



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

DELIVERING THE CARE PROGRAMME APPROACH IN WALES

Interim Policy Implementation Guidance

[July 2010]

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PART 1 – Introduction and background

1. Introduction

1. Evidence and experience has shown the benefits of providing well coordinated care and treatment to those suffering with mental ill-health.
2. Mental health service users, particularly those with complex and enduring needs, often require help with aspects of their lives in addition to care and treatment, such as housing, finance, employment, education as well as their physical health. This places demands on services that no one discipline or agency can meet alone, and it is therefore necessary to have an integrated system of effective assessment, planning, delivery and review, so that all services can work together for the benefit of the service user.
3. For service users accessing assessment and treatment within secondary adult mental health services (see paragraph 14 below) the framework for this integrated system is the Care Programme Approach (CPA). The background to CPA is given at section 3 below.
4. The CPA provides many service users with an mechanism to work towards maximising their ability to live fulfilled lives as independently as possible (sometimes referred to as ‘recovery’) by addressing all the aspects of their lives which together contribute to mental health. This recovery approach to care and treatment should be available to all service users within secondary care, regardless of diagnosis or presentation.

Purpose and status of the guidance

5. This interim guidance is provided to Local Health Boards (LHBs) and Local Authorities in Wales to advise them on how they should proceed in relation to service planning under the CPA. The guidance will also be useful to other statutory and non-statutory agencies and organisations involved in the planning and delivery of care to users of secondary mental health services, as well as users of those services and their carers.
6. The guidance is ‘interim’ in nature: the Welsh Assembly Government recognises that the guidance on CPA issued in 2003¹ needs to be revised and updated in light of developments in service delivery and configuration, and experiences and evidence on how CPA is being used in Wales. It is timely and appropriate for new guidance to be developed now. However, account also

¹ Welsh Assembly Government (2003) *Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users. A Unified and Fair System for Assessing and Managing Care*

has to be taken of the new legislative proposals that are being considered by the National Assembly for Wales in 2010 – the Mental Health (Wales) Measure (see section 2 below).

7. This guidance is therefore issued to LHBs and Local Authorities for immediate use, but on the understanding that it will be subject to further review and refinement based on comments received on the interim guidance, and to reflect the final legal position if the National Assembly for Wales makes the Mental Health (Wales) Measure. The Welsh Assembly Government expects to publish the final guidance in early 2011.
8. When the final guidance document is published, there will also be an accompanying booklet for service users and their carers. This booklet will set out what CPA means for the individual, and how to ensure that service providers are delivering what service users expect to be delivered.

Applicability

9. This guidance applies in respect of all adults who have been referred to secondary mental health services (see paragraph 14 below), including older adults (sometimes referred to as ‘over working age’). It also applies in respect of all adults receiving care and treatment within secondary mental health services, including those under the guardianship of a local authority in Wales².
10. Where young people (those aged 16 to 18 years) are referred to, or receiving services from, adult secondary mental health services this guidance will also apply.

A note on some of the terms used in this guidance

11. The term ‘service user’ is often used for people accessing services for care and treatment for their mental disorder. Some people prefer the term ‘survivor’, ‘client’, ‘consumer’, ‘recipient’ or ‘patient’. This guidance generally uses the term ‘service user’, except where the term ‘patient’ is used to denote a person subject to the compulsory powers of the Mental Health Act 1983 – that legislation uses the term ‘patient’. The Mental Health (Wales) Measure also uses the term ‘patient’ (whether or not referring to an individual detained under the 1983 Act).
12. This guidance also uses the terms ‘child’ and ‘children’ for people aged under 18 years of age, while acknowledging that ‘young person’ or ‘adolescent’ might sometimes be a more appropriate term.
13. Some of the language of CPA, for example ‘care coordinator’ or ‘enhanced CPA’, ‘standard CPA’, etc is used in the guidance ahead of a fuller explanation

² where the person is not also receiving secondary mental health services

of those terms. Guidance on care coordinators is given at Part 4 onwards and on the so-called 'sub-domains' of enhanced and standard CPA at paragraph 167 onwards.

14. This guidance refers to services delivered within secondary mental health services, ie those services delivered within Tiers 2, 3 and 4 of the whole mental health system. A fuller explanation of these Tiers has been given by the Welsh Assembly Government in the recently published *Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards*³.
15. Annex 1 provides a summary of many of the terms and abbreviations adopted in this guidance.

2. Mental Health (Wales) Measure, and other legislation

Mental Health (Wales) Measure

16. In March 2010 the Welsh Assembly Government introduced the proposed Mental Health (Wales) Measure 2010 (a Measure is a piece of law made by the Assembly). Within this proposed Measure, provision is made in respect of care coordination and care and treatment planning within secondary mental health services. The proposed Measure is currently being considered by the National Assembly for Wales, and is expected to become law before the Assembly elections in May 2011.
17. This interim guidance has therefore been drafted to take account of the provisions of the Measure as introduced. The final guidance will take account of the final form of the Mental Health (Wales) Measure.

Explanatory Note:

Where particular aspects of the guidance have been drafted in light of the proposed new legislative provisions of the Measure, this is highlighted to alert the reader to the potential for change.

Carers Strategies (Wales) Measure

18. The National Assembly for Wales is also currently considering the proposed Carers Strategies (Wales) Measure. If agreed, this Measure will place a new duty on NHS authorities and local authorities to prepare and publish strategies setting out how they will work together to provide appropriate information and advice to carers, and to consult carers before decisions are made regarding service provision for the carer or the person cared for, or services in general.

³ Welsh Assembly Guidance (2010)

19. The Welsh Assembly Government has commissioned an independent review of respite (replacement) care across Wales. The findings may have implications for care planning where there is a regular and substantial input from a carer. The researchers will be reporting to Ministers in the Autumn of 2010, and relevant findings will be fed into the final guidance on CPA.

Children and Families (Wales) Measure 2010

20. The Children and Families (Wales) Measure 2010 takes forward the Welsh Assembly Government's commitments in terms of child poverty and its strategy for vulnerable children by providing support to families where children may be at risk, and strengthened regulatory enforcement in children settings.
21. This Measure requires, amongst other matters, the establishment of Integrated Family Support Teams (IFSTs). These teams focus on families where mental disorder is the primary presenting problem, and interventions will be evidence based and designed to impact favourably on family outcomes and the formulation and review of adult and children's individual plans. The IFSTs will be required to develop family plans drawing together the planned outcomes from adult and children services planning, including CPA.
22. Three pioneer areas (Newport, Wrexham, and a consortium in Merthyr Tydfil and Rhondda Cynon Taf) have so far been established with an initial focus on families in which the primary presenting problem is parental substance misuse where the children are at risk or in high level need. The final CPA guidance will provide guidance on the relationship between CPA and the approaches taken within IFSTs.

3. History of CPA

23. CPA was introduced in England in 1991 to provide a framework for effective mental health care. This was mirrored in Wales by the introduction of 'Guidance on Care Planning' process and documentation in 1998.
24. The adoption of care planning processes in Wales was not without its problems, with a number of audits during the initial years indicating that service users did not have copies of care plans, and limited evidence of care planning apparent in case notes.
25. Standard 7 of the revised Adult Mental Health National Service Framework (*Raising the Standard*)⁴ made clear commitments around effective client assessment and care pathways. The associated Key Actions to Standard 7 of *Raising the Standard* made clear reference to the effective implementation of

⁴ Welsh Assembly Government (2005) *Raising the Standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales*

CPA across Wales. Standard 7 also made reference to the Welsh Assembly Government guidance on CPA issued in 2003, which this interim guidance now replaces.

