The Sainsbury Centre for Mental Health

BRIEFING 29

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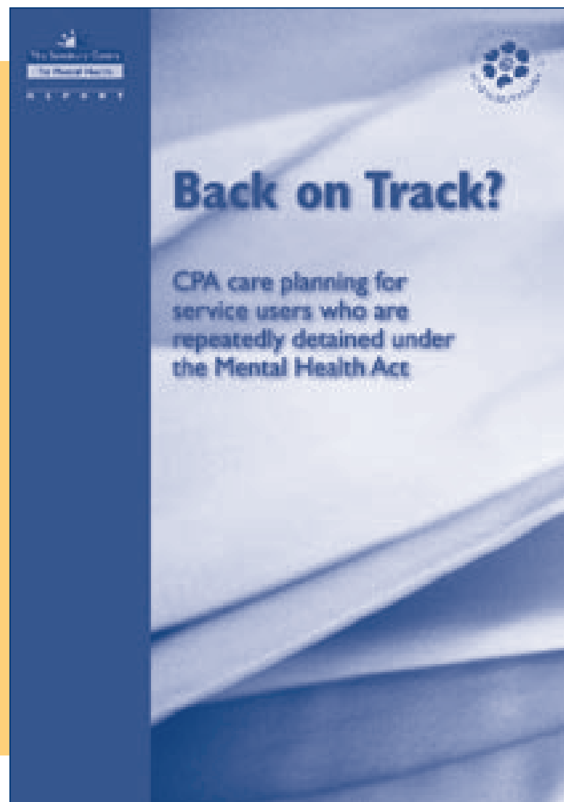

BRIEFING 29

The Sainsbury Centre for Mental Health (SCMH) is a charity that works to improve the quality of life for people with severe mental health problems. We carry out research, development and training work to influence policy and practice in health and social care. The Sainsbury Centre is affiliated to the Institute of Psychiatry at King's College, London.

Back on Track? CPA care planning for service users who are repeatedly detained under the Mental Health Act **is available @ £10 plus 10% p&p from SCMH Publications on 020 7827 8352 or www.scmh.org.uk.**

The Care Programme Approach – Back on Track?

The Care Programme Approach (CPA) is the framework that underpins mental health care for all service users, in all settings. A recent study by the Sainsbury Centre for Mental Health (SCMH) and the Mental Health Act Commission (MHAC) examined CPA care planning for service users who had been detained under the Mental Health Act more than once in a three year period. Our findings and recommendations, and the specially developed CPA Brief Audit Tool (CPA-BAT), are equally relevant for the care of other service users. This briefing paper firstly outlines key information for NHS Trusts on implementing the CPA, and then presents a summary of the main findings and recommendations from the joint SCMH and MHAC study.

Development of the CPA

The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care of people with mental health needs in England (DH, 1990). The key elements were the systematic assessment of individuals' health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the

service user's changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users and their carers. The Mental Health Act Code of Practice (DH & Welsh Office, 1993) made it clear that the CPA applied to all those receiving specialist mental health care, including detained and informal hospital inpatients.

The CPA was revised and integrated with local authority Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the format for assessment, care planning and review of care by health and social care staff in all settings, including inpatient care (NHSE & SSI, 1999). Two tiers of CPA were established nationally, standard and enhanced, and key workers were replaced by Care Co-ordinators. Standard CPA is described as being for those people whose needs can be met by one agency or professional or who need only low key support from more than one agency or professional, who are more able to self-manage their mental health problem, who pose little danger to self or others, and who are more likely to maintain contact with services. People on the enhanced CPA level are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services.

The Care Programme Approach Association (CPAA) was established in 1996 to support the implementation, operation and development of the CPA, with members drawn from mental health service providers, commissioners and other interested groups. Their publications on national standards and auditing the CPA (CPAA, 2003a), and guidance for CPA Care Co-ordinators (CPAA, 2003b), stemmed from wide experience in the implementation of the CPA.

The National Service Framework for Mental Health (DH, 1999) set national service models and national standards for mental health services, along with performance indicators to support effective performance management. A number of these related to the CPA.

Plans to abolish Supervision Registers were conditional on NHS Trusts establishing "robust CPA", with the Department of Health stipulating the criteria for robust CPA (in, CPAA, 2003a).

The CPA was introduced in Scotland in 1992 and, more recently, in Wales in 2004.

What does the CPA mean for service users?

Much service user-led research has explored the extent to which the CPA has been implemented, and how involved service users were in the process. Findings suggest that service user involvement in the CPA is still not widely practised, although where service users *are* involved in the process, they are happier with the services they receive (see the Review of the Literature on the CPA, available on the SCMH website at www.scmh.org.uk and on the Mental Health Act Commission website at www.mhac.org.uk).

