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REVIEW OF THE CARE PROGRAMME APPROACH IN WALES 2009

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The Care Programme Approach (CPA)

Key Message

Within Wales the Care Programme Approach (CPA) is regarded as the cornerstone of the Government's mental health policy. It was introduced in 2004 and is the framework for the care of people with mental health problems who are accepted as clients by mental health services either in an inpatient or community setting.

All NHS Trusts in Wales participated in this review and all had processes in place to deliver CPA. Appreciating that the review sample was small, many of the findings were consistent across all the organisations and demonstrated that CPA had not been implemented effectively. If this randomly selected review sample is representative of all mental health services in Wales, there is a high risk that services are failing clients and carers because of inadequate risk management processes, a lack of focus on the outcome of patient interventions, and a lack of service planning and service models to safely and adequately meet client's needs.

Greater focus is needed on the assessment and management of risk. Practitioners need to be prepared and trained to fulfil the role of care co-ordinator. Information systems need to meet client need rather than organisational priorities. The current system is overly complex and too bureaucratic particularly where CPA and Unified Assessment (UA) have been integrated as a single process. A record management system needs to be developed that supports CPA and UA whilst providing the least administrative burden for clinicians and practitioners.

EXECUTIVE SUMMARY

In 2008, following concerns raised centrally about the implementation of CPA in Wales a high level review of the CPA was requested by the Chief Executive of the NHS in Wales and Head of the Department for Health and Social Services. The review was completed and a report published in October 2008. This review is referred to as the 2008 CPA review throughout this report. At the same time as the 2008 CPA review was published the findings of a homicide inquiry that occurred in North Wales in 2006 were made public. Consequently, during the media briefing the Chief Executive of the NHS in Wales and Head of the Department for Health and Social Services formally stated that there would be an "All Wales" review of CPA. The findings of the 2008 CPA review and this subsequent 2009 CPA review echo those of the recent Health Inspectorate Wales (HIW) **(1&3)** homicide investigations, particularly in relation to risk assessment and risk management.

With the exception of the three organisations who participated in the 2008 CPA review, all health organisations providing Adult Mental Health Services participated in the 2009 CPA review. 253 client's notes/records were audited and semi-structured interviews were conducted with 106 CPA care co-ordinators. The review methodology and sample size was influenced by the time available to complete the work and the need to ensure parity with the first review. The areas covered by the review of CPA related to the care planning process, care co-ordination and caseload management, management of risk, transfer of care arrangements, management of unmet need and the systems established to support the implementation of CPA.

The key findings of the Review reflect concerns in the following areas:

- Risk Assessment
- Care planning
- Unmet need and service planning
- Training
- Information requirements (including targets) and systems
- Transfer of care arrangements
- Leadership

Effective coordination of a person's care includes a comprehensive needs assessment, risk assessment and risk management plan, crisis planning and management, outcome focused care planning and a review process. These functions are regarded as the cornerstone of an effective CPA process. Although these elements could be evidenced in part, a number of shortcomings were identified. Care plans were neither goal orientated nor focussed on the outcome of interventions. Risk assessments were absent in 14% of the case notes audited, and in 26% of cases the risk assessment had not been reviewed in the last year. One team achieved a compliance rating of 100% whilst in others it was as low as 45%. Care plans address the findings of a risk assessment in only 34% of cases. It was noted in one health community that risk assessments were an integral part of the care plan and this was considered to be an example of good practice that could be shared.

Care plans rarely identified physical health needs or promoted physical well-being. Although crisis and contingency plans were in place, in the majority of case notes these were not considered comprehensive. Care plans did not reflect a recovery model of service intervention and they appeared to be focused on maintenance of condition rather than recovery, with limited outcomes evident for clients. There was little evidence that unmet needs were identified or responded to which inevitably impacts on service planning and service delivery.

In general, all members of the Community Mental Health Team (CMHT) act as the care co-ordinator although in the majority of cases this will be either a Community Psychiatric Nurse (CPN) or a social worker (SW). Psychiatrists and Psychologists will act as a care co-ordinator when a client is receiving a specific single intervention from them, usually within outpatient clinics. The picture for Occupational Therapists (OTs) is mixed with some co-ordinating a range of clients and others acting as associate referrers to the care plan. Psychiatrists and Psychologists rarely complete CPA documentation and Psychologist records were often kept separately from the main client records.

Given the skill mix within the teams and the working methods of some practitioner's i.e. out patient sessions and prescribed therapeutic interventions, consideration needs to be given to whether the care co-ordinator role is appropriate to be undertaken by certain specialists.

To fulfil the role of care co-ordinator requires preparation and on going training. Whilst care co-ordinators received initial training in the CPA process there was no evidence that training was in place in relation to care co-ordination. It was evident that further training was needed in risk assessment and risk management, and in developing outcome focussed care plans. Of immediate concern was the lack of preparation, other than via informal mentoring, for new starters and locums on all aspects of CPA. In the event of an adverse incident occurring, organisations are potentially exposed to a high level of risk.

It was also evident that care co-ordinators provided most interventions rather than making associate referrals to other services or delegating to others. This usually occurred when local services were not available or where there would otherwise be a delay to the implementation of the care plan.

