

## **Reviewing the Care Programme Approach: Consultation Responses**

This report gives a summary of the responses received to the consultation document [Reviewing the Care Programme Approach 2006](#) published November 2006. Around 300 individuals, groups and organisations responded. They represented a wide range of interests including service users and carers, practitioners and managers and organisations in the public and third sector. Targeted feedback events were held for service users and carers. There was much consensus, but also some disagreement and differing perspectives and views on solutions to the issues raised. All views will be considered in developing the policy and implementation guidance which we aim to publish November 2007.

### Section 2: CPA Values and Principles

There was general support for underpinning CPA with values and principles and agreement that values and principles were missing from previous guidance. Responses suggested values and principles should apply to all services users not only those on 'new' CPA/ the 'defined group'. For ease of understanding, practical examples of values and principles should be provided wherever possible in new guidance. There should not be an 'opt out' or 'grey areas'; values and principles should be explicit.

Readers were pleased to see recovery and positive risk taking included in the values and principles. Greater emphasis was encouraged on realistic goals, social inclusion, carer involvement, genuine partnerships, open communication, continuity of care, and the family unit.

Respect and valuing diversity were seen as necessary core values of CPA; respect for service users, respect for service user and carer involvement, and respect for spiritual beliefs. The service user should be at the centre of CPA rather than fitting into the CPA system. Creative engagement should be encouraged as well as movement away from a formal system which described by some as excluding. CPA should be promoted as a best practice tool and place emphasis on service user and, where appropriate, carer involvement.

Improvement to the language used within the values and principles section was recommended. Simple, easy-to-understand language in a clearly set out format was requested by service users, carers and professionals. It was acknowledged that considerable information was alluded to within the statement and more explicitness would bring about greater understanding.

Values and principles of CPA should be taught at an early point within CPA training to offer grounding in the purpose of CPA. There should be accountability for achieving and maintaining CPA values and principles in practice. Audits and

supervision provide an opportunity to assess and ensure values and principles are being met by staff. Principles and values are equally as important as elements of the care framework and should be reflected throughout the system (e.g. paperwork).

### Section 3: Who should CPA be for?

There was much interest and concern about the removal of standard CPA with mixed views on the benefits of this. Some views were based to some extent (particularly, but not solely, from service users) on the assumption that just being on CPA gives entitlement to services - rather than CPA being a system that supports service delivery and co-ordination. This was compounded by the view that other services sometimes inappropriately use levels of CPA as a proxy for service entitlement (eg "housing services won't even consider you if you are not on CPA") – with clearer guidance needed on links between assessment and eligibility criteria. Others commented that as assessment, planning and review are needed for all services users anyway, just not calling it standard CPA wouldn't simplify anything – just confuse – and may lead to a lowering of quality for this group. Also, arguments were made that, rather than reducing bureaucracy, removing the requirement for standard CPA and leaving things to local decisions could in fact lead to more bureaucracy. Another point was made that this might pressurise a move of service users to primary care before specialist services are developed there and lead to higher admission criteria to secondary care.

There was interest and support for the approach to the definition of higher need for CPA as defined by complexity along the axes of individual need and service delivery. Other dimensions and considerations were suggested as critical, mainly: significant risk (but not an over-emphasis on this), vulnerability, and instability. Some urged that the combined impact of lower levels of need should be a consideration. The point was made that cumulative impact over time should be taken account of as assessment develops.

There were representations that there should be clearer guidance on when CPA starts and when it ends – and some thought be given to a fast-track back to higher levels if circumstances change. Clarity also needed on links between CPA guidance and (new) Mental Health Act legislation.

There was general agreement that individuals in the key groups described might need higher level of CPA support but many questioned the rationale for describing groups rather than individual characteristics, some even saying that this could be stigmatising. Almost everyone suggested other groups that should also be considered as "key" including: range of co-morbidities including - severe learning disability, physical health problems, dementia, and Asbergers syndrome. And other groups including: people from BME communities, refugees and asylum seekers, victims of domestic violence, child abuse survivors, and people

with severe mental health problems who are also carers. What was generally supported was the need for mental health assessments and plans to take account of the range of life factors that impinge on mental health problems and that allow for recovery.

