Care Programme Approach (CPA)

Five key points to remember:

**Care Plan**
- You are entitled to a copy of your care plan – it is your right
- You should be involved in the creation of your care plan from your first assessment

**Involvement**
- It’s your care plan so you should be fully involved in it including setting goals, risk assessment and reviewing
- The care planning process must be meaningful to you
- Your input should be genuinely recognised and your choices respected

**Attendance**
- You should attend your CPA meeting
- You should be consulted about who will be in your CPA meeting

**Crisis plan**
- You should have a copy of your crisis plan alongside your care plan
- You have agreed this plan and can review it and make changes as needed

**Not on your own**
- You have the right to have a friend or carer or advocate in the CPA meeting with you if you would find this helpful
Care Programme Approach (CPA)

General Points

The Care Programme Approach (CPA) has four key elements:

1. Assessment of your health and social care needs and strengths
   This will not be a ‘one off’ event

2. Development of your Care Plan
   This is agreed by all involved, including you and your carers if you have any and want them to be involved

3. Your Care Coordinator
   This is your main point of contact. They will monitor the delivery and review of your care plan

4. Review
   - A review will happen every six months after the initial review unless there are special circumstances
   - All information relating to your CPA assessments, care plans and meetings should be written up and stored in your case notes
   - Your wishes must be taken into account regarding confidentiality
   - With your agreement, everyone relevant including your carers should be kept informed and included in changes to your CPA
   - CPA is used to ensure that any transfer between mental health services you use, is done smoothly
Care Programme Approach (CPA)

When you might want the services of an Advocate:

Support with your Care Plan

If following assessment, it is felt that you need advice and support to make some decisions at your CPA meeting, a suitable independent Advocate will be found for you.

The Advocate should discuss their role with you and attend the meeting to help you to express your views.

Useful things to know:

- Involvement of an independent Advocate in CPA planning must be promoted to all service users.

- Appointing an Independent Mental Capacity Advocate comes under the Mental Capacity Act.

The Mental Capacity Act says everyone should be treated as being able to make decisions. The Act does not make a distinction between good and bad decisions. Doctors and others have to prove that a person cannot make decisions, even when given help to do so. If it is proved that a person cannot make decisions, The Act tells carers and mental health staff who can make decisions for a person and when they can do this.

- Section 30 of the Mental Health Act 2007 gives all detained service users and those on a Community Treatment Order (CTO) access to independent Advocacy services delivered by Independent Mental Health Advocates.

- In the case of service users not detained under the Mental Health Act who may not have capacity to consent to a care plan, please refer to the West London Mental Health NHS Trust Mental Capacity Act Guidance.
Care Programme Approach (CPA)

CPA meetings: The basics

- You should always be invited to your CPA meeting

- The care coordinator or their representative must be in attendance

- The CPA meeting should start on time

- The CPA meeting will have someone that Chairs the meeting

- The meeting will invite you (and others present) to comment on identified needs, strengths and problems

- The meeting will acknowledge any agreement or disagreement regarding needs. Those present should indicate how needs might be met or if they cannot be met

- You will be involved in your risk management care plan within the limits of confidentiality

- A CPA meeting should not take place in your absence unless you are absent without leave or physically unwell. Meetings can proceed in your absence if you are invited and leave the meeting part way or refuse to attend
Care Programme Approach (CPA)

You and Your Care Plan

What is included in the draft Care Plan?

- The team contact details
- Plan of care
- Contingency plan
- Crisis plan
- Risk assessment
- Notes of the discussion
- Copies of reports

Ask your care co-ordinator or Advocate to explain any terms that are unclear

Signing your Care Plan

- Signing the care plan is your right
- A signed copy of the care plan will be sent to all those listed on the CPA invitation list (including you)
- The care co-ordinator will ensure that a signed copy is filed in the CPA section of your proper case file
- An electronic copy of the care plan is also held

Reviews of your Care Plan

A review will happen every six months after the initial review unless:

- You have applied for a Mental Health Review Tribunal
- You have transferred from one team to another
- A significant event (untoward or otherwise) has occurred which requires an urgent review of your care plan
Assessment of needs and care planning