Timely communications with the General Practitioner (GP) are crucial for the successful management of clients in the community. It was difficult to evidence whether GPs were kept fully informed about the ongoing arrangements for the client. The current electronic systems make it difficult for care co-ordinators to achieve the target of notifying the GP and service users within 7 days.

The majority of care co-ordinators received managerial supervision. However, this supervision needs to encompass more robust discussions, particularly relating to outcome focused care planning, risk management and caseload management.

Generally, the transfers of care arrangements between organisations are less than optimal and need strengthening. CMHTs should have common eligibility criteria for CPA to facilitate transfer of care arrangements at least within Wales. The management of "Out of Area" placements needs further investigation and review to ensure the smooth transition of the most vulnerable and high-risk clients. A standard process for CPA including the use of common documentation across Wales, would support information

exchange, transfer of care arrangements and benchmarking. An “All Wales” Transfer of Care policy needs further urgent consideration.

The current information management arrangements do not effectively support the delivery of care. IT systems do not support the client/professional interface and are seen by practitioners as cumbersome and bureaucratic. Significantly, care co-ordinators report that IT systems and associated processes reduce the time available to spend with clients. A common all Wales IT system that meets the need of health and social care would have many advantages for clients, practitioners and managers enabling better integrated care arrangements. This is not however, a pre-requisite for improvement. In most areas health and social care services operated separate systems. In one health economy, four different systems were used and none of these systems enabled electronic information sharing. It was not unusual for social work colleagues to be unable to access health records and similarly for health staff to be unable to access social services records. This is problematic during times of crisis and out of hours when client information is required promptly. Information sharing protocols need to be implemented as soon as possible in advance of an IT solution being developed.

Technological solutions for rural practitioners are needed to ensure timely and accurate record management and improved communication, particularly at times of crisis. The implementation of any IT system will need careful planning and a proper training plan if benefits are to be realised for patients and organisations.

Practitioners spend a significant amount of time collecting information to report against both the Local Authority (LA) and Trust’s performance indicators. Health and Social Care agencies do not work to common targets for the implementation of CPA. Practitioners work in multi-disciplinary and multi-agency teams, consideration of common targets is therefore needed.

The case mix in Community Mental Health Services is reported to be changing. There is evidence that there is an increase in the number of clients presenting with multiple morbidity i.e. a mental health and a substance misuse problem and there is evidence of an increase in the numbers of people presenting with a personality disorder. In 39% of records audited, clients had a co-morbidity of a mental health and substance misuse problem. When considering the care plans for these individuals, there was little evidence that these dual needs were being properly addressed.

Care co-ordinators identified a cluster of clients on their caseload that fell between primary and secondary care. The infrastructure was not available in primary and community care to support these clients. As a consequence, there is a reluctance to discharge clients from CPA as local service models are not viewed as comprehensive. Discharge from secondary care has been improved in areas that have seen the integration of ‘gateway’ workers within CMHTs.

In teams where CPA is working well there was clear evidence of clinical leadership. Practitioners in those teams had a problem solving approach and found solutions even when service models were not fit for purpose.

Is some areas, UA & CPA have been integrated and in others there are two separate processes requiring different forms to be completed. This leads to duplication of information and effort when completing this documentation. In one area the integrated

UA/CPA document was 65 pages long, substantially increasing the administration time for completion at the expense of patient contact time.

In some of the records audited it was identified that the Protection of Vulnerable Adults (POVA) process should have been initiated but this had not occurred. POVA must be an integral part of practice when dealing with vulnerable service users **(3)**.

There was evidence of significant difference in the implementation of CPA across the teams visited. Feedback has been provided to each organisation to ensure a focus for the development of local actions to support the improvement for clients that will lead to the achievement of the 2009/10 Annual Operating Framework (AOF) Target 13.

RECOMMENDATIONS

The findings of the 2009 CPA Review have identified actions for the Welsh Assembly Government, the new Local Health Boards, Social Services, the DSU and NLIAH to ensure the effective implementation of CPA. It is paramount that Health and Social Services work together at all levels if there is to be sustainable change for the effective implementation of CPA. It is recommended that the following be addressed:

Risk Assessment

1 WAG to consider the findings of this report and provide central guidance for organisations on the expectations and requirements in delivering appropriate risk management processes for CPA. **(Action WAG)**

2. The introduction of a standardised approach to risk assessment that reflects best practice and meets the requirements of minimising the potential for:

- harm to others
- deliberate self harm
- suicide
- adverse risks associated with people abusing alcohol or substances
- social vulnerability **(Action LHB/LA)**

3 Ensure every client on either standard or enhanced CPA has a current risk assessment and risk management plan that responds to the identified needs and is included within the care plan. This assessment should be recorded at the time of the initial assessment and have a confirmed date for review. **(Action LHB/LA)**

4. Training to be provided on risk assessment and risk management for clinicians and practitioners that:

- reflects the requirements as identified in the recommendations 1,2 and 3 above:
- is updated in line with best practice and responds to the needs of any identified change in morbidity or case mix: and
- ensures each clinician / practitioner receive mandatory training prior to undertaking the role of care coordinator. **(Action LHB/LA**)

5. Organisations to review the application of the POVA process to ensure it is used appropriately when considering vulnerable clients at risk of exploitation/abuse **(Action LHB/LA**)

Care planning

6. Ensure all clients have a designated care co-ordinator to promote continuity of care and practice. **(Action LHB/LA)**