26. CPA has also been the subject of past Strategic and Financial Frameworks (SaFF) as well as the Annual Operating Frameworks (AOF) for 2009/10 and 2010/11.
27. Despite guidance and focus via the SaFF and AOFs, research and audit at a local level across Wales has indicated varying degrees of implementation, a situation borne out by a recent national review of the implementation of CPA undertaken by the Delivery Support Unit and NLIH⁵. This review found that the “...*general view of practitioners [is] that CPA is an excellent framework in which to manage clients with a severe mental illness. However it is being undermined by the perceived bureaucracy associated with it, taking practitioners away from the therapeutic aspects of their work*”.
28. This guidance aims to redress this balance, so as to ensure that safe, effective and ongoing assessment of need and risk is translated into safe, effective and ongoing planning, delivery and review of care and treatment.
29. **CPA is not a process of document management, but rather the essential underpinning framework for assessment, planning, delivery and review of care, and ultimately discharge from services.**

⁵ Elias E and Singer L (2009) *A review of the care programme approach in Wales*. Delivery Support Unit and National Leadership and Innovation Agency for Health (unpublished)

PART 2 – Guiding Principles

30. The Care Programme Approach in Wales is based around three guiding principles. These guiding principles should be considered when undertaking assessments, planning and delivering care and treatment.

The guiding principles

31. **Care and treatment will be holistic**

Holistic care and treatment addresses the medical, psychological, social, physical and spiritual needs of people accessing mental health services.

32. **Care and treatment will be coordinated and integrated**

Health, Local Authority, and voluntary organisations must work together in a coordinated and integrated way to improve the effectiveness of the services provided for an individual.

33. **Individuals will be involved and engaged**

The individuals accessing mental health services must have the opportunity to be involved and engaged in identifying, planning, delivering and evaluating a range of services to meet their needs. This should also apply to their families and/or other significant people in their lives, subject to the ongoing agreement and consent of the service user.

Focus

34. People with mental health problems, and their carers, should live as fulfilled a life as possible, with additional support when needed to help them achieve this goal.

35. As set out in *Raising the Standard*⁶:

“Services need to ensure timely delivery of evidence based interventions that focus on outcomes and service user recovery.”

36. The focus on recovery should be available for all individuals within secondary mental health services, regardless of diagnosis or presentation. Recovery means regaining mental health to the maximum extent possible and achieving a better quality of life, lived as independently as possible.

⁶ Welsh Assembly Government (2005) *Raising the Standard: The Revised Adult Mental Health National Service Framework and Action Plan for Wales*

37. CPA provides the key means by which service users can be assisted to achieve recovery. Recovery depends on:
- Empowerment and self-management - CPA should offer the service user the opportunity to agree and take ownership of their care and treatment plan and its implementation
 - Commitment to progress – care and treatment plans should contain the short steps and long term goals to which the service user , their carers, and service providers can commit themselves.
 - A holistic approach – care and treatment plans should comprehensively address all the areas of life which collectively contribute to mental health

PART 3 – Care Programme Approach for individuals

1. Introduction

38. The five components of CPA are:
- a. **assessment** – an assessment of the service user’s needs, risks (including vulnerabilities) and strengths;
 - b. **planning of care and treatment** – developing a plan to meet the agreed outcomes which will address the identified needs and the management of identified risk (including vulnerability). This includes planning for recovery and achieving maximum individual potential.
 - c. **delivery of care and treatment** – in line with the plan, the delivery of care and treatment (and where applicable other services)
 - d. **monitoring and review** – reviewing the delivery of services and whether these have achieved the expected outcomes, and where necessary revising the plans for delivery of care and treatment;
 - e. **discharge** – the planning for and constructive discharge of the service user from secondary mental health services when they no longer require the intervention of such services.
39. For an individual service user the first four components should be integrated and ongoing, until discharge. Planning for discharge should be in place from early on in the individual’s contact with secondary mental health services, and such planning should involve the service user, their family and the health and social care professionals working with them.
40. Each service user will have a care coordinator appointed for them, who will be responsible for ensuring these five components are delivered. The care coordinator is central to the effective delivery of the CPA: they are responsible for ensuring a care and treatment plan is developed and delivered, and where necessary reviewed and revised. They are also responsible for coordinating the care which is delivered (both by themselves and others), and for keeping in touch with the service user (see also Part 4 below).

2. Assessment

Purpose

41. At the initial point of contact with an individual who has been referred to secondary mental health services, the purpose of assessment is to identify the needs and risks (including vulnerabilities) of that individual. Such assessment will firstly identify whether or not the individual has a mental health problem that is best served by such services, and secondly, will inform the outcomes that such services will be aiming to achieve.

42. Unless a person is assessed as having a severe and or enduring mental disorder that may be appropriately managed within secondary care, the CPA process stops at this point for those assessed as not in need of secondary care input. Suitable information and options support should be provided to the individual and their referrer (see also paragraph 47 below).
43. For individuals deemed to have needs that can be addressed by secondary care services, the assessment process will identify needs and risks (including vulnerability), alongside the personal strengths of individuals. Such an approach maximises the opportunity for recovery and independence. Recognising, reinforcing and promoting strengths at an individual, family and social level should be a key aspect of the assessment process.
44. The assessment process will establish an information base from which future work, including care planning, can take place.
45. Assessment is an ongoing process, and should not be seen as a 'one off' activity.

Referral to secondary mental health services

46. Referrals to secondary mental health services may be received from a range of other services and the recently published *Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards*⁷ provides further information on referral and access.
47. Where, following assessment, a decision is made that the individual does not require secondary services, the individual should instead be referred back to the referring agency, this should be undertaken swiftly and the referring agency should be advised why secondary mental health services were not required. The referral back may also include recommendations relating to care outside of secondary mental health services, including signposting to other services or organisations as relevant.
48. In such cases, the individual who has been assessed should be informed of the outcome of the assessment, and the recommended next steps.

Assessment of need

49. A holistic assessment of an individual should be undertaken by a mental health professional (or professionals) within secondary mental health services. Such an assessment should seek to identify the needs of the individual as a whole, together with their strengths.

⁷ Welsh Assembly Guidance (2010)

50. The process of assessment should be undertaken in a systematic and comprehensive way, which involves the individual concerned and enables them to effectively contribute. Assessment is an ongoing process, and may be undertaken over a period of time. Assessment may identify needs which exist even though resources are not available to address them; such needs are commonly referred to as 'unmet' needs (see also paragraphs 83 and 84 below).
51. The quality of information, and indeed the assessment process itself, can be enhanced when it is undertaken by a range of professionals including, but not necessarily limited to, both health and social care. However in all cases the potential and possibility for duplication should be minimised. The service user should not be asked for the same information repeatedly.
52. During the assessment process, attempts should be made to determine whether or not the individual has made an advance statement or an advance decision, or made a lasting power of attorney (LPA) on welfare and/or financial matters in accordance with the Mental Capacity Act 2005. Further guidance on these can be found in the *Mental Capacity Act 2005 Code of Practice*.⁸
53. CPA does not prescribe a standard assessment tool, or a specific method of assessment. In all cases, professional practice skills influenced by best practice and the evidence base should dictate methodology. Assessment should be seen as an ongoing, rather than a one-off, process.
54. Guidance is given on engagement with carers of service users (see paragraph 100 onwards below), but during the assessment the needs of the service user as a carer and/or parent for others should also be explored. The need for appropriate support, as well as crisis and contingency plans for the service user and the person(s) for whom they care, should be considered by the care coordinator. The role and functions of the care coordinator is set out in Part 4 below.

