

Trust-wide Care Programme Approach (CPA) Policy

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Version Control Summary

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1.0	14 December 2016	Trust Social Care Lead	Final	A revised Trust-wide CPA Policy was required in conjunction with the New CPA Process approved by the Service Delivery Board on the 14 December 2016. This policy replaces the Trust-wide Care Programme Approach Policy (Version 4.1 15/4/15)
1.1	22 March 2017	Trust Social Care Lead	Final	A re-formatted version of the revised Trust-wide CPA Policy submitted for approval by the Trust's Quality Committee.
1,2		Trust Social Care Lead	Final	A revised version of the Trust wide CPA Policy (April 2017) - submitted for approval by the Trust's Quality Committee.
1.3				Extended via chairs action

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1 Introduction

1.1 This document sets out the policy governing the operation of the Care Programme Approach (CPA) within East London NHS Foundation Trust (ELFT). This policy supersedes existing CPA policies within the Trust.

1.2 This policy is based on the following principles:

- All CPA Planning and documentation should be done in collaboration with service users, focusing on strengths and ability.
- Be based on principles of recovery, social inclusion and participation
- Supports the Care Act (2014) principle of wellbeing and the eligibility outcomes set out in the Care and Support (Eligibility Criteria) Regulations 2014
- Ensuring effective partnership with relatives, carers, advocates, and statutory and third sector agencies.
- Recognises the role of carers, children and parents and their support needs.
- Be based on integration of health and social services (or alternate local configuration of health and social services delivering holistic care).
- Includes positive risk assessment, contingency and crisis planning.

2 Purpose and Scope of the Policy

2.1 This policy will describe how the Care Programme Approach is to operate in East London NHS Foundation Trust.

2.2 The process is based upon a Care Act compliant mental health assessment which promotes service user-led, recovery focused care. The mental health assessment is an holistic, health and social care assessment which will result in a recovery plan and safety plan.

3 Roles and Responsibilities

3.1 Chief Medical Officer

The Medical Director undertakes the role of Trust Executive Lead for the Care Programme Approach (CPA).

3.2 Service Directors

To ensure all teams operate the revised CPA in a way which delivers optimum care for service users.

3.3 All Clinicians

All clinicians working for the Trust will use the process of CPA to underpin all care delivered by the Trust. Therefore all service users should be assessed to establish whether they fall within the criteria for CPA. Service users who do not meet the criteria for CPA should still have access to recovery plans and regular review; however it will usually be a less detailed plan. This should cover how the Trust will work with the service user, who is the main person to contact in the Trust, how to contact them and who to contact in an emergency along with consideration of risk assessment, contingency and crisis issues.

3.4 Care Coordinators

To coordinate the on-going assessment of the service users mental and physical health, needs and risk, and respond accordingly.

To ensure service users and carers are central in planning and agreeing the care plan. To consider any Advance Directives the service user may have made.

To ensure that the care plan is regularly reviewed.

In collaboration with the service user, identify who attends the CPA review Meetings and seek consent from the service user about who can be invited, ensure that invites are sent out to attendees who chair the meeting, who presents information about progress at reviews and decides what is discussed.

To act as a reference point for other professionals, relatives, carers and advocates.

To maintain contact with the service user wherever they are e.g. in hospital. To ensure dynamic risk assessment is undertaken and a crisis, relapse and contingency plan is established.

To record the assessment of the service users' needs, My Recovery Care Plan, risk assessment and My Safety Plan including changes, decisions and goals on RiO, using DIALOG+ and the other appropriate RiO screens and templates.

The Care Coordinator needs to also ensure that the service users' needs assessment and any care and support plan put in place to meet those needs are also recorded, as necessary, on the relevant Local Authority's electronic information system

Care coordinators should ensure consistency in care during planned or unplanned absence by ensuring that there is a clear handover for the person covering (where possible), recovery plan / safety plan information is up to date and accessible on RiO. Arrange reviews for service users unless they are on an acute mental health ward, where the Primary Nurse will take responsibility.