7. Provide training for Care Co-ordinators in outcome focussed care planning that reflects best practice, to ensure that clients' needs are responded to appropriately and in a timely manner. (**Action LHB/LA)**

8 Ensure all new staff including locums receive induction on:

- the role and requirements of the care co-ordinator
- the process for recording assessment of needs and risks
- the process for recording care plans
- the process for monitoring and evaluation of care
- the application of local information systems
- the integrated working arrangements with partner agencies.
  (Action LHB/LA)

9. Care co-ordinators should ensure that clients of mental health services have (as a minimum) an annual physical health screening assessment. This should include access to health promotion (smoking cessation, healthy eating) and screening of long-term conditions (eg.diabetes, chronic heart disease) and be recorded in the CPA care plan. **(Action LHB/LA)**

10. Introduce appropriate assessment and care coordination processes to meet the needs of people with a multiple morbidity of mental health and substance misuse, people having a mental health and physical problem and those people with a personality disorder. **(Action LHB/LA)**

11. Implement a programme of audit that reflects the requirements of the AOF Target 13 2009. **(LHB/LA)**

12 Coordinate a national review of Service User experiences on the effectiveness of CPA .**(Action WAG)**

<u>Information Requirements</u>

13. Reduce the associated bureaucracy in implementing CPA and introduce care recording processes that enable increased clinical / practitioner intervention time with clients by:

- reviewing the information requirements for the CPA and UA process with clinicians and practitioners. (Action **WAG)**
- reducing the information requirements for Standard CPA into a shorter process (**Action WAG)**
- ensuring all clinicians and practitioners receive training in the use of local information processes **(Action LHB/LA)**

14. Standardise processes between Health and Social Care reducing duplication by:

- developing either a shared information system or, as a minimum, establishing, processes that set timescales for the transfer and sharing of information
- developing and introducing a minimum data set for mental health services that includes capturing client casemix data
- introducing a standardised integrated procedure for reporting Health and Social Care Mental Health Performance.
- exploring options for managing information between Local Health Boards and Local Authorities where systems are not compatible.
  (Action WAG)

15. To integrate CPA information requirements within LHB and LA IT strategies. **(Action LHB/LA)**

16. To identify designated resources to support:

- the management of CPA information
- the collection and analysis of local LHB/ Local Authority CPA data for benchmarking and national reports

(Action LHB/LA)

Caseload Management

17. Develop and implement a policy to manage service demand which must include:

- a definition of the clinical criteria, and service response times for emergency, urgent and routine referrals.
- the process for referral with set timescales for service responses to referrers
- uses a standardised proforma which informs on a person's level of risk.
- a standardised process for the management of the waiting list.

(Action LHB/LA)

18. Introduce a process for caseload management that:

- assists Team managers and practitioners in the allocation of new referrals
- ensures practitioners are allocated cases that they are competent to care coordinate
- ensure complex cases are managed appropriately across the team
- assists Team managers and practitioners in the closure of cases.

(Action LHB/LA)

19 Undertake a review of the therapeutic skills available within the CMHT against the clinical demand on the service to:

- ensure the skills available are being used appropriately.
- plan for future CMHT service delivery assessing and responding to the workforce needs
- the training and development needs of the CMHT.

(Action LHB)

20. Develop a programme of education to enable referrers to understand and adhere to the referral process. **(Action LHB)**

Transfer of care

21. Each organisation to have in place a process that manages clients in out of area placements and informs on :

- the number of clients in out of area placements
- the management arrangements for CPA including the name of The identified local care coordinator responsible for monitoring and evaluating progress on out of area placements
- the transfer of care arrangements.
  (Action LHB/LA)

22. Provide central guidance on a standardised approach for transfer of care arrangements between organisations that confirm the accountabilities, responsibilities and timescales for client transfer for both Health and Social Care organisations. **(Action WAG)**

23. Provide central guidance on the transitional care arrangements for the following services:

- CAMHS to Adult Services with particular reference for those people who are 17 years old and not in full time education
- Learning disabilities to Adult Mental Health Services
  (**Action WAG)**

Unmet need and Service Planning

24. Each organisation to:

- have a process in place that identifies unmet health and social care needs
- have a reporting process to communicate unmet needs to the new LHB strategic boards, the equivalent local authority forum, for use in service planning and to inform on service delivery.
- provide an annual report to WAG on unmet needs and information on the plans / actions being taken to respond to these needs.
  (Action LHB/LA)

25. Implement a process whereby local health services and LA:

- are made aware of local developments in the independent and private sector (**Action WAG)**
- identify likely demands from these developments **(Action LHB/LA)**
- put in place protocols for the integrated management of clients residing within the independent and private sector **(Action LHB/LA))**

Performance Management

26. Deliver a programme of supportive interventions targeted at improving organisational performance. **(Action DSU/NLIAH)**

INTRODUCTION & BACKGROUND

CPA was introduced in Wales in 2004 to improve the delivery of care for people with severe mental illness and/or complex enduring needs **(3)**. It aims to work with those people to provide integrated services that improve the quality of life by ensuring that services are planned and co-ordinated and that resources are used effectively to best meet clients needs. The co-ordination of care requires health and local authority partners to jointly establish systems and processes to support the implementation of CPA.

