nuffield Institute)
5. EL(93)57: Factors Influencing the Implementation of the Care Programme Approach
6. Key Area Handbook Mental Illness (2nd edition)
7. Keys to Engagement - Review of the care for people with severe mental illness who are hard to engage with services (Sainsbury Centre)
8. CI(95)34: Social Services Departments and the Care Programme Approach: An inspection.
9. EL(91)116: Care Management and Assessment - Manager's Guide
10. Care Management: Is it working? (Sainsbury Centre)
11. CI(98)15: Care Management Study: Report on National Data & Care Management Study: Care Management Arrangements
12. Co-ordinating Community Mental Health Care: The Care Programme Approach (A training pack for social services staff and others caring for mentally ill people (prepared for the Department of Health by the Open University, 1996)
13. CI(99)3: Still Building Bridges: The Report of a National Inspection of Arrangements for the Integration of Care programme Approach and care Management
14. National Standards and Audit Tool (CPA Association)

## Glossary and Terms

1. ASW	Approved Social Worker
2. CMHT	Community Mental Health Team
3. CMHN	Community Mental Health Nurse
4. CPA	Care Programme Approach
5. CPAA	Care Programme Approach Association
6. DGH	District General Hospital
7. EL	Executive Letter
8. GP	General Practitioner
9. HA	Health Authority
10. HSC	Health Service Circular
11. HSG	Health Service Guidance
12. IT	Information Technology
13. LA	Local Authority
14. LAC	Local Authority Circular
15. LASS	Local Authority Social Services
16. LASSL	Local Authority Social Services Letter
17. MISG	Mental Illness Specific Grant
18. NHS	National Health Services
19. PHCT	Primary Health Care Team
20. RO	Regional Office
21. RMO	Responsible Medical Officer
22. SHA	Special Health Authority
23. SSD	Social Services Department
24. SSI	Social Services Inspectorate