A change of care coordinator must be agreed and the rationale recorded in the service user's progress notes. The service user must also be informed, preferably well in advance and wherever possible, a handover period agreed to allow the service user to get to know their new care-coordinator

3.5 Team Managers/Operational Leads

To ensure all service users receiving care through their service are assessed to establish whether they meet the criteria for CPA. To ensure all service users who meet the criteria for CPA are allocated an appropriate care coordinator. To ensure service users under the care of their team are appropriately and regularly reviewed. To monitor training and support for care coordinators. To monitor the quality of care plans and CPA process for care coordinators in their team.

3.6 Responsible Consultant Psychiatrist

A Consultant Psychiatrist may be consulted by a Care Coordinator in relation to the care delivered to the service user. The Consultant Psychiatrist may not, however, be clinically responsible for all decisions taken by the Care Coordinator. Decisions regarding changing CPA level must be made with the Consultant Psychiatrist's agreement. Overall responsibility for physical healthcare will remain with the service user's GP.

4 Legal Framework

4.1 The Care Programme Approach is guidance not statute, and the Trust must work in accordance with the legislation relevant to mental health services. Relevant legislation and guidance includes:

- Mental Health Act (1983/2007) – <https://www.legislation.gov.uk/ukpga/2007/12/contents>
- Refocusing the CPA: Policy and Positive Practice Guidance (2008) – https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf
- Mental Capacity Act (2005) – <https://www.legislation.gov.uk/ukpga/2005/9/contents>
- Human Rights Act (1998) – <https://www.legislation.gov.uk/ukpga/1998/42/contents>
- Data Protection Act (1998) – <https://www.legislation.gov.uk/ukpga/1998/29/contents>
- Children Act (1989) – <https://www.legislation.gov.uk/ukpga/1989/41/contents>
- Care Act (2014) – <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

- Equality Act (2010) – <https://www.legislation.gov.uk/ukpga/2010/15/contents>

5 Categories of CPA

5.1 The Best Practice Guidelines for CPA (2008) removed the category of standard CPA, so now service users will either be under CPA or non-CPA. However regardless of whether a service user is on CPA or non-CPA, the key principles guiding the care they receive from the Trust, continue to be:

- Every person, accepted for assessment should receive a thorough, holistic and comprehensive assessment of their health and social care needs which is compliant with the Care Act (2014) and consideration needs to be given to whether or not there may be social care responsibilities to meet identified needs.
- The assessment should include an accurate diagnosis using ICD10 coding, and cluster.
- The assessment should include assessments of risk, crisis and contingency.
- The assessment should address (and assess and record if appropriate) any capacity issues.
- The development of a recovery care plan, in collaboration with the service user and carer which sets out how these needs will be met and by whom. It should promote recovery, social inclusion and choice.
- The recovery plan should be written in accessible and clear language that the service user understands (including translation and large font where needed).
- There should be regular reviews at agreed intervals, or sooner where needed.
- The recovery plan should be given in writing to the service user
- Service users and clinicians are encouraged to review and if necessary update the recovery plan at every contact and not simply at a formal review.

5.2 CPA

Some service users have complex needs which requires being on CPA. The guiding principles for a service user requiring CPA are those with complex characteristics whose needs are met from a number of services or who are most at risk and who need a higher level of engagement, co-ordination and support. Some clients should default to CPA because of parenting or significant caring responsibilities, unless a thorough assessment indicates otherwise, and those reasons should be clearly documented.

Wherever possible, the aim should be to support a move from CPA to non-CPA and back to primary care in line with the Trust's commitment to recovery principles.

5.3 Criteria for a Service User being on CPA may include:

- Severe mental disorder with high degree of clinical complexity
- Current or potential risk(s) to self or others (including history of offending)

- Relapse history requiring urgent response
- Self-neglect/non concordance with treatment plan
- Vulnerability / safeguarding concerns
- Financial (or other social) difficulties related to mental illness, including experiencing disadvantage as a result of this
- Disinhibition
- Child protection issues
- Current (or significant history of) significant distress/instability or disengagement
- Co-morbidity such substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies
- Currently or recently detained under Mental Health Act (including CTOs and Guardianship) or referred to crisis services
- Own significant caring responsibilities
- Significant impairment of function due to mental illness
- Ethnicity, sexuality or gender issues.