In Wales, the National Service Framework for Adult Mental Health set a target for full implementation of CPA by December 2004 **(4)**. The Assembly Government signalled its commitment to CPA, as the main driver of care, by setting a Service & Financial framework Target for 2004/5 for Trusts and Local Health Boards. This was not a rolling target and is now currently monitored via scrutiny of local action plans. An AOF Target has been established for 2009/10

There are two categories of CPA: 'Standard' and 'Enhanced' and these have been described in the Policy Guidance issued in 2003 **(4)** as set out below:

Those service users covered by the Standard Care Programme Approach will be likely to:

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

Those included on the Enhanced Care Programme Approach will be service users who present with all or some of the following:

- Multiple care needs, including housing, employment etc. requiring interagency co-ordination;
- Willing to co-operate with one professional or agency, but have multiple care needs;
- May be in contact with a number of agencies (including the Criminal Justice System);
- Likely to require more frequent and intensive interventions;
- More likely to have mental health problems co-existing with other problems such as substance misuse;
- More likely to be at risk of harming themselves and/or others; and
- More likely to disengage with services.

PURPOSE OF THE REVIEW

In January 2008, (under the Chairmanship of the Director of Service Delivery and Performance Management, Welsh Assembly Government), a Performance Management Group for Mental Health was established. The purpose of the group was to provide a focus for improving the performance management of mental health services in Wales. It utilised a service improvement and performance improvement approach in order to address concerns on current practices within mental health services.

A paper on the activity and progress of the work of this group was presented to the Health & Social Care Department Performance Group meeting in April 2008. At that meeting, the Chief Executive Officer NHS Wales and Director of Health and Social Services requested that a review of CPA be undertaken.

Concerns had also been raised centrally about the effectiveness of CPA in Wales. As a result, it was agreed that the Delivery and Support Unit (DSU) and the National Leadership and Innovation Agency for Healthcare (NLIAH) would undertake a joint review of the care co-ordination process in 3 organisations, one from each region. This was to be completed by September 2008. The review was not intended to be a full audit of CPA but rather, a review of progress, identifying issues that would facilitate the on-going implementation of CPA across Wales. The findings of the 2008 CPA review were published in a report **(8)** that was presented to the Performance Management Group and copied to the Chief Executive NHS Wales and Director of Health and Social Services in October 2008.

At the same time as the 2008 CPA Review reported its findings, HIW made public its findings of a homicide in North Wales **(7).** HIW concluded that there were inadequacies in the application of CPA and failings in the approach of local services to the assessment and management of risk **(7).** Also," steps that may have rendered the homicide unlikely were not taken" **(7).**

The then Chief Executive of NHS Wales and Director of Health and Social Services was present at the media presentation on 22 October 2008. It was announced that, the 2008 CPA review conducted jointly by DSU and NLIAH would be extended to encompass all NHS Trusts providing mental health services across Wales. This subsequent review was undertaken between January 2009 and March 2009.

METHOD

The details regarding the background and method used in the 2008 CPA review can be found in the original report **(8)**. It was agreed to use the same method for the 2009 review i.e.

- The audit focussed on adult services rather than older adult / dementia designated services. However, it is recognised that clients accessing 'Adult Services' might be aged 65 years and over based on clinical need rather than chronological age.
- A randomly selected sample of case records in a randomly selected number of Mental Health Teams in each organisation. (Organisations in the 2008 review were excluded from the 2009 review)
- An 'audit of case records' was undertaken using the amended Care Programme Approach Associations audit tool (appendix 1). Each organisation was given a list of the case records audited: and
- Semi structured interviews (appendix 2) with Care Co-ordinators. The care co-ordinators functioned at different levels and grades within the organisations. The majority were CPNs and SW but also included a number of O.T.s, senior nurses, health and social care managers. The interview schedule was undertaken in each area through local group meetings to gather a more operational view on the implementation of CPA and current issues faced by practitioners. Although no psychiatrist or psychologist attended the meetings the invitation from the reviewers was extended to every member of the CMHTs.

The reason for using the same approach was to provide a benchmark with the 2008 CPA review, this review and future reviews. Because of the limited time it was not possible to examine a representative/statistically valid sample of client records. Rather, the 2009 CPA review sought to identify the key issues and messages to assist with further implementation of CPA and the action needed to achieve the related 2009/10 AOF target.

The timetable for the review can be found in Appendix 3.

A letter from the Chief Executive Officer, NLIAH and Director of DSU to Chief Executives in each Trust set out the terms of the review (appendix 4)

253 records were reviewed bringing the total number of audited records across the 2 reviews to 313. 65 care co-ordinators participated in the interviews bringing the total number of care co-ordinators interviewed to 106. However, no psychiatrists or psychologist representatives attended although invited.

The reviewers undertook to provide feedback on local findings to the General Manager at each organisation at the conclusion of each review.

PRINCIPLE FINDINGS

Fieldwork Findings

Care Programme Approach

There are several fundamental components to the process of CPA (3). It requires;

- The collection of a range of demographic information;
- An initial needs assessment that should include both a physical and mental health assessment;
- A current risk assessment and risk management plan;
- A care plan that is outcome focused, reviewed regularly and reflects client needs.
- An assessment of carers needs, where appropriate;
- Arrangements for contingency/crisis to enable patient/carers to cope and access help quickly when it is most needed;
- Regular reviews that actively involve the key and relevant individuals including carers and voluntary agencies;
- Clarity on the care co-ordinator and whether the client is on enhanced or standard CPA; and
- Where necessary;
    a) transfer of care arrangements
    b) the means to document and communicate unmet need

Demographic Information

Of the 253 records reviewed, the majority of demographic information was routinely collected. 51% of cases reviewed were male and 49% female. Ethnicity was recorded in 50% of notes.