Assessment of risk

55. All service users assessed at any point in their contact with secondary mental health services must have a risk assessment completed. Accurate risk assessment relies upon a high quality history-taking, sharing of information between individuals and services and locating relevant past information which may indicate areas of current and future risk.
56. CPA does not prescribe that any specific or particular risk assessment tool should be used. Instead there should be locally agreed approaches to the tools that may be used, and which professionals should use them. Practitioners and providers should ensure that all tools used for risk assessment are sound and have some research-based validity. The Minister for Health and Social

⁸ Department for Constitutional Affairs (2007)

Services has set out expectations regarding the training of professionals in risk assessment and management in a letter to the Chairs of LHBs and NHS Trusts (April 2009). This is reproduced at Annex 3 of this guidance.

57. Where appropriate, criminal justice agencies can provide support to the risk assessment process and should be consulted as part of a holistic assessment. Mental health service providers (such as Local Health Boards and Local Authorities) should consider introducing and delivering a standardised approach to risk assessment. Such an approach should seek to minimise the potential for:
 - harm to self (including deliberate self harm)
 - suicide
 - harm to others (including violence)
 - self neglect
 - adverse risks associated with abuse of alcohol or substances
 - social vulnerability.
58. A number of serious case reviews have highlighted the need to ensure that comprehensive risk assessment takes accounts of the risks to and by the individual. Separate guidance is available on risk assessment in relation to child protection and protection of vulnerable adults. In addition the NPSA has published a rapid response report on preventing harm to children from parents with severe mental illness (for further information see Annex 4).
59. For some individuals, the period around discharge from in-patient services is a time of elevated risk, particularly of self-harm. This underlines the need for a thorough assessment prior to discharge and effective and timely follow up and support services after discharge.
60. Assessment of risk is an aid to clinical decision making (rather than a substitute for decision making), and assessments must be translated into management of risk. All care planning processes should take account of the risk management arrangements.
61. The assessment of risk should be kept under review and monitored in an ongoing process of professional engagement with an individual. Clear and accurate documentation of risk, including regular and ongoing reviews of potential risks, should be made. Such reviews of risk also need to be translated into reviewed plans for the management of risk. This process should feed into the review of care and treatment plans more widely (see Part 5 below).

Physical health checks

62. Care coordinators should ensure that, as a minimum, the physical health needs of all service users within secondary mental health services are considered in the assessment and care planning process. Individuals should be supported to take up primary care, and register with a GP. Ongoing or serious physical

health needs should be accurately recorded and considered within care and treatment plans.

63. For individuals on enhanced CPA (see below), the care coordinator should also ensure that a physical health screening assessment undertaken is undertaken. Such screening should provide access to health promotion (such as smoking reduction or cessation, healthy eating) and also the screening for long term conditions (for example, diabetes, chronic heart disease). Physical health checks may be undertaken by the individual's general practitioner. They may also be undertaken by an appropriately qualified member of the secondary mental health service where reasons of location apply or to improve uptake of health screening checks.
64. When undertaking their functions under CPA, the care coordinator should seek the involvement of the individual's GP, and keep that GP informed as necessary.

Responsibility for assessments

65. The care coordinator may undertake need and risk assessments themselves, but equally these assessments can be undertaken by other mental health professionals. The care coordinator is responsible for ensuring such assessments are undertaken and their outcomes collated, and where necessary communicated to the relevant professionals/practitioners involved in the delivery of the care and treatment plan.

3. Care and treatment planning

Involvement, engagement and consultation

66. As set out in the guiding principles above, a service user should be involved and engaged in the process of planning their care and treatment. In some cases the service user may wish to nominate a representative to be engaged in the planning process. In some cases the care coordinator may need to take action to ensure that there is appropriate support for an individual in developing the care and treatment plan, for example identifying that an advocate could provide help and support to the individual.
67. In addition to the service user and the care coordinator, those who should also be involved in preparing the care and treatment plan include:
 - the service user's carer (where they will be providing care which is identified in the care plan, and subject to the normal procedures for respecting a service user's right to confidentiality)
 - members of the care team (including inpatient care team if applicable)
 - the service user's responsible clinician (if the service user is subject to the compulsory powers of the 1983 Act)

68. Those who could also be involved in preparing the care and treatment plan may include:
- the service user's GP and primary care team
 - representatives of relevant voluntary organisations
 - in the case of a patient subject to restrictions under Part 3 of the 1983 Act, the probation service
 - subject to the service user's wishes, his or her nearest relative
 - a representative of housing authorities, if accommodation is an issue
69. Where the relevant provisions of the Mental Capacity Act 2005 are engaged, the following must also be involved in the care and treatment planning decisions:
- a donee⁹ of a relevant Lasting Power of Attorney
 - a deputy of the Court of Protection
 - an independent mental capacity advocate (IMCA)
 - the relevant person's representative (within the meaning of the Deprivation of Liberty Safeguards)
70. Those involved in making decisions must be empowered to make commitments on behalf of their agency's involvement. If approval for plans needs to be obtained from more senior officials (for example, for funding) it is important that this does not delay implementing the care and treatment plan. Where such a plan is concerned with the patient's discharge from hospital, this is particularly important.
71. For service users placed in services away from their home area, there should continue to be engagement by services from the service user's 'home' area. The service user's 'home' area should remain involved through appropriate attendance at care planning meetings, and regular involvement in other discussions.¹⁰

Agreeing the outcomes

72. The care coordinator should work to agree the outcomes that the provision of mental health services for the service user should be designed to achieve. The care and treatment plan should set out these outcomes, and interventions and actions necessary to achieve these agreed outcomes.

⁹Someone appointed under the Mental Capacity Act 2005 who has the legal right to make decisions within the scope of their authority on behalf of the person who made the power of attorney

¹⁰ Guidance is also given on this matter in *Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards* published by the Welsh Assembly Government (2010)

73. In agreeing outcomes it is important that the care coordinator should discuss these with the service user, as well as the mental health professionals involved in the proposed delivery of services.

Explanatory Note:

Section 17 of the proposed Mental Health (Wales) Measure prescribes the functions of a care coordinator, which will include working to agree the outcomes that the provision of services are designed to achieve.

Matters which should be considered in the care and treatment plan

74. The development of a fully-agreed care and treatment plan should be based on a thorough assessment of need and risk. The care and treatment plan should set out the agreed outcomes, and then focus on how these outcomes will be achieved.
75. For all service users, not just those in hospital or residential accommodation, care and treatment plans need to work to retain and support independence, wherever practicable, and promote the recovery of the individual. In the same way that assessments focus on strengths as well as needs, so should care and treatment plans. Recognising, reinforcing and promoting strengths at an individual, family and social level should be a key aspect of the planning process.
76. In all cases, care and treatment plans should be proportionate to the level of clinical need and input. The outcomes which mental health services are aiming to achieve should be set out, and the care and treatment plan should proportionately address each of the areas in the table set out below.
77. Service users with relatively straightforward needs may be able to take any necessary action alone in relation to several of the areas but it is important that this is still recorded: for example, if a service user has rented accommodation that is satisfactory and well managed by them, then it is sufficient simply to state that they will continue to maintain their tenancy. By contrast a service user with complex needs may need more detailed action recorded against several or indeed all of the areas. This methodical approach is important in order to sustain a holistic focus on recovery.