The role of the non-statutory sector and CPA was raised and the need to address commissioning and quality issues. Also sharing of information highlighted as critical. The idea of care co-ordination being separate from service provision was an idea supported by some.

#### Section 4: Care Co-ordinator

There was agreement that the role of the care co-ordinator is central to the CPA approach and that as the role has not been clearly defined has been subject to diverse local interpretations and criteria. Responses highlighted the perceived lack of guidance on fundamental aspects of care co-ordination and the need for a consensus-seeking initiative. There was general agreement that there needs to be more clarity on: who can be a care co-ordinator; their role, responsibilities and expectations; the balance of therapeutic and administrative functions; the distinction between care co-ordination and care management and the need for guidance on levels of care co-ordination. Some questioned if it is possible to be a care co-ordinator and not be directly involved in the delivery of care.

On the matter of resource and capacity issues concerns were expressed on: caseload sizes; over-bureaucratic and excessive paperwork; inefficient IT systems; lack of administrative support; lack of supervision and the issue of the care co-ordinator having responsibility without authority.

Training issues raised included whether training should be mandatory for the role; if there should be a register of qualified care co-ordinators; training included in pre-registration programmes; lack of service user/carer involvement in training. Respondents urged for competence based training; more inter-professional learning; involvement of third sector in training and the need for/frequency of updates.

#### Section 5: Continuity of Care

Generally there was support for the issues raised and statements made in this section. Also highlighted were particular concerns about transitions between CAMHS and adult services; and adult to older people's services; and the links between the respective assessment and planning systems. Out of area placements was also an area raised as a challenge to continuity.

It was the general view that any transition point can be problematic and the care coordinator is crucial in the process. These transition points can be going into care of any kind, transferring to another area or transferring to other specialist

teams within the same area. A view was put forward that for rural areas with less mobility of its residents the creation of specialist teams may have created unnecessary transition points and a fully integrated locality structure may prove more effective in coordinating care with greater local knowledge of the area and the mental health users within it.

A number of good practice examples were received from trusts adopting integrated care pathway approaches to CPA policy and implementation.

Effective local transfer of care protocols at each and every transition point were seen as key. Some of these issues would also be assisted by: formal alert systems between teams and agencies; the development of crisis plans, relapse plans & contingency plans which should be completed in partnership with service users and carers; service user held care plans.

### Section 6: Service User and Carer Engagement and Involvement

The title 'CPA' and 'care co-ordinator' held little meaning for some service users and carers, especially those who only recently came into contact with services, and service user and carers stated the use of terminology felt excluding. There were substantial requests for care plans to be easy-to-read and understand, with translation offered where necessary, and completed in full. Some service users reported care plans being completed partially.

Responses showed different understandings of information sharing good practice and a lack of consistency in application of information sharing protocols. Information sharing included both between agencies and between service users, carers and staff.

A strong request from service users, carers and professionals, was for simple, easy-to-understand and easy-to-access information on what CPA is and what service users and carers are entitled to (also see carers' assessments). Access to local crisis information was also seen as essential information. For those new to the mental health system, and due to the range of new information published, piecing together all relevant areas of policy was said to be challenging. E.g. Mental Health Act, Carers' Assessment, Mental Capacity Act, Power of Attorney.

Service users reported in some cases not knowing whether a care plan existed for them or what their care plan was. While there was acknowledgement that at times of acute illness awareness of care plans may not be possible, in all other circumstances there should be clarity of care plan content and involvement in setting the outcomes and the means to achieve these outcomes. Responses emphasised that greater focus on self-assessment would strengthen service user ownership and involvement in CPA.

The focus of CPA was perceived as predominantly medically focused, however service users also reported their concerns that side-effects of medication were frequently dismissed or medication was not revisited throughout the care plan.