National Patient Survey

The Healthcare Commission (formerly the Commission for Health Improvement) was responsible for the first national 'patient survey in mental health', in 2004. This is the largest ever survey of service users in England, in which the views of more than 27,000 people were obtained by means of a postal questionnaire. Ten questions on the CPA were included. About half the respondents said they had been given (or offered) a copy of their CPA care plan, and altogether three quarters said they definitely, or to some extent, understood what was in it. Most people agreed, at least to some extent, with what was in their care plan. Half the service users had not had a review in the past year; of those who had, most felt they had been given the chance to express their views at the meeting. Two thirds of respondents knew who their Care Co-ordinator was, and a similar number had seen them within the last month. The national report, reports for all individual NHS Trusts, and the detailed responses for the questions on the CPA, for each Trust, are available on the Healthcare Commission's website (HCC, 2004c and 2004d).

User Focused Monitoring

The first SCMH User Focused Monitoring (UFM) project, in 1996, was designed to assess services users' knowledge of, and satisfaction with, community mental health services in three London Trusts (Rose *et al*., 1998). Interviews took place with service users on the top tier of the CPA (equivalent to the current enhanced level), who all had a key worker and a care plan. Less than two thirds knew they had a key worker; a third of the group knew they had a care plan, but only a fifth said they had been involved in drawing it up. A small minority knew about their CPA review, but

Box 1: Standards relating to service users' involvement in the CPA

- *Standard 4:* sets out the requirement for service users to have a written copy of their CPA care plans; this should include the action to be taken in a crisis by service users themselves, their carers, and their Care Co-ordinators, should advise the GP how they should respond if the service user needs additional help, and should be regularly reviewed by the Care Co-ordinator.
- *Standard 5:* says that service users who are admitted to hospital should have a copy of a written aftercare plan, agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the Care Co-ordinator, and specifies the action to be taken in a crisis.
- *Standard 6:* says that carers should have an assessment of their own needs, and a written care plan. Additionally they should, with the service user's consent, receive information on the services and treatment available to the person they care for, and what to do in a crisis.

From: *The National Service Framework for Mental Health* (DH, 1999)

- Service users' care plans should be reviewed before they are discharged from hospital, and the date of the next CPA review should be recorded in their notes.
- Care plans should include action and outcomes in all aspects of an individual's life where support is needed, including psychological, physical and social functioning. They should also reflect service users' cultural and ethnic backgrounds, and should include an assessment of risk.

From: *Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach* (NHSE & SSI, 1999)

- Service users' need for employment/occupational activity, housing and welfare benefits should be assessed.
- Care plans for service users on the enhanced level of CPA should include crisis and contingency plans.

From: *Abolition of the Supervision Register Criteria for a Robust CPA* (in, CPAA 2003a)

nobody considered they were involved in the CPA review process. Two thirds of respondents felt their needs had been fully assessed, while just one third felt their strengths had been taken into account. When the UFM team returned to the area two years later (Rose, 2001), they found a statistically significant improvement in service users' knowledge about their key worker, care plan, and CPA review.

Rose returned to the CPA and the issues of partnership, co-ordination of care and the place of service user involvement, concluding that where service users were involved in planning their own care they were more satisfied overall with the care they received (Rose, 2003).

Around 20 NHS Trusts nationally are currently employing the UFM model developed by SCMH to audit their provision of mental health care from the service users' point of view, about ten of which are involved in auditing CPA implementation. Further information on UFM can be obtained from the SCMH website at www.scmh.org.uk.

The Healthcare Commission has measured NHS Trusts' performance in relation to a number of standards concerning service users' involvement in the CPA. These are shown in Box 1.

What does the CPA mean for staff?

A number of research studies have examined the implementation of the CPA on a local or wider scale. Some benefits of the system have been identified, along with a number of difficulties in fully implementing the CPA, although a few authors have been unremittingly negative (see the Review of the Literature on the CPA, available on the SCMH website at www.scmh.org.uk and on the MHAC website at www.mhac.org.uk).

In 2003, the former Commission for Health Improvement (CHI), reported that "large numbers of users are not being placed on the care programme approach or allocated a care plan and co-ordinator" and ascribed this to continuing clinical resistance and the burden of the documentation in some trusts, with the result that practice surrounding the CPA "remains inconsistent" (CHI, 2003a; CHI, 2003b).

The Care Co-ordinator has the key role of overseeing the development of the CPA care plan, and monitoring the care delivered and the outcomes achieved. The standards that relate to this role are shown in Box 2.