Areas for inclusion in the care and treatment plan	Care and treatment plan for a person in hospital	Care and treatment plan for a person in the community
Medical treatment (medication etc)	Information for the service user and discussion with them about any proposed treatment	Information for the service user and discussion with them about any proposed treatment, including ongoing review, in partnership with the GP where appropriate
Other forms of treatment, including	Access to appropriate psychological and other treatments	Access to appropriate psychological and other treatments

Areas for inclusion in the care and treatment plan	Care and treatment plan for a person in hospital	Care and treatment plan for a person in the community
psychological interventions	in hospital	in the community
Personal care and physical well-being	Review all aspects of the service user's general health including medical issues, dentistry, optometry and lifestyle issues and how these will be covered in hospital Consideration of appropriate management of ongoing/serious physical healthcare issues, in partnership with other services	Encouraging appropriate contact with GP and continuing consideration of all aspects of a service user's physical well-being and personal care Consideration of appropriate management of ongoing/serious physical healthcare issues, in partnership with other services
Accommodation, including housing	Consideration of appropriate accommodation issues inside hospital Consideration of the security/maintenance of the service user's home in their absence Support to handle housing/property issues when patient is unlikely to be able to return home/make a decision about such matters	Registration of homelessness/referral for supported housing where necessary For service users being discharged from hospital, preparation of the home for discharge Arranging appropriate placement in residential/ nursing care
Work and occupation	Occupational therapy and other structured opportunities in hospital Support to maintain contact with an existing employer or to seek vocational guidance	Support to maintain existing employment Support to contact employment agencies, access to specialist mental health employment services, seeking new job opportunities or volunteering
Training and education	Opportunities for learning in hospital or access to opportunities from hospital	Opportunities to take up training or educational courses in the community
Finance and money	Support for accessing benefits or other income, and dealing with financial problems or anxieties when in hospital Considering vulnerability to financial abuse and putting steps in place to protect the individual Longer term planning, eg LPA, where capacity likely to fluctuate or be lost	Support with maximising benefits, budgeting, and responding to financial anxieties Considering vulnerability to financial abuse and putting steps in place to protect the individual Longer term planning, eg LPA, where capacity likely to fluctuate or be lost
Social (including leisure), cultural and spiritual	Access to social activities within hospital Support to maintain or build relationships with friends, family and community networks when in hospital	Support to maintain or build a social network and leisure activities in the community
Parenting or caring	Support to maintain links with	Support to maintain parenting and

Areas for inclusion in the care and treatment plan	Care and treatment plan for a person in hospital	Care and treatment plan for a person in the community
relationships	children Support/consideration for meeting needs of those cared for by the service user Management of risks to children, vulnerable adults and general public	caring roles Support in role within the family Management of risks to children, vulnerable adults and general public

78. It is anticipated that in setting out the interventions and actions necessary to meet the agreed outcomes, the care and treatment plan will describe the intensity of planned interventions and the contributions of all the agencies involved.

79. For all service users their care and treatment plan should include contingency and crisis plans (see paragraphs 85 to 87 below).

Explanatory Note:

Section 17(8) of the proposed Mental Health (Wales) Measure provides Welsh Ministers with the powers to make Regulations prescribing the “form and content of care and treatment plans”. It is anticipated that the final CPA Guidance will reflect these Regulations and give further detail on the content which must be included within care and treatment plans.

Mental health legislation

80. For all service users the statutory principles of the Mental Capacity Act 2005 must be adhered to and case notes for an individual must reflect the considerations which the care coordinator, and other professionals involved in the care and treatment of the individual, have given to an individual’s mental capacity and support for decision making.

81. It may be appropriate for consideration to be given, within the care and treatment plan, for setting out:

- the arrangements for keeping the assessment of the individual’s capacity under review
- the practical steps that need to be taken to help an individual make decisions
- planning for a time when capacity may fluctuate or be lost.

82. Where an individual is subject to the provisions of the Mental Health Act 1983, including within the community, care and treatment plans should include outcomes relating to those provisions. Consideration must be given to the

Guiding Principles set out in Chapter 1 of the *Mental Health Act 1983 Code of Practice for Wales*¹¹.

Unmet need

83. Any unmet needs should be clearly identified and recorded on the care and treatment plans. Such unmet needs should be regularly reviewed, and alternative ways of meeting the needs considered. Consideration should be given to the risks associated with not meeting a need.
84. On a service-wide basis, unmet needs should be considered as part of service planning processes.

Crisis and contingency plans

85. For all service users their care and treatment plan should include contingency and crisis plans.
86. The contingency plan is aimed at preventing circumstances escalating into a crisis by detailing the arrangements to be used at short notice, whereas the crisis plan specifies the actions to be taken in a crisis. By anticipating the nature of a potential crisis, appropriate action can be taken, and this should be the least restrictive possible. For example, for a service user on supervised community treatment (under the Mental Health Act 1983) the plan could set out the behaviours or circumstances that could indicate a worsening of the service user's mental health. It could suggest the early involvement of additional support that could be provided in the home, such as the input of a crisis resolution home treatment service, which may avoid the recall of the individual into hospital.
87. Where carers are involved in the care and treatment of the individual, the crisis and contingency plan could identify for them how to highlight any concerns they may have about an emerging crisis for an individual – for example, who to contact and how.

Form of the care and treatment plan

88. Care and treatment plans should be in writing and proportionate to the level of clinical need; there is no 'standardised' format for care planning currently in Wales and the Welsh Assembly Government recognises that service providers have developed a range of formats for care plans. This interim guidance does not prescribe a 'standardised' format for the care and treatment plan, but does set out (see above) the areas which must be considered for all care and treatment plans.

¹¹ Welsh Assembly Government (2008)

Explanatory Note:

As noted above, section 17(8) of the proposed Mental Health (Wales) Measure provides Welsh Ministers with the powers to make Regulations prescribing the “form and content of care and treatment plans”. It is anticipated the final CPA Guidance will reflect the Regulations and the details contained within those of the form of care and treatment plans.

Timeliness of the care and treatment plan

89. Care and treatment plans should be provided for all service users as soon as is reasonably practicable after the individual has been assessed as requiring secondary mental health services.

Copies of the care and treatment plan

90. In all cases, service users should be provided with a copy of their plan (including any subsequent revisions), and given support and information to help them understand the plan. Service users also may choose to write parts of their care and treatment plan, and should be encouraged to sign their plans wherever possible.
91. A copy of the plan will also be provided to the members of the team directly responsible for care delivery, and any other relevant parties (with the consent of the service user where required).
92. Where family members or carers provide care or support, it is important that they are also aware of the care and treatment plan. The service user’s consent must be sought before disclosure of the plan to carers and family members; if such consent is not given (or is not capable of being given) the guidance on confidentiality at paragraph 178 onwards should be followed.
93. Copies of care and treatment plans should be provided to the service user, members of the care delivery team and other relevant parties as soon as it is made, and in any case within seven days of being agreed. In cases where it is not possible for the service user to be given a copy of their care plan immediately after a planning or review meeting with their care coordinator, the service user should have a clear understanding of what services are being provided and the arrangements for provision, together with an understanding of what needs are not being met and why.

Explanatory Note:

Sections 17(8) and (9) of the proposed Mental Health (Wales) Measure provide Welsh Ministers with the powers to make Regulations prescribing the persons to whom care and treatment plans are to be provided (including in specified cases the provision of copies without the consent of the individual to whom the plan relates). It is anticipated the final CPA Guidance will reflect the Regulations in this regard.

4. Delivery of services

Approach

94. In line with other guidance published by the Welsh Assembly Government, this guidance recognises that services should be organised and delivered in ways that support good practice and establish therapeutic partnerships between service users and practitioners. Whenever possible, services should be aimed at meeting the needs and choices of individuals, rather than focussing on those services which professionals can offer or make available in their local area.

Cooperation in the delivery of services

95. Evidence indicates that collaborative care interventions are associated with sustained improvement in outcomes for services users, without necessarily incurring additional health and social care costs for service providers. Collaboration and sharing of care is also more consistent with supporting personal care, as well as organisational continuity of provision.
96. It is important therefore that to improve the effectiveness of the mental health services provided to a service user, service providers ensure that the different components of the service are coordinated with one another. Such an approach should not be limited to health and social care services delivered by statutory organisations, but should include those services which may be provided by third sector organisations, criminal justice agencies, and other components of a local authority (such as housing).