Victims of violence or abuse, minority groups, and those with a history with particular members of a care team were suggested as specific groups who would benefit from choice of care co-ordinator.

Where service users and carers provide training and/or are involved in developing local policies, payment should be provided which does not jeopardise benefits payments.

Pre and post meetings were seen as a way to strengthen communication and offer service users continued support at meetings/reviews as these can be intimidating. Care co-ordinators may also benefit from time to prepare with the service user prior to meetings. These meetings will be in addition to the continued contact of the CPA process and specifically to prepare for reviews/meetings; a review is one part of the CPA. Comments were received on the lack of consultation with the service user and relevant carer and/or advocate over: time, date and venue of review meetings, lack of notice when details were circulated and the formal nature of CPA reviews which can be intimidating for service users. Frustrations were reported over meetings and reviews being coordinated around consultant's availability and not that of the service user.

There was support for carer involvement. Comments were received both to improve working with carers and also to abide by service users' wishes. In circumstances where the service user may not consent for the carer to be involved or receive information regarding care this should be respected. However, information regarding the safety of the carer should be passed on and consent over sharing information should be recorded and revisited.

A better awareness of carers' needs, especially young carers' needs, were identified in responses. The link between carer's assessment and CPA differed with some responses - stating carers' assessment were part of CPA policy. However, it was acknowledged that CPA should highlight and signpost carers' assessment to help join together policies and ease the process for carers. Responses requested greater emphasis on viewing the service user within the family unit.

Services users asked for more honesty regarding available options and support to make informed decisions. Open and honest discussions will encourage greater trust between service users and professionals. Where there are disagreements within the CPA or where the service user does not sign the CPA documentation the reasons for this should be noted.

There were requests for clear complaints procedures which the service user and carer are made aware of and for all complaints to be viewed seriously. Both professionals and non-professionals asked for a streamlined and clear complaints procedure. The process should seek to resolve issues quickly and with the minimal bureaucracy.

To empower service users the focus of CPA should centre on recovery, strengths and achievements. Responses suggested focus upon a medical model can cause disillusionment and feed a power imbalance.

Power imbalance was identified as a barrier to service user ownership of CPA and for care co-ordinator's to be in a position to lead the CPA, where necessary. To enable services to change and improve, unmet need should be recorded to identify where developments are required.

### Section 7: Physical Health and Social Outcome Needs

Overall there was agreement that these were important areas that should take greater prominence in the CPA process. There was a view that physical health and social outcomes should be considered as separate issues as they are different and may need different local approaches. Discussion mainly focused on: how assessments and plans should be used to highlight these areas; difficulties agreeing who carries the main responsibility for screening and monitoring physical health; and improving working arrangements and agreements between primary care, social care and secondary mental health care.

It was felt that improved service approaches to assessment and planning should cover the range of a service user's needs by: "whole person" assessments – including service user-led assessments; use of appropriate outcome measures; better links between secondary and primary care. This includes using a good assessment and review tool, service user and carer participation, involvement of advocates and other agencies that are part of the care plan training for care co-ordinators and consultants in recovery and social inclusion concepts.

The consensus was that that documentation needs to be clear and easy to use and share. Physical and social outcome needs are accepted as relevant by practitioners in mental health and allied services (although there may be professional practices that get in the way of this). The practical barrier, which can be overcome, is documentation that is over-elaborate, alienating or wasteful.

There were also calls for routine screening against national Continuing Health Care Criteria and Fair Access to Care Services (FACS) at each CPA review with staff trained to undertake these. Care co-ordinators need appropriate training skills in assessment/tactful questioning on physical health matters.

It was proposed that there should be an expectation that anyone referred for consideration for enhanced CPA should be referred with an appropriate history of physical health problems. Where staff lack the competencies to make a basic assessment of physical wellbeing or give basic health promotional advice they should exercise an assertive approach to ensuring their client gets this work done with a primary care practitioner, as signposting is rarely adequate when clients have amotivational states.