5.4 Non-CPA Service Users

Service users require care and support from secondary care specialist mental health services, but do not meet the characteristics outlined above that would instigate care under the formal CPA process. This is usually a service user with straightforward mental health needs who requires single agency support and with an appropriate named Health Care Professional (HCP) facilitating their care.

The named HCP is responsible for overseeing the care provided by the secondary mental health service and ensuring that the process of assessment, care planning and review is done in collaboration with the service user (and carer where appropriate).

The HCP is responsible for identifying any carers involved and ensuring they are aware of their own right to an assessment of need.

The HCP will liaise as necessary with others involved in the service user's care as well as ensure that transfer of care, in the event of any transfer of responsibility to another healthcare professional, or social services professional either within or outside of the Trust, is agreed and that all relevant information transferred is appropriate and timely.

6 Completing the Assessment (including risk)

6.1 When a service user has been accepted by any professional within secondary mental health services, the professional involved must, in collaboration with the service user, complete an assessment of need and risk. The outcome of this assessment should be shared with the referrer, other team members, and the service user (and carer if appropriate).

There may be a legal duty under to share the outcome of the assessment with the Carer, if needs are to be met by them in line with Section 13 of the Care Act (2014).

This assessment should, in line with the Care Act (2014) include strengths and needs in the following areas:

- Mental state and behaviour
- Past psychiatric history
- Medication, side effects and compliance
- Substance misuse
- Physical health
- Personal function and self-care
- Social function and family relationships including:
 - Child care and parenting issues
 - Carer issues including young and older adult carers
 - Managing and maintaining nutrition
 - Personal hygiene needs
 - Toileting requirements
 - Dressing
 - Safety issues and safeguarding
 - Keeping home clean and safe
- Relationships
- Employment, volunteering and learning
- Accessing local community
- Financial circumstances
- Accommodation
- Daytime activity (including employment, training, education)
- Degree of risk and dangerousness and safeguarding of children and adults
- Identification of any precipitating factors to breakdown

6.2 These themes can be explored and assessed under the following DIALOG+ domains :

- How satisfied are you with your mental health?
- How satisfied are you with your physical health?
- How satisfied are you with your job situation?
- How satisfied are you with your accommodation?
- How satisfied are you with your leisure activities?
- How satisfied are you with your relationship with your partner/family?

- How satisfied are you with your friendships?
- How satisfied are you with your personal safety?
- How satisfied are you with your medication?
- How satisfied are you with the practical help you receive?
- How satisfied are you with your meetings with mental health professionals?
- How satisfied are you with your expression of identity (including religious, cultural, spiritual, and gender identity?)
- How satisfied are you with your finances?
- How satisfied are you with your substance / alcohol use?

The DIALOG+ Domains also align with the specified outcomes under the Care Act (2014). Consequently the DIALOG+ Assessment Tool can be used to determine whether or not there may be a social care responsibility to meet any of the identified needs.

When determining whether or not there are many eligible Social Care needs the HCP completing the assessment must consider whether:

- The Adults needs arise from or are related to a physical or mental impairment or illness
- As a result of the adults needs the adult is unable to achieve two or more of the specified outcomes
- As a consequence of being unable to achieve these outcomes there is or is likely to be a significant impact on the Adults wellbeing.

An adult is only eligible where they meet all three of these conditions

The outcomes specified under the Care Act (2014) and listed in the Care and Support (Eligibility Criteria) Regulations 2014 are as follows:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of home safely
- Maintaining habitable home environment
- Developing and maintaining family and other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community including public transport and recreational services
- Carrying out any caring responsibilities the Adult has for a child

6.3 Further specialist assessment by members of the multi-disciplinary team (MDT) should then be arranged, as required.

- 6.4 If there are other members of the MDT involved in the assessment, it is good practice to hold an assessment meeting to discuss the findings. If it is decided that the service user fulfils the criteria for CPA, the selection of an appropriate Care Coordinator must be considered.

7 My Recovery Plan

- 7.1 The plan includes sections to help the service user think about how they can meet personal goals and stay well. It is also an opportunity, to let others (professionals, friends, family etc.) know how to best support the service user and what matters most to the service user. The recovery plan should be about the service user's own ideas and experiences, and the mental health professional should support the service user to develop their plan as far as possible. The recovery plan can be shared with others such as carers, friends or relatives and these people will be listed on the recovery plan. The Trust Permission to Share Information form should also have been completed and will outline any restrictions around information sharing.