Box 2: Standards relating to the role of the Care Co-ordinator

- ❖ The Care Co-ordinator's responsibilities include overseeing care planning and the delivery of care.

From: *Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach* (NHSE & SSI, 1999)

- ❖ The Care Co-ordinator should have face to face contact with the service user within a week following their discharge from hospital.

From: *Abolition of the Supervision Register Criteria for a Robust CPA* (in, CPAA 2003a)

Box 3: Standards relating to organisational implementation of the CPA

- ❖ Services are required to deliver the CPA according to two levels, standard and enhanced, and they should record the CPA level that applies to each service user. The characteristics of people on the enhanced level include having multiple, complex needs which are likely to be met by more than one agency; needing more frequent and intensive interventions, being more likely to harm themselves or others and being more likely to disengage with services. An assessment of risk also contributes to the decision about CPA levels. All inpatients should be on the enhanced CPA level.

From: *Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach* (NHSE & SSI, 1999)

- ❖ CPA systems implementation: care plans must be held on an electronic central database which is regularly updated and available 24 hours a day.
- ❖ 'A Balanced Scorecard': includes an Enhanced CPA indicator (formerly the CPA/complex care indicator), for which NHS Trusts are assessed on the CPA status of service users receiving complex specialist mental health care.
- ❖ Full implementation of the Mental Health Minimum Data Set, a computerised record of every Finished Consultant Episode, which includes information on each service user's CPA level, date last seen, and details of Care Co-ordinator.

From: *Healthcare Commission Standards for Star Ratings* (HCC, 2004a); *Healthcare Commission Targets for Star Ratings* (HCC, 2004b)

As part of their performance management by the Healthcare Commission, service providers have other targets to meet in relation to CPA implementation. These are shown in Box 3.

CPA Self Assessment Systems

NHS Trusts are required to conduct an annual audit of their CPA implementation (NHSE & SSI, 1999) and to ensure they are meeting the standards set out in the *National Service Framework for Mental Health* (DH, 1999) and the criteria for a "robust CPA" (in CPAA, 2003a). Services are expected to use an audit tool for "reporting into NHS clinical governance structures and Local Authority Cabinets and Scrutiny Committees". Clinical governance provides systematic feedback at the local level to those bodies with responsibility for the level and quality of services, with reporting based on service user feedback and objective data.

The Department of Health has produced an audit pack for monitoring the CPA, in collaboration with the Royal College of Psychiatrists (DH, 2001).

The CPA Association has also published an audit tool which mental health services can use to survey the views of service users on the enhanced level of CPA, with a number of different issues being examined sequentially over a three year period (CPAA, 2003a). This can be complemented by a survey of carers, an audit of case files, and a review of the organisational implementation of the CPA.

The CPA brief audit tool (CPA-BAT), developed by SCMH and the MHAC, is designed to be a quick and simple way for staff in mental health inpatient services to assess the quality of their CPA care planning for detained patients, although it could also be used to assess CPA care planning for other groups of service users. Including a small number of key questions, it enables steps to be taken to correct any identified deficiencies. It is intended to complement, rather than replace, NHS Trusts' annual

Box 4: A comprehensive CPA care plan will:

- Record the CPA level.
- Identify the Care Co-ordinator.
- Include an assessment of all the service users' needs, including: mental health (including symptoms, psychological needs, medication issues); physical health; daily living skills; housing; daytime activities (including employment, educational, and leisure activities); social and family relationships (including the needs of carers and family members); finances (including welfare benefits); risk behaviour (including self neglect, self harm, use of alcohol and drugs, and risk to other people); disability; communication; dietary needs; and needs associated with gender, sexuality, ethnicity and spirituality.
- Specify plans to meet all the identified needs, including the identified interventions and expected outcomes, the actions needed to achieve the stated goals, who will do what, and by when. Unmet needs should also be recorded.
- Include a contingency plan, specifying action to be taken to prevent a crisis developing, and a crisis plan, including early warning signs and relapse indicators, and specifying the action to be taken in a crisis.
- Indicate that the service user has been involved in drawing up the care plan, and will be signed by them to say they have been given (or offered) a written copy.
- Say who else was involved in drawing up the care plan, and who has been given a copy of it – e.g. Care Co-ordinator, GP, carer.
- Record the date of the next CPA review meeting.
- Record that the needs of carers and family members were assessed and planned for.