Standard/Enhanced CPA

This was generally not well recorded. It was noted that it was occasionally difficult to determine the level of CPA from the case notes as clients moved between the two categories.

Of the records reviewed in this audit, 50% of clients were on enhanced CPA and 26% on standard. In 24% of cases it was not possible to determine the level of CPA. The 2008 identified only 6% of cases where it was not possible to identify the level of CPA. Where the level of CPA is not confirmed the client may not receive the appropriate care package and the response to a client's needs may be less than required.

Needs Assessment

A fundamental component of CPA is the initial holistic needs assessment: without this it is not possible to put in place a comprehensive care plan. In addition, all clients discharged from an in-patient setting require a new or revised assessment. In this audit, initial needs assessments were completed in 83% of notes audited. Without this assessment, care plans would not be fit for purpose. In the remaining 17% clinician/practitioners instigated interventions without the benefit of a holistic assessment.

Risk Assessment

The policy guidance **(3)** makes specific reference to the need for a risk assessment to be undertaken when a service user is in contact with mental health services. Risk assessments were completed and updated within the last 12 months in 74% of clients' notes surveyed. There were however, examples where risk assessments remained unchanged over a four-year period. It is of concern that in 26% of cases the risk assessment had either not been completed or updated in the last year.

*All three recent HIW reports **(1, 2 & 7)** make specific reference to the development of "a culture which supports risk management .... addressing the view among some staff that risk assessment is currently a 'tick box' exercise". The potential for this client group to behave and act in unpredictable ways requires them to be managed within a framework that minimises risks to their well-being and others*.

Risks were adequately addressed within the Care Plan in 34% of cases. In total therefore, over 150 of clients did not have an adequate 'up to date' Risk Management Plan or one that addressed their needs. There is a requirement to assess and record risks and to put measures in place to reduce the risk and this cannot be overstated. During the review it was necessary for the reviewers to bring some urgent clinical governance issues to the attention of the senior management team for immediate action.

Carer's Assessment

The audit question related to a carers assessment as defined by the Carers Act 2005. There was little evidence of carer's assessments being offered and completed; less than 10% of case notes reviewed had evidence that a carer's assessment was offered. Notes often identified 'no carer' when in fact a carer attended a review. However, the absence of a completed carer's assessment in client records is not necessarily an indication that one was not completed. There was confusion/no agreement over where the carer's assessment should be filed as it may identify carer's issues that may not be specifically related to the client. In one CMHT, once a carer's assessment was undertaken a separate case file was initiated and the carer was supported / managed through the CPA process.

Care Co-ordinators

Care co-ordinators were identified in over 85% of cases with the majority of care co-ordinators being CPNs. 52% of case notes identified a CPN as the care coordinator. In 15% of case notes the care co-ordinator could not be identified and in 17% of case notes

the designation of the care co-ordinator was not clear. This situation is not acceptable because it confuses the responsibility and accountability arrangement for client care.

Care Plans

Care Plans were completed in 84% of cases although only 70% of care plans had been completed in the last 12 months. There was little or no reference to the expected outcomes for clients in more than 75% of client records.

Where client records were in a written format, care plans were signed by service users in 42% of cases. Where there is an IT system it was not possible to confirm that the care plan was developed with the agreement of service users.

The signing of the care plan by the client and its distribution to the client and GP within seven days is considered to be best practice. Care plans were found to be distributed to GPs within seven days on less than 32% of occasions. However, this may not be a true reflection of communication with primary care as the CPA documentation may not always have been completed to meet the 7-day timeframe specified in the audit tool. Good communication with primary care is an essential component of managing this client group and information technology solutions should be available to disseminate information quickly. A simple solution of using a date stamp in one CMHT enabled reviewers to easily determine whether this timescale had been met. Care plans were found to be distributed to service users within seven days on 37% of occasions. The audit tool did not allow for those service users who declined a copy of the care plan to be identified.

Care co-ordinators found it easier to evidence the client's involvement in developing care plans where these were paper based, particularly when the patient is seen at home/community as care plans could be completed with the client and signed on the same day.

Where there are electronic systems, the care plans needed to be entered onto the system at the CMHT office and then sent/handed to the client at a later date. Care co-ordinators indicated that it was difficult to get care plans signed and distributed within the seven-day timeframe specified within the audit. The delays could be compounded where care plans had to be signed by the team manager. In one team, care plans had not been sent to the service user or other members of the multidisciplinary team as the team manager was on long term sick leave and no alternative arrangements had been put in place.

There is evidence of changing case mix with an increasing number of clients presenting with a multiple morbidity that includes substance misuse and personality disorder. 39% of case notes reviewed identified a problem with substance misuse. However, there was little evidence (less than 10%) within the care plans that substance misuse problems were being addressed. This may signal a need for training for care co-ordinators in this aspect of client care or development of other service models.

Even within the same team there was no standard documentation and a plethora of forms related to the same element of the process.