8 My Safety Plan

- 8.1 Assessing Risk, Capacity and the ability of Service Users to Protect Themselves

When considering an assessment of risk please refer to the ELFT Clinical Risk Assessment and Management Policy

(<https://www.elft.nhs.uk/uploads/files/1/Clinical%20Risk%20Assessment%20and%20Management%20Policy%205.0.pdf>)

Decisions involving clinical risk always involve balancing the health and safety of service users and others with service users' quality of life, their personal growth and their right to exercise choice and autonomy in the care they receive.

- 8.2 Service users assessed at any point in their contact with mental health services should have some form of risk assessment undertaken as part of their initial and subsequent assessments of health and social care need. Clear recording of risk assessment is essential to minimise risk and identify strengths.
- 8.3 Collaboration with the service user and those involved in the service user's care should be intrinsic to the risk management process.
- 8.4 Risks are not static and therefore require regular review and assessment in response to the service user's changing presentation and circumstances.
- 8.5 Risk information should be gathered from a wide range of sources, including and should be evaluated for its quality and relevance to the risk management process.
- Assessment of risk to self, others and of self-neglect, requires a high quality of history taking, sharing of information between services and tracking down key past clinical information, which may indicate future potential risks.
 - Consideration of risk to a child if the service user is responsible for or in contact with children.

- Where risk concerns are identified consideration must be given as to whether procedures for protecting children, adults at risk and the public should be triggered.
Please refer to relevant guidance:
 - Local Authority and Trust MAPPA guidance
[https://www.elft.nhs.uk/uploads/files/1/Policies%20-%20Alisha/ELFT%20MAPPA%20policy%202019%20draft%20\(2\)%20to%20upload.pdf](https://www.elft.nhs.uk/uploads/files/1/Policies%20-%20Alisha/ELFT%20MAPPA%20policy%202019%20draft%20(2)%20to%20upload.pdf)
 - MARAC guidance
<https://bswccg.nhs.uk/for-clinicians/safeguarding/adult-safeguarding/235-toolkit-for-multi-agency-risk-assessment-conference-domestic-violence/file>
 - Safeguarding adult guidance
<https://www.elft.nhs.uk/uploads/files/1/Communications/16.04.2020%20Safeguarding%20Adults%20Policy%20Quality%20Committee%20version%20-%20Final.pdf>
 - Safeguarding children guidance
<https://www.elft.nhs.uk/About-Us/Freedom-of-Information/Trust-Policies-and-Procedures/Safeguarding-Children-Policies>
- The period around hospital discharge following an admission for mental health needs is a time of particularly high risk of suicide. Therefore the need for proper assessment prior to discharge and effective follow-up afterwards is essential. Service users must be seen within 7 days of discharge.
- Key clinical indicators for assessment of risk of violence could include:
 - Previous history of violence/documentated incidents.
 - Problems of control of temper.
 - Alcohol and drug misuse associated with violence, or offending.
 - Domestic violence.
 - History of child abuse.
 - Poor concordance/relapse and associated factors relating to violence.
 - Poor engagement with services.
 - History of unsettled accommodation/frequent moves.
 - Altercations with the police.
 - Key relationships, which might present risks to the service user.
 - Key relationships where another person might be considered at risk, e.g. a carer experiencing carer stress or a child.
 - Key mental state indicators, with particular reference to hallucinatory voices which might be encouraging violent action or persecutory beliefs, particularly associated with increasingly unpredictable behaviour.
 - Recent changes in mental state and a reduced ability to engage in services as a result.