- You should be assessed for your mental health, social and psychological needs and strengths on your first contact with our service and then on an ongoing basis.
- You and relevant professionals should be involved in the assessment process.
- If you agree, your carer will be asked to contribute to your assessment.
- You can request that an Advocate or anyone you feel can support you, is invited.
- Assessment is a continuous process. If your needs are seen to change before the next CPA meeting they should be addressed as soon as possible and the care plan updated.
- A care plan based on your needs and strengths should be identified by you and your care coordinator.
- You should always be involved in the development of your care plan.
- Proposed changes to your plan of care should be discussed with you.
- Your plan of care should be explained to you as often as you need.
- Professionals involved in your assessment will monitor the care plan closely.
- You should be told how to contact your care team or get support if your needs change between meetings.
Care Programme Approach (CPA)

Assessing risk

- Risk assessments are part of your care plan
- A risk assessment is not a one-off process and should continue throughout your contact with the Trust on admission, at reviews, at discharge, and at ad hoc times
- Updates to your risk assessment should not wait until the next CPA meeting but should be made as soon as there is a change in risk

Risks that are assessed include:

- Risk of harm to yourself or harm to other people
- Risk of significant deterioration in your mental health
- Risk of harm from other people
- Risk of being unwilling to continue with agreed care and treatment

Who sees the risk assessment?

- All relevant staff and other people with your consent, for example your carer

What is in the Care Plan to manage my risk?

- Contingency plan
- Crisis plan
- Warning signs
- Trigger factors
- Significant behaviour changes
- Failure to comply with medication, treatment and attend scheduled appointments
Care Programme Approach (CPA)

On admission to in-patient settings

On admission

As soon as ward staff are aware you are being admitted they must check if you have a current care plan.

Current Care Plan

The care plan must be obtained immediately so that all care planning and assessment can take account of the current care plan.

Medical assessment

Your medical assessment will be conducted within six hours of your admission and your physical examination within 24 hours. If you are unsure what to expect speak to a staff member on the ward.

Risk assessment

A risk assessment will start immediately on arrival at the ward and will be completed within eight hours of admission and reviewed as necessary. It is important you let staff know if there is anything that may influence you feeling or being safe on the ward.
Care Programme Approach (CPA)

Your Care Plan as a letter

If your needs are less complex or you are only seeing one professional in the community, you may receive your care plan in the form of a letter.

Your health and social care needs and strengths will be assessed and any risks identified. A letter will be sent to your GP that will include a basic care plan. This will be reviewed at appropriate intervals determined by you and the clinician providing care.

The care plan will take the form of a letter which will contain the following:

- Whether you are supported within CPA or not
- Care Coordinator
- Diagnosis and ICD 10 code*
- Assessment Today
- Care Plan
- Date of Next Care Plan Review
- Date of Next Appointment
- Professional’s Signature

Useful things to know:

- You should be encouraged to be actively involved in planning your care.
- The clinician is responsible for ensuring that appropriate care is provided to you and that there is a regular review.
- A risk assessment must be completed at the initial assessment and be reviewed on an ongoing basis.
- You will get your copy of the letter, unless you request otherwise.
- If you have not received a copy of the letter, it will be given to you at your next appointment with the agreed care plan review.

*ICD-10

ICD-10 is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records.
Care Programme Approach (CPA)

Addressing the role and needs of carers

- Carers, including young carers, must be identified at assessment.

- Wherever possible, all carers, including young carers, should be involved in your treatment planning.

- Carers should be given information to make sure they are actively involved and supported in the treatment process, with your consent.

- Carers should be given information about their right to an assessment of their own needs, called a Carers Assessment.

- It is the responsibility of the care co-ordinator to offer a Carers Assessment and make sure it's completed if requested.

- Multi-disciplinary team involvement in the development of the Carer Assessment care plan may be appropriate. However, as carers may live a distance from the service user, liaising with service local to the carer may be necessary.

- Carers must have their own written care plan given to them.

- All carers providing substantial care must have an annual review of their caring, physical health care needs and mental health needs.

- Carers can discuss with the team any changes to their needs that may require an earlier review.