Review Process

Only 58% of case notes identified the next review date and of these, 64% of reviews occurred within the timeframes set. Evidence was available to show that the relevant people were invited to attend in 53% of cases. However, communication of the outcome of the reviews to the relevant GP and service user was not always evident.

Crisis & Contingency Plans

Notwithstanding the fact that clients on standard CPA do not always require a crisis/contingency plan, such were in place and easily retrieved in 55% of cases. Crisis/contingency plans are a core requirement of the Policy Guidance and need to be robust and easily accessible to the patient, carer and others involved in the client's care. Of concern during this review was the fact that crisis/contingency plans often comprised of a set of contact telephone numbers rather than including actions that clients and carers could undertake in times of crisis. It was noted that rarely was any reference made to the Crisis Resolution and Home Treatment Team as part of the crisis/contingency plan.

Transfer of Care Arrangements

Arrangements were in place for the discharge and transfer of care for clients. However, the audit was unable to determine the robustness or otherwise of these arrangements. Transfer arrangements varied across different teams and there appeared to be no consistency of approach.

Unmet Needs

Unmet need was identified in 3% of records audited. This aspect of the findings is discussed further, later in the report on page 22.

Physical Health

Physical Health Care needs were assessed in 20% of the case notes audited**.** Recent evidence confirms that people with a mental health problem have a higher incidence of chronic physical ill health and their life expectancy is lower than their peers in the general population. Physical health assessments were not routinely completed or recorded as part of the initial needs assessment. The GP was considered by the care coordinators to have a key role in this regard. However, this arrangement needs clarifying if there is to be any change in the current position with regard to co-morbidity and the reduced life expectancy for this client group.

Findings from Semi-structured Interviews with Care Co-ordinators

Over 65 care co-ordinators took part in the semi-structured interviews and included principally SWs and CPNs. A copy of the interview questions can be found at appendix 2. The comments made during the different meetings with care co-ordinators have not been tested objectively. However, they represent the perceptions and feelings of care co-ordinators who are at the forefront of CPA implementation.

It was confirmed that for the majority of Services all team members could be care co-ordinators although the majority of the more complex cases required regular input by CPNs and SWs. There are a number of factors that influence the decision on who should be a care coordinator. These include the capacity of the team, the available skills and the composition of professionals within the team. Where the critical mass of this workforce is small such as psychiatrists, psychologists and/or where the clinician/ practitioner provides very specialist interventions it is questionable whether their time is best used fulfilling the role of care co-ordinator i.e. their expertise would be diluted and would not be able to see as many clients for specialist interventions. Universally, Psychiatrists appear to manage the majority of their caseload through out patient clinics. As a consequence Psychiatrists time may be utilised for those with less complex needs to the detriment of those with the most complex needs.

In addition to being care co-ordinators, a number of other issues were raised which affected clinicians' and practitioners' capacity to undertake the care co-ordinating role. CPNs' and Social Workers' workload included duty assessment rotas, management of out of county placements, Approved Mental Health Practitioner duties (Mental Health Act applications); Section 117 After Care Reviews within and out of localities. These were in addition to running clinics and providing therapeutic interventions.

Case load numbers for care co-ordinators varied across the organisations visited but ranged between 10-35 cases at any one time. It was stated that CPA caseload numbers are lower for OTs because of other commitments. Care co-ordinators reported that the quality of patient care could be adversely affected where caseload numbers are high, the case mix is complex and clients require frequent contact and interventions.

Caseload management was organised through managerial supervision and although consideration had been given to the weighting of cases, this proved difficult because of changes in the complexity of client needs within relatively short time frames.

Although most practitioners had received some initial training this did not include regular updated training in Risk Assessment, Care Planning or the role of the Care Coordinator.

CPA leads and practitioners all identified the benefits of further training in risk assessment and care planning. Similarly, the recent HIW **(8)** Review of a homicide in North Wales identified that "the training provided to staff in relation to CPA, in particular its relationship to risk assessment and management had not, been optimal **(7).** Similarly**,** the reviewers found, in some areas, that risk assessment was treated as a tick box exercise and we would agree with the HIW report on the need for "further training …. *the development of a culture which supports risk management emphasising the importance of team work and addressing the view among some staff that risk assessment is currently a 'tick box' exercise".*

A variety of risk assessment tools are currently in use across Wales. It is not for the reviewers to recommend a particular risk tool. Suffice to say there may be benefits in having a common approach to risk assessment between agencies and across Wales.

Two areas reported they had a waiting list for the allocation of care coordinators following initial assessment. This was as a consequence of the lack of capacity of the local teams. Waiting lists were managed in a variety of ways with one area assessing risks and dependency levels through the introduction of a points system (based on complexity of need and waiting time). The maximum wait was 12 weeks. In another area, there was no such system and allocation was only made when a care coordinator had 'space' on their caseload. Patients who are not allocated a care coordinator will receive support from the local duty team, but no comprehensive care plan will be implemented. This can have an effect on the quality of interventions provided and possibly increases the risk of relapse or a critical incident occurring. The findings demonstrated that the waiting list for allocation of care coordinators has limited controls in place to support effective coordination of care (enhanced and standard). It was reported anecdotally that one service user with a diagnosis of psychosis waited 9 months before being allocated a care coordinator.