9 Involving/Supporting others and sharing information

- 9.1 Service users have a right to confidentiality, underpinned by the Data Protection Act (1998). This is clarified in the Trust Information Governance & IMT Policy) <https://www.elft.nhs.uk/uploads/files/1/Information%20Governance%20and%20IMT%20Security%20Policy%205.8.pdf>
- 9.2 The presumption made throughout this policy is that of:
- Full disclosure of relevant clinical information to Trust professionals directly involved in a service user's care;
 - Disclosure to relevant professionals in other organisations with which the Trust has an information sharing agreement; and
 - Disclosure is justified for the safety of the service user or others. This must be fully explained to the service user by the care coordinator
<https://www.elft.nhs.uk/About-Us/Freedom-of-Information/Trust-Policies-and-Procedures/Information-Governance-Policies>
- 9.3 The care coordinator should complete the Additional Personal Information section on RiO. Any objections raised by the service user regarding information sharing must be recorded on this form and observed in line with Data Protection guidance. Note that Data Protection guidance permits the sharing of information without consent for health and social care purposes under GDPR 9(2)(h)
- 9.4 If information may need to be shared and the service user has not consented please refer to the Trust Principles for Sharing Information
<https://www.elft.nhs.uk/About-Us/Privacy-and-Your-Data>
and adhere to the Caldicott principles, namely:
- Principle 1 – Justify the purpose for using confidential information.
 - Principle 2 – Only use it when absolutely necessary.
 - Principle 3 – Use the minimum necessary confidential information
 - Principle 4 – Access should be on a strict need to know basis.
 - Principle 5 – Everyone with access to confidential information should be aware of their responsibilities.
 - Principle 6 – Understand and comply with the law.
- Principle 7 - The duty to share information for individual care is as important as the duty to protect patient confidentiality
- Principle 8 - Inform patients and service users about how their confidential information is used

Staff should also have knowledge regards to Section 133 of the Mental Health Act concerning the duty to give information to nearest relatives, and when a service user may restrict information sharing.

- 9.5 All letters written by Trust professionals to other professionals within or outside the Trust, for example a GP, should be copied to the service user except where: the letter contains personal data that would reveal information that relates to and identifies another person, unless the person has consented to the disclosure, or can be fully anonymised in the letter, or it is reasonable to provide the information without consent.

10 Refusal to Maintain Contact with Services

10.1 This is when a service user subject to CPA whose whereabouts and physical wellbeing is known and who has made it clear that they refuse to have contact with services or engage with the Care Coordinator, despite their best endeavours having been made to try and contact and engage with them.

10.2 Where there is a refusal of engagement, there must be a timely discussion within the Multi-Disciplinary Team (MDT) and with the GP. Consideration should be given to the risks that the service user presents to him/herself (including risks of self-neglect), or others. And appropriate action taken.

Please note: There is a duty under section 11(2) of the Care Act (2014) to continue to assess even with capacitated refusal of services if the person is in need of care and support and at risk of abuse and neglect.

10.3 Where there are serious concerns, consideration should be given to conducting a Mental Health Act assessment if indicated.

10.4 Where there are serious concerns regarding the safety of children, family members or the public, consideration should be made as to whether the police should be informed of the situation including via MAPPA or MARAC processes / Children's or Adult safeguarding referral.

10.5 An action plan is required in all cases of refusal to maintain contact following discussion within the team and where appropriate family members and carers. The action plan should be clearly documented on RiO (in progress notes, correspondence to the GP and RiO risk assessment and management). This action plan is likely to include the following elements:

- A documented multi-disciplinary review should take place following attempts to engage the service user in services. Timescales around this will depend on the strengths and risks involved in each case.
- Prior to this review there should be a consultation of people involved in the service user's care and support, which might include mental health team members, GP, carer/family members and other relevant agencies as appropriate e.g. housing officer, third sector agency.
- A team decision on the minimum type of contact with the service user, for example, an attempt to visit, an offer of outpatient appointments once every three months, or support/monitoring via a third party such as a housing support worker will need to be agreed, documented and shared as appropriate.

10.6 Exceptionally service users may be discharged from CPA when there has been no contact for a period of time deemed by the multi-disciplinary team to be appropriate based on the safety plan and potential risks. This step should be fully discussed within the MDT and documented on RiO. The named HCP should ensure that the GP and carers are aware of this decision.

11 Loss of Contact with Services

11.1 If it becomes clear that contact with a service user has been lost, a meeting should be held by the MDT to discuss a new contingency plan. Every effort should be made to make contact with him/her, either directly, through the GP or family, if appropriate. Consideration should be given to contacting local A&E departments and other community services, and the police, if the person is felt to be a risk of harm to themselves or others. The care coordinator should take responsibility for co-ordinating this.