Explanatory Note:

Section 16 of the proposed Mental Health (Wales) Measure places a duty on mental health service providers (ie LHBs and Local Authorities) to take all reasonable steps to ensure that the different mental health services which they provide for the service user are coordinated with one another, and with any other mental health services provided by other organisations (such as third-sector providers). The purpose of such coordination is to improve the effectiveness of the mental health services for the service user.

97. Clearly defined working arrangements should be in place to support and manage individuals who have a history of offending. Specific arrangements will also need to be in place to support and manage service users with mental health needs complicated by a substance misuse problem, and/or a learning disability.
98. The recently published guidance on community mental health

'Another important area for attention is the continuity of care that mentally disordered offenders receive on release from prison. These individuals often have complex needs and it is reported that they cannot always get access to the appropriate specialist support they need on discharge. This can increase the risk of re-offending and contribute to problems of social exclusion. Continuity of care is also important when transfers within the prison system occur.'

Wales Audit Office (2005)

teams¹² provides further detail on the integration of health and social care within Tier 2 services.

99. If aspects of the care and treatment plan are being delivered by carers, mental health professionals should ensure that they work in partnership with those carers.

Engagement with carers

100. This interim guidance provides advice on:

- situations where the service user is themselves a carer;
- involvement of carers as partners in the provision of care and in care planning; and
- involvement of carers in emergency and contingency planning and triggering review.

101. In addition, all individuals who provide 'regular and substantial' care for an individual receiving services under CPA must, under the Carers (Equal Opportunities) Act 2004, be advised of their right to request an assessment of their ability to provide and to continue to provide care for the person cared for. It is important that the assessment process does not assume that the carer wants to continue to provide care, or should be expected to do so¹³. Carers assessments should be carried out within the framework of the Welsh Assembly Government guidance for local authorities and health services 'Creating a Unified and Fair System for Assessing and Managing Care'¹⁴, particularly Annex 12 of that document which is concerned with Carers Assessments.

102. Young carers in particular, that is children and young people affected by caring situations, should not be expected to undertake inappropriate levels of caring which have an adverse impact on their development and life chances. It should not be assumed that a child should take a similar level of caring responsibility as an adult would in a similar situation.

103. Particular guidance on hospital discharge arrangements is set out in circular WHC(2005) 035. This asked all NHS trusts (to now be read as including Local Health Boards) to have clear procedures to be followed to discharge patients from hospital to the next stage of care, and sets out a number of requirements that local policies should include. These requirements include the provision of information for carers and full engagement with family and carers at all stages in the discharge process.

¹² Welsh Assembly Government (2010) *The Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards*

¹³ Welsh Assembly Government (2001) *Practitioners Guide to Carers' Assessment*

¹⁴ Welsh Assembly Government (2004)

5. Monitoring and review

Need to monitor and review

104. The care and treatment plan should be regularly reviewed to ensure that it continues to meet the individual's assessed needs and to check that the outcomes of the interventions are being achieved. A review of the care and treatment plan should be preceded by reassessment of need and risk.
105. This guidance does not prescribe set review periods, as frequency should be determined by need. However, in all cases a formal review of the care and treatment plan must take place at least annually (i.e. once in any twelve-month period) and should be clearly documented.
106. It is recognised that in maintaining regular contact with the service user, the care coordinator will (in an informal manner) be reviewing and evaluating the care and treatment plan on an ongoing basis.

The process of review

107. Because the needs and risks (including vulnerability) of the individual should be kept under review, changes in these areas over time will lead to review of the planned outcomes and interventions set out in the care and treatment plan. Therefore in addition to the ongoing monitoring that care coordinators will undertake by virtue of their contact with the service user, there will be occasions when a more formal review of the plan needs to be undertaken.
108. Such a formal review may be undertaken in a meeting involving a number of members of the care team and other interested persons. Equally such a review may only include the service user and the care coordinator, if few or no other health and social care professionals are involved. In all cases the approach to review must be proportionate to the issues and matters being considered in the review.
109. To ensure that information is shared to support safe and effective care management, the care coordinator should ensure that members of the care team are given adequate notice that the plan is to be reviewed and how members of the care team may contribute to the review and access records if required. The care coordinator is very much the "hub" of the review process.
110. After a review of the care and treatment plan (and its coordination and achievement of anticipated outcomes), the plan may need to be revised. Such revisions should follow the same requirements regarding content, consultation, documentation and distribution that are set out in section 3 above in relation to the development of the original care and treatment plan. It is appropriate for a proposed date of the next formal review to be set out in any revised care plan.

111. Reviews (both formal and informal) should continue until it is agreed that the service user can be discharged from secondary care services (see paragraph 121 onwards).

Triggers to prompt a review

112. There may be occasions between scheduled reviews of the care and treatment plan where more urgent action is needed. Such events should trigger an emergency review and assessment, and can be initiated by any member of the care team, the GP, the service user, or carer, by contacting the care coordinator. This information should be included in crisis plans within the care and treatment plan.

113. In addition, service users and carers should be encouraged to request a review of the plan if they consider that the needs and risks of the individual have changed.

114. Admission to hospital could well be a trigger to review the care and treatment plan, and this is particularly the case in unplanned admissions (including those under the Mental Health Act 1983) or where a deprivation of liberty¹⁵ may result. Where possible, discharge from hospital should be planned, and account taken of the need to revise the care and treatment plan with any support arrangements that need to be put in place to secure and maintain discharge from hospital.

115. A formal review should also be held prior to discharge from prison or other residential setting; such a review should receive input from the secondary mental health services team for the individual's 'home' area, as well as the team which will be caring for the individual on discharge (if different).

116. As noted previously, the period following discharge may well be a time of elevated risks for the individual (and possibly others). The care and treatment plan should reflect this in the component responding to the management of risk.

Non-compliance and missed contact

117. It is recommended that there are simple, clear, joint protocols in place for LHBs and Local Authorities that set out the explicit arrangements for responding to non-compliance and/or missed contact with a service user. These arrangements may be linked with supportive/assertive outreach teams where these operate.

118. Changes in levels of compliance with the requirements of the plan and/or contact with services could well be good indicators of the need to review the care and treatment plan.

¹⁵ within the meaning of the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005

119. It is also recognised that there may well be increased risks to vulnerability of the individual, or safety of others, that loss of contact or non-compliance could bring. Therefore consideration may also need to be given to the potential use of the Mental Health Act 1983. For service users already subject to the 1983 Act who are on leave of absence under section 17, supervised community treatment, or conditionally discharged, urgent consideration may need to be given to revoking leave (or changing conditions), or recalling the individual to hospital.
120. The recently published *Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards*¹⁶ provides further information on engagement in the event of lost/reduced contact. The *Mental Health Act 1983 Code of Practice for Wales*¹⁷ provides guidance in relation to assessment for detention, as well as leave of absence, supervised community treatment and conditional discharge.

6. Safe and effective transfer of care and discharge

121. This section provides guidance on CPA in relation to:

- transfers of care (where the individual remains within secondary mental health services)
- discharge from hospital (where the individual may either remain in secondary mental health services, or be discharged fully from secondary services at the same time)
- discharge from secondary mental health services.

Transfers of care

122. Individuals may need to access different levels of mental health services at various stages in their care and treatment. The level of service provided needs to be commensurate with the level of assessed need and risk. The need to transfer care can arise for a number of reasons, including:

- changes in the services that are to be provided (for example, transition between services, new services becoming available, transfer to a different hospital, etc)
- relocation of the service user to another area (including outside the current Health Board/Local Authority)
- admission to prison, hospital or other residential setting.