Practitioners' agreed that they maintained contact and attended the reviews with clients who were in "out of area placements".

Local authority colleagues seemed to be better informed about out of area placements as a consequence of SWs monitoring funded placements as per the requirements of the NHS and Community Care Act (1990). The new LHBs will need to develop robust systems to monitor and review out of area placements particularly for those individuals in receipt of NHS Continuing Healthcare Funding.

There was a high level of frustration amongst practitioners when they tried to transfer clients' care arrangements to another area. Some CMHTs refuse to accept transferred clients until they had been resident in the area for over 6 months. There is an expectation that social workers will continue to act as care co-ordinators for clients whose residency has changed to another local authority area. These decisions are influenced by the funding responsibilities for care packages that remain with the host local authority. This arrangement can have a negative effect on co-ordinating care particularly in a crisis if the client resides some distance away. Whilst, for funding purposes, local authorities may not be able to accept clients, it should be possible for the health component of clients' care and indeed the co-ordination of that care to be transferred. An all Wales Transfer of Care Policy to which all new integrated organisations and local authorities are signed up to would go some way to overcome this problem.

Particular problems have arisen in areas where there has been substantial development of independent and private sector facilities. These sectors appear to be responding to the market and are providing services for clients from Wales and England. As a consequence, demands for local NHS services are increasing and there is evidence of tensions arising between organisations concerning the accountability and responsibility for providing different aspects of care. This could lead to increasing risks for clients, the public and organisations if an incident occurred and agencies have not responded.

The general view of practitioners was that CPA is an excellent framework in which to manage clients with a severe mental illness. However, it is being undermined by the perceived bureaucracy associated with it, taking practitioners away from the therapeutic aspects of their work.

Practitioners felt that the use of IT systems increased the time spent away from clients. An example was given of a half hour review needing three hours of computer input. Anecdotally it was reported in one area that a CPN used to undertake 25 home visits a week but since the introduction of CPA/UA is now undertaking only 12 home visits a week. This was reportedly as a consequence of the bureaucracy surrounding the completion of the assessment and access to IT. The focus appears to be on meeting the information recording requirements rather than the care needs of the individual.

Where IT systems are in place not all care co-ordinators complete the information required and not all systems are fit for purpose. Practitioners' views were almost unanimous that IT systems appeared to support the collection of management information rather than supporting the co-ordination and delivery of care interventions. Because of limited equipment, practitioners are often required to share computers.

In order to manage and monitor other activities e.g. Direct Payments, additions have been made to the CPA process making it even more cumbersome.

Efforts have been made by the CPA leads to integrate UAP and CPA documentation. In some areas a more pragmatic approach to UAP is taken whilst in others there is up to 65 pages of paperwork to complete. This seems inordinately complex and burdensome for practitioners.

Staff maintained that they are required to collect different datasets to support reporting against different LA and NHS performance targets. Common targets for LA and the NHS would help to address this situation.

The policy guidance **(3)** makes specific reference to identifying unmet need. This is an important aspect of the CPA process as it helps to highlight service shortfall. Although organisations had in place processes to capture unmet need, practitioners had seen little or no changes as a result of reporting. They reported that this had a demotivating effect and made them reluctant to report unmet need. It was clear from the audit that across Wales there are unmet needs in the areas of:

- supported accommodation
- personality disorder services
- dual diagnosis service (mental health/substance, misuse physical health/mental health)
- eating disorders and young people during transition from CAMHS to adult services

An analysis of the August 2008 *All Wales* position shows that 60% of clients are on standard and 40% on enhanced CPA. During the semi-structured interviews, care co-ordinators maintained that this was not representative of the CMHT caseload. They were of the view that the figures could be skewed as Doctors, Psychologists, and Specialist Therapists' outpatient activity that is usually reported as standard CPA. These

professionals provide specific individual interventions with limited reference to the integrated holistic care planning process.

CONCLUSION

Since its implementation in 2004, the CPA process has become embedded in the working practices of mental health services. Whilst accepted by the practitioners who participated in this review as an excellent framework for managing clients with severe or enduring mental health problems, critical issues remain that require immediate and urgent action.

A greater focus is needed on the assessment and management of risk. Practitioners need to be prepared for the role of care co-ordinator i.e. training. Information systems need to meet clients' needs rather than organisations' priorities. The current system is overly complex and too bureaucratic particularly where CPA and UA have been integrated as a single process. A record management system needs to be developed that supports CPA and UA whilst providing the least administrative burden for clinicians and practitioners.

The two CPA reviews have looked at a relatively small random sample of notes and a cross section of CMHTs; nevertheless it has been necessary to make representation to organisations as serious clinical governance issues were uncovered. If this review sample is representative of all mental health services in Wales, there is a high risk that services are not effectively meeting clients and carers needs because of inadequate risk management processes, a lack of focus on the outcome of interventions, and a lack of service planning and service models to safely and adequately meet client's needs.

Significant improvements are needed for patients and carers if Wales is to deliver a modern, world class Mental Health Service.

REFERENCES

1. Healthcare Inspectorate Wales (2008) Report of a review in respect of Ms A. and the Provision of Mental Health Services, following a Homicide committed in October 2005. Cardiff. HIW.

2. Healthcare Inspectorate Wales (2008) Report of a review in respect of Mr B. and the provision of Mental Health services, following a Homicide committed in April 2006. Cardiff. HIW.