There was a call for further guidance around shared care arrangements between secondary and primary care - in particular who is responsible for service user's physical screening and well being where this is not covered by the existing Quality and Outcomes Framework (QOF). In many cases it is not clear who is going to monitor the physical health of the service user, or rather who is going to monitor which aspects of it. It was felt that there is poor understanding in secondary care of the primary care obligations under the Quality and Outcomes Framework and how they are being met locally.

Care co-ordinators were urged to guard against the assumption that other health care staff are undertaking physical assessment in primary care. Clear competencies within CPA training for care co-ordinators to understand the importance of physical health assessment.

Many highlighted the need for and secondary health care services and local authorities to work more closely together to the point where boundaries may become blurred. It was felt that CPA may be able to assist here if it were to be considered something that gelled the care pathway together. Joint staff training will help. Information sharing protocols necessary as is multi-agency input to care assessment and planning and review. Greater emphasis should be placed on networking with GPs and local colleagues for health promotion and education.

Secondary Mental Health Services should liaise with Primary Care to ensure that patients attend for Primary Health Care Screening and that Primary Care takes a role in coordinating and reviewing the results.

Clear shared arrangements supported by national guidance between PCTs and secondary mental health services should ensure users of secondary mental health services get access to physical health checks and clarity over which aspects of health care monitoring lie with each agency. Guidance should include the requirement for the sharing of information with service users consent.

The QOF and CPA are the main mechanisms and prompts for ensuring that those with mental health problems gain good physical health care. The CPA process can improve physical health care by ensuring adequate exchange of information between primary and secondary care regarding co-morbidities and current medication, which will affect prescribing decisions in mental health and primary care.

There needs to be a clear set of documented roles and responsibilities for the delivery of physical health care for each individual. While the QOF should ensure delivery for the majority of those with psychosis, inevitably some will not engage with primary care, and physical care must therefore be provided by an alternative providers which may well be mental health led.

Services should ensure that mental health service users are not missed out of other national and local health initiatives eg tackling obesity and also there could be explanation of 'prescription' activities into mental health settings

Engaging GPs in the CPA process was highlighted as a difficulty. We were urged to highlight the responsibility of primary care teams to support and monitor the physical health needs of people on CPA. However, it was also recognised that as GPs rarely attend CPA meetings, the issue is as much about communication and joint working and how to improve links between GPs and secondary care.

It was reported that social care inequalities continue for groups of patients who graduate to other services e.g. older adults, learning disability etc. Where services are not integrated it is important to remain vigilant that inequalities do not exist for those with a serious mental health problem subject to CPA. As social care initiatives develop it is important to ensure that tendering contracts explicitly state how the agencies will support and adhere to CPA principles and practice. This must be explicit and also place requirements on Trusts to engage other agencies in overall CPA care planning.

It was suggested that social care pathways should be developed to assist staff in accesses timely support for service users. Social care mapping should be undertaken to assist care co-ordinators with information as to what services are available within the local community to assist with accommodation, employment, access to learning, local amenities and other day services.

### Section 8: Choice in Mental Health

This Section was for information rather than consultation. Some comments were received and they have been forwarded to the Choice policy team at CSIP.

### Section 9: Risk Assessment and Management

Key areas were identified as: open service user and carer discussion and agreement in managing risk; better training for all staff; better multi-disciplinary team working; guidance on evidence-based practice including risk assessment tools; appropriate and clear paperwork; recognising risk as an everyday occurrence – and positive as well as negative; confidentiality and information sharing; positive risk management at the centre of CPA; and advocacy support for service users. Other issues raised included:

Integrating processes such as the CPA and MAPPA. Staff feel distanced from MAPPA and are not always fully conversant with the tiers below the most serious level MAPPA such as options to go for local area risk management meetings. Local risk panels of Police, the LA, Health, Education and Housing allow cross-age identification of individuals presenting public risk.

Need for more positive communication/use of media surrounding mental health issues – reducing stigma & misinformation - by active involvement of all relevant parties.