11.2 The MDT will decide the extent to which resources should be directed towards re-establishing contact, based on factors such as clinical complexity, risk and alternative support as well as the timescales involved. A decision to discharge should only be made after extensive discussions by the MDT and documented in the clinical notes.

11.3 For service users who are liable to compulsory powers under the Mental Health Act, account must be taken of the provisions of the Act. For those service users subject to Restriction Orders under the Mental Health Act (sections 41, 44, 45A or 49), or those that have been conditionally discharged from such Restriction Orders, decisions can only be made following discussion with the relevant case worker at the Ministry of Justice. Advice should also be sought from the local Mental Health Act Administration office and Local Authority solicitor.

12 Changes to CPA

12.1 Moving between CPA levels

Every formal CPA review meeting should consider whether the support provided by the CPA framework needs to be considered. In line with recovery principles, service users where possible, should be supported to move towards non-CPA.

12.2 A decision to move service users on CPA to non-CPA should be made after careful consideration at a CPA review meeting and the reasons why, recorded in the revised recovery plan and on RiO. The CPA must be attended by relevant members of the MDT and information about the decision shared with all relevant professionals and family members (subject to consent by the service user to share this information)

12.3 For service users on non-CPA, a decision to move on to CPA should be made by the MDT, after discussion with the service user and named HCP who had been involved in the treatment of the service user whilst on non-CPA.

12.4 Any service user who is admitted to a mental health inpatient setting, regardless of whether they were under CPA or not prior to admission, and is assessed as requiring inpatient care should be placed under CPA during the admission and a discharge CPA Meeting held with the representation from the relevant Community Team meeting held prior to discharge. Inpatient CPA, discharge planning and post discharge follow-up arrangements should be in accordance with the Trust Admission & Discharge Policy.

<https://www.elft.nhs.uk/uploads/files/1/Policies%20and%20Procedures/Clinical%20Policies/Admission,%20Transfer%20and%20Discharge%20final%20version%2011.pdf>

12.5 Transfer of responsibility for care

For all service users under CPA, all decisions regarding transfer to another team or service within the Trust, must be made at a formal CPA review, with the full involvement of the service user and explanation of the implications of the transfer. For seamless transfer from tertiary services to secondary care services, the locality team should allocate a care coordinator as early as possible before discharge. When a transfer of care co-ordination responsibility occurs within a team, the new care coordinator will inform the members of the MDT.

12.6 For CAMHS service users approaching eighteen years of age and identified as meeting the criteria for CPA, the transfer process would usually start six months before his/her eighteenth birthday and the transfer meeting should usually be arranged by the CAMHS team approximately one month before the young person's eighteenth birthday. However, this process should be initiated at least six months before the eighteenth birthday. For those CAMHS service users approaching eighteen and identified as not meeting the criteria for CPA, the Adult CMHT will advise the CAMHS team of the appropriate consultant in Adult Psychiatry for onward referral where needed.

- 12.7 The accepting Adult Mental Health Team should also refer to Section 58 of the Care Act (2014) which sets out the assessment duty in relation to a child.
- 12.8 Transfer of care between Adult Mental Health Services for people of working age and Mental Health Care of Older People should involve discussion between the Adult and Older Adult Consultant Psychiatrists to agree the need for transfer.
- 12.9 Prior to the transfer, the current care coordinator must ensure that the following have been agreed:
- The receiving team/service has identified a new care coordinator.
 - Appropriate services have been put into place by the receiving team to meet the service user's needs, before the transfer takes place.
 - Effective communication has taken place and detailed information has been given to the receiving team/service.
- 12.10 For service users being transferred outside of the Trust, the referring team will retain responsibility for providing and co-ordinating their care until the transfer has been agreed and completed.