Where NHS Trusts have separate sets of case notes for community and hospital services, copies of CPA care plans must be included in both sets to enable continuity of care. The most recent CPA care plan should be available at all times, to all staff who come into contact with the service user, via an eCPA system.

audit using tools such as those published by the CPAA and Department of Health. The CPA-BAT is available on the SCMH website at www.scmh.org.uk and on the MHAC website at www.mhac.org.uk.

Developing a comprehensive CPA care plan

A comprehensive CPA care plan should combine a full assessment of the service users' needs and a clear plan of care and intervention to be provided (what, who by, when, etc), collaboratively arrived at and agreed by the service user and Care Co-ordinator, with the minimum of bureaucratic effort for the mental health worker who has to complete the paperwork.

Through our routine contact with NHS Trusts and independent mental health providers, we obtained some examples of CPA documentation, and examined these in the light of the CPAA Handbook (CPAA, 2003b), and the CPAA National Standards and Audit Tool (CPAA, 2003a), to assess whether all the essential elements were included. From these, the electronic CPA forms for the enhanced CPA provided by South London and Maudsley (SLaM) NHS Trust most closely matched the ideal (Howells and Thompsell, 2002). SLaM has subsequently developed "The Patient Journey", a single, integrated clinical information process, designed to include all relevant information about patients' care from their first contact with the Trust until their final discharge from the service (SLaM, 2004). It supports the CPA, and will also meet the requirements for the Mental Health Minimum Data Set and other statutory returns. The elements needed in a comprehensive care plan are shown in Box 4.

The *Back on Track* report

Introduction to the study

Mental Health Act Commissioners undertaking routine visiting to facilities where service users are detained under the Mental Health Act 1983, felt that special care was needed in the discharge planning, follow-up, and delivery of aftercare as part of the Care Programme Approach for service users whose route into hospital was habitually through compulsion.

A joint project, undertaken between the MHAC and SCMH, aimed to examine and describe the

quality of the CPA care planning for people who had been detained under the Mental Health Act more than once in a three year period. It also aimed to assess the factors that contribute to the best quality of care and the most effective care planning for these service users, and to develop a tool for use in monitoring, assessing and evaluating care planning, through an examination of CPA care plans and case notes, and interviews with service users.

Mental Health Act Commissioners, as part of their normal visiting programme, visited 119 wards in 57 units within 15 NHS Trusts, drawn from all eight National Institute for Mental Health in England (NIMHE) regions. Information was collected from the case notes of 277 service users, 151 of whom were also interviewed. Full details of the methodology, findings and recommendations are given in the *Back on Track* report. The key messages from our study are shown in Box 5.

Box 5: Key Messages

Effective implementation of the CPA is vital to ensure appropriate services are planned and delivered to service users who are repeatedly detained under the Mental Health Act.

Local systems should ensure that all groups of service users are treated equitably.

Staff from all disciplines and agencies should work together to ensure continuity of care between hospital and community services.

Assessment and care planning should put service users at the heart of the CPA process.

Assessment and care planning should be comprehensive, including all the factors that contribute to service users' health and well being.

Ensuring equitable service delivery

Findings:

We found that ethnicity was not recorded for all the service users whose case notes we examined; without this information, NHS Trusts cannot assess whether they are effectively providing services to service users from all ethnic groups.

We also found some statistically significant differences between the way different groups of service users had their needs assessed, their care planned, and help provided after discharge from hospital.

Service users in Black and Asian groups had fewer needs assessed and planned for than those in White groups. Similarly, people over 40 did less well than younger people, and those whose previous admission had been on an assessment Section of the Mental Health Act did less well than those who had been on a treatment Section.

Women service users reported having fewer needs met after discharge from hospital than did the men, and people who had been admitted on an assessment Section had fewer needs met than those previously admitted on a treatment Section.

Having identified 17 areas of an individual's functioning which should be assessed as part of CPA care planning, based on the key documents and examples of good practice nationally, we found that not all types of needs were equally well assessed and planned for.

Recommendations:

1. NHS Trusts should record the ethnicity of all service users, in order to ensure that the services planned and delivered meet service users' cultural needs and to avoid inequalities in the delivery of care.
2. Regular monitoring should enable NHS Trusts to assess whether some groups of service users – e.g. those of different gender, age, and ethnicity – are being treated less equitably than others. Where such inequities are detected, they should be addressed.
3. Service providers should ensure that aftercare services are provided equitably to men and women, and to people who were admitted on all assessment and treatment Sections of the Mental Health Act.

Information sharing

Findings:

In some instances, case notes were difficult or impossible for Commissioners to find. Two thirds of the service users had a copy of the CPA care plan relating to their previous discharge from hospital in their inpatient notes. Few wards had access to an electronic CPA system.