¹⁶ Welsh Assembly Government (2010)

¹⁷ Welsh Assembly Government (2008)

123. In order to achieve an effective transfer of care, careful assessment by competent clinicians, responsible planning decisions and effective case management arrangements are essential. A system of co-operation that is founded on the understanding of individual agency role and responsibilities at each level of care provision is required between planners, clinicians and service providers.
124. There should be robust procedures in place to support the timely and effective transfer of care between services. It is not acceptable for care to be adversely affected because of administrative or organisational barriers. All efforts must be made to avoid any negative impact on care and treatment for the individual.
125. A transfer of care will not necessarily result in a change to the care coordinator, but where it does, guidance on changing care coordinators is given at paragraphs 153 to 155 below.
126. The care coordinator must ensure that the outcomes of any proposed changes to care are clearly understood by the service user and any carer(s) or relative(s) with whom the plan is shared, and documented on the care plan, and that any revisions to the care and treatment plan are made in accordance with the review guidance at section 5 above. It is important that the service user is involved in decisions about changes in care, and the transfer of information between services.
127. Although originating in Wales, the Wales Accord on the Sharing of Personal Information (WASPI) framework¹⁸ can easily transfer across to non-Welsh information sharing communities, as the concept of principles and delivery will fit most situations.

Discharge from hospital

128. Ahead of full discharge from hospital, leave of absence may be granted (for both informal and detained patients). Any leave should be carefully and fully planned, and should form part of the care and treatment plan. Further guidance on leave of absence (particularly for detained patients) is given in Chapter 28 of the *Mental Health Act 1983 Code of Practice for Wales*¹⁹.
129. Where possible, discharge from hospital should be planned, normally from early in the inpatient episode, and account taken of the need to revise the care and treatment plan with any support arrangements that have to be put in place to secure and maintain discharge from hospital. Risk assessments should also be reviewed and updated, and where necessary the risk management plans also reviewed.

¹⁸ see Annex 4 'Further Reading' for publication and access information on the WASPI framework

¹⁹ Welsh Assembly Government (2008)

130. Care coordinators should ensure that any service user discharged from hospital, but who will be remaining in secondary care, is seen within five working days of discharge by a mental health professional. This does not need to be the care coordinator²⁰. Where an inpatient has discharged themselves from hospital against medical advice, effort should be made to contact that person in the community as expediently as possible.

Planning discharge from secondary mental health services

131. Guidance on the purpose, process and function of review is set out at section 5 above, and reviews should continue until it is agreed that the service user can be discharged from secondary care services.

132. Discharge from secondary mental health services is regarded as a key outcome of the recovery model within mental health, the aim of which is to maximise the opportunities for good mental health and achieving a better quality of life for the individual. Therefore to support discharge it is recommended that:

- the process is coordinated by a named individual (usually this will be the care coordinator);
- there are clear discharge plans, that are made in advance and agreed with all concerned. These plans should include information for the service user and/or carer about the action to take, who to contact, and how, in the event of relapse or change with a potential negative impact on the individual's well-being;
- information is shared with relevant people, including both health and social care professionals and carers;
- there is some follow-up afterwards to ensure that the process worked and that the person is safe.

133. The care coordinator manages the review process, and remains central to discharge planning. The care coordinator should ensure that the individual's GP and other clinicians/practitioners involved in an individual's care are advised about discharge plans, and receives advice on ongoing management and support in primary care to support discharge (including information about crisis or relapse management).

134. In terms of CPA, discharge from secondary mental health services will also mean discharge from CPA.

135. Where an individual is receiving after-care services within the meaning of section 117 of the Mental Health Act 1983, consideration should be given to ending the duty to provide after-care services when discharge from secondary

²⁰ See also *Community Mental Health Teams: Policy Implementation Guidance and Standards* (Welsh Assembly Government, 2010)

mental health services is being planned. Further guidance on after-care is given in Chapter 31 of the *Mental Health Act 1983 Code of Practice for Wales*²¹ and Part 5 of this guidance below.

Explanatory Note:

Part 3 of the proposed Mental Health (Wales) Measure aims to encourage safe and effective discharge, by providing individuals with a mechanism to swiftly re-access secondary mental health services should these be required again at a later stage. LHBs and Local Authorities will be required to make arrangements to support self-referral for assessment in these circumstances.

²¹ Welsh Assembly Government (2008)

PART 4 – Role and functions of the care coordinator

1. Introduction

136. The care coordinator is central to the individual's journey through secondary mental health services; each service user must therefore have a care coordinator.
137. Whilst care coordinators may deliver components of the care and treatment plan, not every mental health professional working with a service user will be the care coordinator.
138. This Part of the interim guidance gives further advice and guidance on the role, functions and appointment of care coordinators.

2. Role

Overview

139. Simply put, the care coordinator is responsible for ensuring a care and treatment plan is developed and delivered, and where necessary reviewed and revised. They are also responsible for coordinating the care which is delivered (both by themselves and others), and for keeping in touch with the service user.
140. The role of the care coordinator includes:
- developing the care and treatment plan;
 - keeping that care and treatment plan under review, based on ongoing assessment, and revising the plan as necessary;
 - maintaining regular contact with the service user and any significant others in the life of the service user, so that changes in their health and social circumstances are known, and appropriate action taken;
 - remaining actively involved in the care and treatment of the individual, regardless of the setting for delivery (including admission/discharge from hospital).
141. As set out in the guiding principles at Part 2 above, service providers should work together in a coordinated way to improve the effectiveness of the services provided for an individual. The role of the care coordinator in this respect is crucial: one of the key aspects of the care coordinator's role is the effective coordination of the services identified within the care and treatment plan.

Explanatory Note:

Section 16 of the proposed Mental Health (Wales) Measure will place a duty on mental health service providers (ie LHBs and Local Authorities) to take all reasonable steps to coordinate services; section 16(3) provides that a care coordinator may, at any time, give advice to service providers on how to discharge these duties. Similarly the service providers may seek the advice of the care coordinator in this regard (section 16(2)).

142. The care coordinator is responsible for ensuring that:

- a comprehensive needs assessment for the service user has been undertaken, and where necessary reviewed;
- a comprehensive risk assessment has been undertaken, and risk management plan (which is part of the care and treatment plan) is in place. Both the risk assessment and the management plan should be kept under review.

143. The care coordinator may themselves undertake need and risk assessments, but equally these can be undertaken by other mental health professionals. The care coordinator is responsible for ensuring such assessments are undertaken as soon as is reasonably practicable after their appointment in relation to a service user.

3. Appointment

Eligibility to act as a care coordinator

Explanatory Note:

The proposed Mental Health (Wales) Measure will place a duty on mental health service providers (ie LHBs and Local Authorities) to appoint care coordinators. Such appointments may only be made if the person is eligible to be appointed under the regulations which will be made by the Welsh Ministers. The regulations will prescribe the skills, training and experience that mental health professionals should possess in order to coordinate care within secondary mental health services.

144. In advance of the Mental Health (Wales) Measure and relevant subordinate legislation coming into effect, the majority of care coordinators in Wales are qualified mental health professionals, such as nurses, social workers, occupational therapists, psychologists and psychiatrists.

145. In general the following will not usually be identified as a care coordinator:

- general practitioners
- unqualified/unregistered health or social care workers
- advocates

146. When determining who should be the care coordinator, consideration should be given to:

- the identified needs of the service user
- the preference and choice of the service user as to who their care coordinator may be
- the experience, training and skills of the mental health professional and how these compare to the needs of the service user
- the potential level of input to care that the mental health professional will provide, and their relationship with the service user
- the current caseload of the mental health professional, together with other duties they may perform within the team (for example, working on an AMHP duty rota).