Accurate diagnosis and a clear understanding of the type of risks that may be associated with a particular diagnosis or problem, is important. This should be followed by good communication and frank discussion within the capabilities of the care co-ordinator with access to appropriate supportive supervision. The main principles are good communication, straight forward explanations, open discussion and respect.

Given that previous behaviour is the best predictor of future behaviour, a comprehensive historical incident list must be kept for each service user. This is probably the best guide to future care decisions and is easily transparent to service users and carers.

Risk decisions should not be made in isolation. Good support and clinical supervision is vital. Sharing of risk management plans across agencies will bring benefits. Mistakes should be used as learning tools. Basic psychological skills training, listening skills are needed for all staff to recognise underlying issues which if missed can lead to higher risk and poorer outcomes.

Risk assessments should be appropriate for the settings they are in, or going to be in if discharged.

Reference should also be made to the Mental Incapacity Act – which also sets out a framework for assessing capacity and risk.

Professionals need to work within a framework of accountability which clearly sets out how they make risk assessments and how they can access help and support from senior colleagues if they have concerns. Senior level ownership is needed with high risk cases.

### Section 10: Tackling Bureaucracy

The issue of tackling bureaucracy received a wide-ranging number of comments which impinge on many of the aspects covered in all sections of the consultation document.

Calls were made for one care plan to follow the user through all care settings and a recommendation was made for this to be piloted. Key elements of the CPA that need to be recorded are service user's views, the risk issues and care plan (including who is responsible for what and when). As long as these are written and circulated in a simple format using understandable language, nothing else is necessary. CPA meetings are sometimes used to decide on allocation of resources, such as in Section 117 meetings, and this has required systematic assessment of needs to justify the decisions made. However, this does not have to be a standard practice for effective planning. Service users have expressed a desire for service user held electronic card which contains all relevant information relating to their care.

There were calls for: electronic patient records; increased administrative support to meet the demands; combined assessment and initial care plan documentation; simple and nationally agreed template to facilitate effective communication and transfer of client through service boundaries. And the need to reinforce the guidance on effective care co-ordination that documentation should be proportionate to the complexity of need and the level of risk. Ease of information captured through drop-down lists, effective information loops back to teams and practitioners about their case load and performance, and clarity of information record.

It was felt that short narrative/summaries were more useful than use of tick boxes. A standard form to be designed by an expert group of practitioners, service users and carers. Policy should urge services to keep language and terminology simple, clear and understandable. There should be self-assessment sections in assessment forms.

Care planning that can be used across all services and in any setting, for example in-patient, out-patient, community etc. that is service user focused and friendly were supported. Also, a single system of care planning that can be used across both health and social care was said to be desirable. Extending the involvement of various groups, for example housing, education, police and probation services without involving the need for a multiplicity of parallel records. The single care plan must be evaluated and updated, so it could be used with confidence in the Mental Health Act Managers' Hearings and Mental Health Review Tribunals. CPA review documentation must be standardised and provide the PCT with an accurate portrayal of each service user's progress and any untoward incidents that may have taken place between CPA reviews.

Some called for a review and rationalise all health circulars, guidance and local authority letters. Staff collecting required information should be trained. Reduction in national targets. Focus on quality not quantity. Recording of HONOS and Diagnoses at each review. Different sets of KPIs for Health and Social Services to be reviewed to ensure consistency.

Conflicting demands from a wide variety of different local commissioners and national agencies: PCTs, local authorities, local implementation teams, Healthcare Commission, Strategic Health Authority, Joint Overview and Scrutiny Committees, Mental Health Minimum Data Set, Nation Patient Survey have an impact on bureaucracy.

Local teams should have more powers to make decisions and policies should provide a framework and best practice guidelines to inform how the CPA is applied and care is delivered.