13 Discharge from CPA

- 13.1 At every CPA review meeting the care coordinator should consider the need for CPA. If the multi-disciplinary team agrees that CPA is no longer necessary then a conversation about this should take place with the service user and arrangements will be made for discharge.
- 13.2 A service user should not be discharged from CPA simply because his/her mental health appears stable. This may be, at least in part, the benefit of the extra support that CPA provides
- 13.3 A service user's discharge could mean stepping down to non-CPA and being seen in outpatient clinic or it could mean discharge from secondary mental health services altogether and being referred back to primary care or Enhanced Primary Care.
- 13.4 Prior to any decision being agreed about discharge from CPA, the care coordinator should do a thorough risk assessment. Discussions about possible discharge should also be reflected in DIALOG+. Consideration should also be given to whether or not the service user continues to have eligible social care needs, under the care Act (2014). If this is the case then arrangements need to be put in place to ensure these needs continue to be appropriately met.
- 13.5 Once an agreement has been made to discharge the service user from CPA, and the up to date risk assessment completed, there should be a discharge CPA. This will include a recovery plan outlining the arrangements for any future support. An updated safety plan will need to reflect crisis and contingency arrangements including who to contact once the care coordinator is no longer involved.
- 13.6 The GP must be informed of the discharge and any other agencies / individuals who are involved in future care (in line with the service user's wishes around permission to share information).

14 Section 117 Aftercare

14.1 Section 117 Aftercare may apply to service users who have been detained under any of the following sections of the Mental Health Act - 3, 37, 45A, 47 and 48.

14.2 The statutory definition of what s117 aftercare services encompass states that, this means services which have both of the following purposes:

- Meeting a need arising from or related to the person's mental disorder; and
- Reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)."

14.3 The Care Act (2014) lists general duties relevant to s117 aftercare, including:

- s1 promoting individual well-being
- s2 preventing needs for care and support
- s3 promoting the integration of care and support with health services

14.4 Case law regarding s117 aftercare, has clarified that aftercare "would normally include social work, support in helping with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities." (Clunis v Camden and Islington Health Authority (1998) 1 CCLR) and "psychiatric treatment" is also considered aftercare (R. v Manchester City Council Ex p. Stennett [2002] UKHL 34)

14.5 The Trust's Mental Health Act 117 Policy

<https://www.elft.nhs.uk/uploads/files/1/Section%20117%20Policy%202.3.pdf>

clearly sets out the legal duty to provide aftercare services for certain service users. See also the ADASS Protocol & Principles for Aftercare Services under Section 117:

<https://londonadass.org.uk/wp-content/uploads/2018/01/Section-117-Protocol-reviewed-Dec-2018.pdf>

S117 eligibility should be reviewed at the CPA review meeting. The review should specifically consider whether the service user continues to have a need for aftercare. If there continue to be needs which should be met under Section 117 aftercare then, it needs to be made clear which elements of the care plan form part of the duty under section 117 aftercare and whether or not there are other social care elements of the care plan, not covered by Section 117 aftercare (which may therefore potentially incur charges). If the Local Authority and Clinical Commissioning Group jointly decide that the service user no longer requires after-care under section 117, the local Mental Health Law office should be advised so they can amend the Section 117 register.

15 Review of the need for compulsory powers at CPA (CTO, conditionally discharged patients, Guardianship orders, DoLS)

- 15.1 Service users subject to compulsory powers in relation to their mental health, such as a CTO, Guardianship order, DoLS or conditional discharge such as s37/41 must have these powers reviewed regularly.
- 15.2 The CPA review is a good opportunity to review these powers and reflect any discussion in DIALOG+.

Service users should be provided with accessible information about any compulsory power(s) they are subject to, and any right to recourse. Information leaflets about the Mental Health Act can be accessed here: <https://www.elft.nhs.uk/Professionals/Mental-Health-Act-Leaflets>

Care coordinators should encourage discussions with advocates such as IMHAs and IMCAs, who can also attend the CPA review meeting with the service user's consent. Reports sent to the Ministry of Justice should reflect CPA discussions around compulsory powers.

16 RiO CPA and Dialog+ processes

The Trust has developed a suite of new CPA Documentation in RiO for use when receiving external referrals, completing an assessment of need, developing and reviewing a care plan and communicating with external referrers such as GPs.

Where to find the new CPA documentation, how to use it and who should complete it is set out in the "CPA Operational Guidance" which is appended to this policy (Appendix 3).