- Where young carers are identified, their needs must be assessed and, where appropriate, referral made to Children’s Social Care Services. This may involve referral to a young carers project.

- Account of the needs of children and carers must comply with Carers (Recognition and Services) Act 1995.
Care Programme Approach (CPA)

Getting the most out of your CPA

- Take the time to talk to your care coordinator and tell them your priorities around need, strengths and aspirations

- Whilst CPA Reviews update your care plan, changes can be made in between meetings if there is a need

- The CPA process exists to support you and your carers and to ensure that everyone knows what the priorities are and who should do what. If this is not clear, it is likely that the care plan is not clear

- If you are unsure of anything, ask your care coordinator or Advocate or someone else that you feel comfortable with

- The care plan should not just focus on your mental health but on any of your priorities such as physical health, housing, money, work

- A risk assessment should be completed and you should have the opportunity to say what your understanding is of your risk issues

- Your carer or Advocate should only be invited to your CPA meeting with your consent. It is worth considering the pros and cons of having your carers or Advocate at the meeting

- The care plan is a tailor made plan of care for you based on your individual strengths, needs and problems. It should therefore take account of and recognise your culture, gender, ethnicity and sexuality and anything else that make you who you are
• **If you have contact with children** or are likely to resume contact, the CPA must ensure that implications for the child are taken into account. If this is something that worries or concerns you please speak with your care coordinator, Advocate or someone else that you feel comfortable with.

• **There are targets that apply to CPA.** These include every person having a copy of their care plan, care plans being available to appropriate staff 24 hours a day, people on CPA being seen within 7 days of discharge from hospital and the availability of care plans for carers.

• **Your care plan should arise from a complete assessment** of your needs, strengths, problems and any risks, based on your account, information from your carers and others as appropriate.

• You should have discussed **crisis and contingency plans and relapse indicators, warning signs and risk issues** and these should be documented. If there have been changes, talk with your care coordinator to update the care plan.

• The care plan is **based on the principles of personalised care, recovery and social inclusion**. It will describe the role you have in becoming or staying well. If you do not feel that your care plan does this or it is unclear, talk with your care coordinator, Advocate or someone else in the team you feel comfortable with to make the necessary changes.

• **Your carer’s needs should be assessed** and a plan made if needed to address issues (Carers Assessment). If your carer is unaware of this ask them to talk with your care coordinator.

• **You must be supported in making informed decisions** on core principles for promoting choice such as Direct Payments, Statements of Wishes and Advanced Decisions.
Care Programme Approach (CPA)

What to expect from your care coordinator

At the CPA Review

- **Arranges CPA reviews** within the specified time scales (if you are an in-patient, reviews will be coordinated by your primary nurse)
- Identifies and **invites appropriate attendees**
- **Ensures attendees are introduced** to you and their roles explained
- Ensures **information about progress** of the care plan is presented
- **Records** all discussion, comments and disagreement within the meeting
- **Updates the care plan** in light of the review meeting
- **Ensures that all attendees receive a copy** of the updated care plan

In general

- **Is the main point of contact** for you, your carer or Advocate
- **Has an up to date knowledge** of your care needs and any issues of risk.
- **Keeps a record** of the care planning process
- **Is aware of and always takes account of your wishes**
- **Considers the best interest of any children** with whom you may be in contact.
- **Maintains close contact** with you and your carers
- **Coordinates the involvement of other professionals** and updates them as necessary on your progress
- **Understands and responds to your needs** taking account of your cultural and family context, ethnic background of sexual orientation
- **Coordinates care planning** whilst working collaboratively with you and your carers
- **Helps you access services**
- **Plans for their own absence** by ensuring that a named professional provides cover and updates the care plan and crisis and contingency plans
Regarding the Care Plan

- **Ensures that you have a copy** of your care plan
- Ensures that your care plan has been **negotiated with you** and that there is an ongoing discussion about the care plan
- Ensures that **implementation of the care plan** is progressing between review meetings
- Asks you to **sign a printed copy of the care plan**
- **Returns the signed copy to you** and puts another copy in the team file.
- Records alongside any proposed action, any **views you have that are different from the plan**