Recommendations:

4. Local systems should ensure that case notes are securely stored and easy to access, so that information on previous care planning and interventions delivered is available to contribute to current care planning.
5. Local systems should ensure that CPA care plans are shared between hospital and community services, and with other service providers who are involved in an individual's care. Effective liaison when planning service users' aftercare may reduce the number of readmissions within 90 days.

6. Electronic CPA systems should be fully implemented in each NHS Trust to enable crucial information to be easily shared between staff across hospital and community sites, and between disciplines, and so facilitate co-ordinated planning and delivery of care.

Inpatient care

Findings:

At the time of their current admission, most service users were described in their case notes as being either a danger to themselves or to other people. More than half were said to be non-compliant with treatment in the community. In a small number of cases, non-compliance was the only recorded reason for their compulsory admission. Over 40% of the service user interviewees were generally positive about being in hospital, while a similar number had negative feelings about their admission, reiterating concerns identified in other national studies.

Recommendations:

7. NHS Trusts should ensure that the criteria for compulsory admission are correctly applied.
8. Managers of acute inpatient care should ensure that an adequate range of therapeutic activities is provided, along with social and recreational occupation, especially for detained patients who are unable to leave the ward.
9. All inpatients should be on the enhanced level of CPA, and this should be recorded in their notes.
10. Copies of CPA care plans relating to service users' previous discharges from hospital should be kept in their inpatient notes to facilitate continuity of care.

Discharge planning and provision of aftercare

Findings:

We found some gaps in the CPA information recorded in service users' case notes. The CPA level was recorded for less than two thirds of the service users, and the date of the next CPA review was recorded in just over half the care plans. The CPA Care Co-ordinator was recorded as attending the post-discharge CPA review in a third of cases, and a fifth of service user interviewees said their Care Co-ordinator was involved in drawing up their care plan.

Performance management of NHS Trusts includes reporting on the number of service users readmitted within 90 days of their discharge from hospital. We found that a fifth of the service users were readmitted to hospital within 90 days, with seven people being readmitted within two weeks of their previous discharge. Readmissions within 90 days were found in 14 of the 15 Trusts visited.

In terms of the care provided after their previous discharge from hospital, not all groups of needs were equally well met. Some groups of service users had their needs less well met than others.

The Care Co-ordinator should have face to face contact with the service user within a week of discharge from hospital, as evidence shows this is a crucial time period in order to minimise suicide, self harm and readmission. 60% of interviewees said they had been seen by a mental health worker in that time.

Recommendations:

11. The date of the next CPA review should be recorded in service users' case notes before they are discharged from hospital.
12. The CPA Care Co-ordinator should take the lead in drawing up service users' care plans, and should attend the CPA review meetings.
13. CPA assessment and care planning should be comprehensive, with all needs included. Individuals' cultural and spiritual needs, at present rarely assessed and planned for, should be included in CPA care planning.
14. Timely discharge planning should enable appropriate community-based services – including housing, financial and occupational – to be arranged so that service users can be discharged as soon as their clinical need for inpatient care has ended.
15. Local systems should ensure that community services have face to face contact with all formerly detained patients within a week of their discharge from hospital.
16. Having a comprehensive CPA care plan is not an end in itself. Services should ensure that the interventions specified in the care plan are actually delivered to the service user.

Involving service users in the CPA

Findings:

A quarter of the service users interviewed said they knew a lot about the CPA while almost half said they had heard of it. A quarter of the interviewees said they had been involved in drawing up their CPA care plan at the time of their last discharge from hospital, and a third remembered being given a written copy of it. It was recorded that a third of the service users had signed their CPA care plan, and a fifth had been given a copy of it.

Recommendation:

17. Service users should be informed about the CPA, and fully involved in drawing up their care plans and participating in CPA reviews, with access to an independent advocate if they request this. Their own assessment of their strengths and needs, as 'experts by experience', should inform the care planning process. They should be asked to sign their care plan, and be given a written copy of it.

Learning from examples of good practice

Findings:

Commissioners recorded some examples of good practice.

Recommendation:

18. The good practice which has been identified can serve as an example for NHS Trusts wanting to improve their practice in this area.

Conclusions

Our study has found some examples of good practice, and identified areas in which Trusts need to do much more to ensure the CPA is effectively implemented – particularly, though not exclusively – for service users who are repeatedly admitted compulsorily and have a range of complex needs. Effective use of the CPA, the single care co-ordination approach for adults of working age with mental health needs, has the potential to make a big difference to improving the lives of service users.

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The Sainsbury Centre for Mental Health

Removing Barriers. Achieving Change.

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