147. The care coordinator need not be the person who has the most involvement with the service user, although in practice this is often the case. Direct therapeutic involvement may be provided by a number of practitioners, but the care coordinator should be the person with the most appropriate skills and experience to take on this role.

148. Given the unique nature of the role of the care coordinator, it is important that care coordinators have the necessary authority to undertake their functions. Service providers who appoint care coordinators must ensure that such individuals have the necessary authority to:

- coordinate service provision, including accessing resources;
- monitor service provision;
- call and hold reviews;
- access other members of the service user's care team.

Timeliness of appointment

149. Ahead of the requirements of the Mental Health (Wales) Measure coming into force, the appointment of a care coordinator must be agreed as soon as practicable after the service user is in first contact with services. It is not appropriate, or safe, for service users to be without a care coordinator once they have been accepted into services.

Explanatory Note:

The proposed Mental Health (Wales) Measure will place a duty on mental health service providers (ie LHBs and Local Authorities) to appoint an individual care coordinator as soon as the individual becomes a 'relevant patient'. A 'relevant patient' is an adult who is provided with a secondary mental health service (see section 45 of the proposed Measure), or under the guardianship of a local authority in Wales.

Identification of the care coordinator

150. The name and contact details of the care coordinator should be known and available to the service user. Such information should be clearly marked on the

care and treatment plan, and in case records, including electronic records where these are used.

151. Failure to clearly identify the name of the care coordinator, and their role as care coordinator, can lead to confusion and the potential for a breakdown in accountability arrangements and continuity of care.
152. Where a professional has been the care co-ordinator for an individual who is subsequently placed 'out of area', there is an expectation this role continues, until or unless alternative arrangements are agreed. Effective care co-ordination is central to ensuring that all individuals are appropriately placed within the right care setting and that progress in treatment is kept under review.

Explanatory Note:

Section 15(3) of the proposed Mental Health (Wales) Measure provides that the appointment of a care coordinator does not come to an end as a result of a change in the service provider that appointed them (unless regulations state otherwise). The regulations for this area are currently being developed.

Change of care coordinator

153. It is recognised that care coordinators are likely to develop close therapeutic relationships with service users, and as such, any change in appointment may well be a disruptive event for the individuals concerned.
154. In line with the guiding principles set out above, the reasons for any change should be discussed with both the service user and the wider care team. The service user should be involved in discussions about potential replacements.
155. When there is a change in care coordinator, there must be a clear handover of information (for example, case summary, need and risk assessments, and the care and treatment plan itself). It is important that the service user is involved in decisions about changes in responsibility for their care coordination, and the transfer of information.

Explanatory Note:

Section 13 of the proposed Mental Health (Wales) Measure makes clear that the duty to appoint a care coordinator arises once more for service providers in cases where a current care coordinator ceases to be appointed.

4. Supporting the care coordinator

156. Service providers should ensure that, in line with other Welsh Assembly Government guidance (including the recently published *Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy*

*Implementation Guidance and Standards*²²) there are clear arrangements in place to manage service demand and delivery. Such arrangements should support effective caseload management, and in particular to CPA, how that translates into the appointment of care coordinators. Similarly, care coordinators will need to give consideration to such arrangements when planning the delivery of care and treatment, and the potential identification of unmet needs due to availability of practitioners and services.

157. Care coordinators should have access to clinical and also caseload supervision as part of their role as care coordinators.
158. Care coordinators should be supported by effective training in undertaking the functions of the care coordinator. This includes understanding the importance of maximising opportunities for recovery and achieving a better quality of life for the individual, together with the practical aspects of assessment, planning, and liaising.

²² Welsh Assembly Guidance (2010)

PART 5 – Managing the Care Programme Approach

1. Introduction

159. Whilst CPA is provided at an individual level, there are also organisational issues which need to be considered in effectively supporting and managing CPA within secondary mental health services. This Part of the guidance covers:

- CPA and the Unified Assessment Process (UAP) and after-care under the Mental Health Act 1983;
- the two sub-domains of CPA: ‘standard’ and ‘enhanced’;
- managing information (including considerations around sharing information and confidentiality);
- communication;
- monitoring and evaluating CPA.

2. Relationship of CPA to UAP and After-care

Relationship with Unified Assessment Process (UAP)

160. The Welsh Assembly Government published *Creating a Unified and Fair System for Accessing and Managing Care* in April 2002. That guidance is designed to support and develop a fully integrated, seamless approach to the assessment and care management of all adult service users, including those with mental health related needs.

161. Whilst that guidance anticipated the future development of CPA in Wales, the evidence since 2002 indicates that integration of CPA with the Unified Assessment Process (UAP) has been problematic in a number of areas. Such difficulties have at times been at the expense of direct contact and engagement between service providers and service users, as a result of increased administrative burdens on mental health professionals. The Welsh Assembly Government recognises that whilst many of the difficulties that have arisen are able to be addressed at a local level, some require a national solution.

162. The Welsh Assembly Government is therefore reviewing the implementation of the UAP. The Minister for Health and Social Services has recently announced that during this period of further consideration it is important not to lose sight of the key principles of delivering safe and effective care and treatment for service users. For this reason, until further notice, secondary mental health services (those in Tiers 2, 3 and 4 of the whole mental health system) will only use the CPA. Unified Assessment Process will not apply for secondary mental health

services during this time. Annex 2 provides a copy of the Ministerial Letter setting out this position in more detail.

Relationship with after-care (section 117, Mental Health Act 1983)

163. Section 117 of the Mental Health Act 1983 requires LHBs and Local Social Services Authorities, in collaboration with non-statutory agencies, to provide after-care for certain categories of detained patients. This section applies to patients who are detained under sections 3, 37, 45A, 47 or 48 of the 1983 Act and then cease to be detained and leave hospital.
164. The requirement also includes patients granted leave of absence from hospital under section 17 of the 1983 Act (if they would otherwise qualify when leaving hospital permanently) and patients going onto supervised community treatment (SCT). Section 117 states that after-care must be provided for such patients throughout the time they are subject to SCT.
165. After-care planning should be delivered as part of the CPA. There is no requirement for separate CPA and after-care plans to be in place. All after-care planning, including reviews should be undertaken as part of the CPA process for the service user.
166. Further guidance on after-care is given at Chapter 31 of the *Mental Health Act 1983 Code of Practice for Wales*²³.

3. Standard and enhanced CPA

Background

167. The guidance on CPA published by the Welsh Assembly Government in 2003 identified two “sub-domains” of CPA: standard and enhanced. Within the 2003 guidance, the characteristics of the individuals likely to receive CPA under standard or enhanced CPA were identified (as set out below).

Interim position

168. The Welsh Assembly Government wishes to work with services between the publication of this interim guidance and the final guidance in early 2011, in reaching a determination on whether the two sub-domains of CPA should be retained. The alternative to the current approach would be for *all* service users receiving services within secondary mental health services to be on one level of CPA.

²³ Welsh Assembly Government (2008)

169. However, until the publication of the final guidance, the two sub-domains of CPA (standard and enhanced) will be retained and should continue to be operated by health and social care providers. The sub-domain for a service user (including any changes) should therefore be clearly recorded in care and treatment plans.

170. In a move onwards from the 2003 guidance, this interim guidance makes clear that the five components of CPA (as outlined in Part 4 of this document) apply to both Standard and Enhanced CPA.

Standard CPA

171. Those service users covered by Standard CPA will be likely to:

- require the support or intervention of one agency or one discipline **or** require low key support from more than one agency or discipline;
- be more able to self-manage their mental health;
- have an informal support network;
- pose little danger to themselves and/or others;
- be more likely to maintain contact with services.