### Section 11: Measuring and Improving Quality

Service users and carers were seen as key to measuring improvements in quality by about one third of respondents. Service user and carer involvement in monitoring and evaluating the CPA should be routine and widespread. The following specific methods service users and carers could use, or ways in which they could be involved, in measuring quality were identified: focus groups; national audit (of carers); user focused monitoring; user/carer-led audits; local and national evaluations; random “mystery guest”; patient/carer feedback through external agency; user/carer forums to link with commissioning strategies to evaluate outcomes. The patient survey was the most commonly cited method of involving service users, with suggestions made to improve and extend questions relating to CPA. Feedback at the point of service is crucial to measuring quality, and a way of improving quality would be for service users to be better informed as to how they can hold services to account.

Using outcomes to measure improvements in quality was the second most common response to this question. Several specifically mentioned HoNOS, including the modified HoNOS LD for people with learning disabilities and mental health problems. Outcomes need to be broad to include social (care), social inclusion, quality of life and physical health indicators, not purely medically defined outcomes. Outcomes related to wellbeing rather than illness, with a recovery based approach would be welcome. Importantly, outcomes should be agreed with, and meaningful to, service users and agreed across providers. Outcomes can be used on an individual basis (and as the basis for CPA progress reviews) and aggregated.

Audit was a commonly mentioned method of measuring quality. There was some feeling that existing audit processes are sufficient, however there were a number of suggestions made as to how to improve audits. Some of the improvements noted were about closing the audit loop – ensuring that the results of audits are shared, and acted on (which might include additional resources) so they actually lead to service improvements. Other improvements suggested were greater involvement of service users and carers in audit; including standards and tools relating to parenting and children; ensuring audit of targets

set, achieved and overdue reviews are included; and the degree of involvement of service users. Whilst regular audit, internal and external is seen as necessary, it was also noted that a more focused and integrated approach is needed, with some rationalisation of the numerous audits undertaken in services.

The need to recognise the quality of the relationship between the professionals and service users involved was noted, consequently improvements can be achieved through workforce interventions, such as training, supervision and appraisal. The measures of quality, such as audit information need to be fed back into these workforce development processes, e.g. through to supervision and training.

The need for an overarching or common assessment framework was a common theme. The Common Assessment Framework and the Single Assessment Process were quoted as assessment frameworks that could incorporate CPA. Screening and assessment tools used in prisons should also be considered. It was felt that the accuracy and effectiveness of the assessment carried out as part of the CPA needs to be measured.

There was common ground about the need to standardise systems and processes, across providers. To achieve this some centralised guidance is sought – in terms of national standards, definitions, tools and documentation. A nationally recognised audit tool (presumably in addition to the Audit Pack) and risk management and risk assessment tool would be welcomed. A list of “prompts” for the CPA was called for as were national agreements on KPIs for the CPA.

There was a commonly held view that systems should be aligned, and general consensus that significant improvements are needed to integrate health and social care – in terms of policy, information systems, performance review and reporting. There was a call for reduction of duplication of systems for performance review, and routes for reporting data with a single reporting system and common information and performance framework.

Many respondents noted the need for IT systems to be aligned, and were hopeful that integrated IT systems could overcome some of the issues of duplication currently found and could help measure improvements in quality. CPA needs to be central in the National Care Records Service. National software/national IT systems or at least a national CPA IT network were all noted as possible solutions.

There was a plea to use routinely collected data including that available from SUI reports and to better co-ordinate information requests. Data collected and analysed needs to include ethnicity, gender and information relating to parenting and children. Standardised documentation across services and professionals would be helpful.

Greater sharing of information was requested, with the third sector and with service users, although there should be clarity as to who the information is for when it is collected.

Although there was some feeling that the existing regulation and inspection regime is onerous, a number welcomed the Healthcare Commission and Commission for Social Care Inspection plans for future joint working and joint inspection (incorporating the MHAC) as a way of relieving some of the burden of inspection. However there was also a call by some for more “snap” inspections. The joint review of community mental health services was welcomed – it was suggested by one respondent that this should be carried out to measure progress nationally every 3 years. CPA should be “at the heart of” the annual health check for mental health trusts. It was also noted that Monitor and the Audit Commission should be more closely aligned.