Enhanced CPA

172. Those service users covered by Enhanced CPA will present with some or all of the following:

- multiple care needs, including housing, employment, etc, requiring inter-agency co-ordination;
- willing to cooperate with one profession or agency, but have multiple care needs;
- may be in contact with a number of agencies (including the criminal justice system);
- likely to require more frequent and intensive interventions;
- more likely to have mental health problems co-existing with other problems such as substance misuse;
- more likely to be at risk of harming themselves and/or others;
- more likely to disengage with services.

173. Service users who are admitted to mental health in-patient services, or who are under the care of Crisis Resolution Home Treatment services, or Assertive Outreach services should be considered as falling within Enhanced CPA.

4. Management of information

Information technology, including shared systems

174. Effective care coordination requires the development and ongoing use of shared information systems. Such systems include paper records as well as electronic records. LHBs and Local Authorities should work together to secure effective, cost efficient mechanisms for shared information systems.

175. All record keeping systems should be proportionate and designed to support care and treatment for the individual, not primarily the service planning needs of organisations.

176. Where “single” IT or paper record systems cannot be achieved, there should be clear arrangements in place for the sharing of information in a timely manner. The focus of such arrangements must be for the safe and effective management and support of the individual, rather than on information collection for service planning or reporting.

177. Consideration should be given to IT systems which support appropriate and safe access to information, including out of hours. It may be appropriate for the crisis and contingency component of an individual’s care and treatment plan to be held on an IT system in such a way as to enable practitioners from other teams (and other agencies) not directly providing day to day support to access this in a crisis.

‘Care planning can be significantly impeded by the general lack of a joint IT infrastructure between the key agencies involved. This is not simply a matter of easier administration and better management information and control. Joined up and shared IT is needed to ensure safe and appropriate care – all professionals in a variety of service settings should be able to access individual records particularly when an individual presents to the service with a mental health crisis’
Wales Audit Office (2005)

Confidentiality

178. Involving the service user and others as fully as possible in the CPA will mean that there is an expectation that personal information will be shared with others in order to provide effective care. Such expectation should be supported by an equal expectation that sensitive personal information will be handled lawfully, and safely, and will not be disclosed other than in accordance with relevant legislation, compliance with local policies and good practice.

179. Detailed guidance on sharing personal information is available in the *Wales Accord on the Sharing of Personal Information (WASPI)*²⁴.
180. Personal information is required in order to deliver individual care and treatment, and members of the care team are required to obtain the consent of the service user *before* such information is shared. Where a service user is unable to consent (through lack of capacity in relation to the specific matter of sharing information), the principles and requirements of the Mental Capacity Act 2005 must be followed. Chapter 16 of the *Mental Capacity Act 2005 Code of Practice*²⁵ provides further guidance.
181. Where a service user refuses to give consent to the sharing of personal information about them, such information cannot be shared, other than in prescribed circumstances regulated by legislation as well as the common law duty of confidentiality, and supported by professional codes of conduct on confidentiality. The CPA does not change this, and practitioners should be guided by existing arrangements in respect of confidentiality in their LHB or Local Authority area.

5. Communication

182. Mental health professionals, including care coordinators, should ensure that effective communication takes place between themselves, service users and others. All those involved in CPA (from assessment, planning, delivery of services, review and discharge) should ensure that everything possible is done to overcome any barriers to communication that may exist in an appropriate manner.
183. The Welsh Assembly Government is positive about the Welsh language and the benefits of bilingualism. Key service areas such as health and social care should be delivered in the service user's language of choice/need wherever possible. This means that Welsh language speakers should be given the option of assessment, treatment and provision of information through the medium of Welsh.

6. Monitoring and evaluating CPA within and across organisations

184. Health and social care providers should monitor and evaluate the operation of CPA for individuals and the wider organisation via regular and ongoing

²⁴ Version 2, Welsh Assembly Government (2008) – see Annex 4 for access information

²⁵ The Stationery Office (2007)

programme of clinical audit of practice. For LHBs, care and treatment planning is also part of the performance management arrangements relating to AOF targets.

Annex 1 – summary of terms and abbreviations

The following terms and abbreviations have been used in this interim guidance:

Term	Meaning
The 1983 Act	Mental Health Act 1983
After-care	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Mental Health Act 1983 following the discharge of a patient from detention for treatment under that Act
Attorney	Someone appointed under the Mental Capacity Act 2005 who has the legal right to make decisions within the scope of their authority on behalf of the person (the donee) who made the power of attorney. Also known as a 'donee of lasting power of attorney'
CPA	Care Programme Approach
Carer	A carer is an individual who provides or intends to provide a substantial amount of care on a regular basis for a child who is disabled within the meaning of Part 3 of the Children Act 1989, or for an individual aged 18 or over. This does not include care provided by virtue of a contract of employment or other contract with any person, or as a volunteer for any body
Child (also children)	A person under the age of 16
CAMHS	Child and adolescent mental health services Specialist mental health services for children and adolescents
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Mental Health Act 1983 for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned"
Donee	See 'attorney'
GP	A service user's general practitioner (or 'family doctor')
IMCA	Independent Mental Capacity Advocate Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act 2005. It is not the same as an ordinary advocate, or an independent mental health advocacy (IMHA) service
IMHA	Independent Mental Health Advocate An advocate independent of the team involved in the service user's care, available to offer support to service users under arrangements which are specifically required to be made under the Mental Health Act 1983. The IMHA is not the same as an ordinary advocate or an independent mental capacity advocate (IMCA) Note: The proposed Mental Health (Wales) Measure proposes changes to the Mental Health Act 1983 in respect of the IMHA provisions and entitlements
Local Health Board (LHB)	Type of NHS body responsible for providing NHS services in a local area

Term	Meaning
Local social services authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country
Mental Health (Wales) Measure	The Measure is a proposed legislation, introduced into the National Assembly for Wales in March 2010. It makes provision (amongst other matters) in relation to care planning and coordination.
Nearest relative	A person defined by section 26 of the Mental Health Act 1983 who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative
Responsible clinician	Within the meaning of the Mental Health Act 1983, the approved clinician with overall responsibility for the patient's case
Section 117	See 'after-care'
Supervised community treatment (SCT)	Arrangements under which patients can be discharged from detention in hospital under the Mental Health Act 1983, but remain subject to that Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again
Welsh Ministers	Ministers in the Welsh Assembly Government

Annex 2 – Ministerial letter regarding CPA and UAP

[To be inserted]

Annex 3 – Ministerial letter regarding training on risk assessment and management

[To be inserted]

Annex 4 – further reading

The following documents have been referred to in this guidance, and provide further information and guidance:

Department for Constitutional Affairs (2007) ***Mental Capacity Act 2005 Code of Practice*** London: The Stationery Office

National Patient Safety Agency (2009) ***Rapid Response Report NPSA/2009/RRR003: Preventing harm to children from parents with mental health needs***

Welsh Assembly Government (2008a) ***Mental Health Act 1983 Code of Practice for Wales***

Welsh Assembly Government (2008b) ***Wales Accord on the Sharing of Personal Information (WASPI)***

Welsh Assembly Government (2010) ***The Role of Community Mental Health Teams in Delivering Community Mental Health services: Policy Implementation Guidance and Standards***

Website links:

Mental Capacity Act 2005 Code of Practice
<http://www.wales.nhs.uk/sites3/page.cfm?orgid=744&pid=36239>

Mental Health Act 1983 Code of Practice for Wales
<http://www.wales.nhs.uk/sites3/page.cfm?orgid=816&pid=33960>

Rapid Response Report NPSA/2009/RRR003
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59898&q=0%c2%acmental+illness%c2%ac>

Wales Accord on the Sharing of Personal Information (WASPI)
<http://www.wales.nhs.uk/sites3/home.cfm?orgid=702>

Annex 5 – contact information

For further information in relation to this document, please contact:

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