3. Welsh Assembly Government (2003) The Care Programme Approach for Mental Health Service Users – Mental Health Policy Guidance. Cardiff. NHS Wales.

4. Welsh Assembly Government (2002) National Service Framework for Adult Mental Health Services. Cardiff. W.A.G.

5. Welsh Assembly Government, Community Primary Care and Health Service Policy Development (2006) Snapshot Review of the Care Programme Approach in Wales – One Year On. Unpublished report. Cardiff. Welsh Assembly Government.

6. Walton, Mark (2007) User Guide to the Care Programme Approach. Available at www.markwalton.net.

7. Healthcare Inspectorate Wales (2008) Report of a review in respect of Mr C and the provision of Mental Health Services following a homicide committed in October 2006 Cardiff H/W

8. Review of the Care Programme approach in Wales (2008). Cardiff, Welsh Assembly Government

Appendix 1

AUDIT TOOL

DSU / NLIAH Care Coordination Review 2008			
Please only tick **yes**, if documented notes/electronic record:-	**Yes**	**No**	**N/A**
1) Individual details to be recorded as follows	*In most cases personal details will be recorded on a data sheet in the file or a specific screen within the electronic record.*		
a) Gender b) Age c) Ethnicity			
2) Has an initial needs assessment been completed?			
3) Has a risk assessment been completed in the last 12 months?			
4) Has a risk assessment been reviewed in the last 12 months			
5) Have identified risks been addressed? *Addressing risks should be evidenced by a Risk Management Plan which might be a separate document, a defined section of the care plan/risk assessment or by evidence within the care plan that risk issues are clearly identified within the overall plan of care.*			
6) Has a carer's assessment been offered? Carer defined as in the Carer's Act			
7) Has a carer's assessment been completed?			
8) Is a Care Co-ordinator identified?			
9) Designation of Care Care-coordinator			
10) Is CPA level recorded i.e. Standard or Enhanced?			
11) Is there a completed care plan?			
12) Has the care plan been updated within the last 12 months?			
13) Has the service user signed the care plan indicating participation in its development?			
14) A copy of the care plan has been distributed to:	*Evidence that a care plan or review has been distributed would include a covering letter in the file, a ticked box on the document itself which records distribution, a file note to the effect that a copy has been posted or given to the person.*		
a) The service user			
b) The GP within 7 days			
15) Are arrangements in place for crises and contingencies?			

Arrangements for crises and contingencies should be clearly recorded. This might include a separate document, a defined section of the care plan or by evidence that the arrangements are clearly identified within the overall plan of			
16) Has a review occurred? *A review might take the form of a meeting, a visit to the service user or, in some circumstances, telephone contact.*			
17) Does the review demonstrate the Care Co-ordinator has sought the views of all identified people involved in the review? *There should be evidence in the record that the Care Co-ordinator has made reasonable attempts to seek the views of involved people. This might include face-to-face contact, telephone calls, and letters of invitation to a meeting or reports from involved people. Where involved people fail or are unable to respond to such attempts the 'yes' box should still be ticked. 'Involved people' would include the service user, an identified main carer and the people identified on the care plan as providing support to the service user.*			
18) A copy of the review has been distributed to:	*Evidence that a care plan or review has been distributed would include a covering letter in the file, a ticked box on the document itself which records distribution, a file note to the effect that a copy has been posted or given to the person.*		
a) The service user			
b) The GP			
19) Has a next review date been set?			
20) Has an identified review date been missed? *A review date will have been missed if the review has not occurred or occurs at a later date than was specified on the care plan or elsewhere in the record.*			
21) Are arrangements in place for a transfer of care or discharge?			
22) Has any unmet need within the care plan been identified?			
23) Is there evidence that the unmet need has been communicated to the: - Multi disciplinary team meeting - Commissioners - Others			

Appendix 2

QUESTIONNAIRE

The Reviewers will be Emrys Elias DSU and Liz Singer NLIAH

The review will be informed by:

- A review of patient notes (sample no. to be confirmed) utilizing a data collection tool which reflects best practice guidance on the requirements of the CPA care co-ordination process.

- An interview schedule with care co-ordinators (this could be a one off meeting with several care co-ordinators with a set of questions on the care coordinating process and the organizational arrangements for CPA).

On completion of the review a report will be made accordingly to the Mental Health Performance Group.

Questions to Care Coordinator

Are all Team Members Care Co-ordinators? If not / why not?

Do care co-ordinators receive training in undertaking the role of care coordinator? (Is it one off training or is there a process for update?)

Do care co-ordinators receive training in assessment and management of risk? (Is it one off training or is there a process for update?)

Is there a control in place for the numbers of clients on a care co-ordinators caseload including weighting for complex cases?

Do care co-ordinators receive caseload supervision?

Do care co-ordinators have a waiting list for clients awaiting the allocation of a care coordinator?

Organisational Processes

Does the organization have an IT System to support the implementation of CPA?

Is there a process for identifying?
- Caseload Nos. and weighting (enhanced / standard)
- No's on CPA per population
- No's not on CPA per population

Out of area placements

- No's of local patients in out-of-area placements
- No's of local patients in out-of-area placements under CPA

If there is a numerical difference in the above for out-of-area placements, then clarification should be sought as to the reasons why.

Is there a system in place to inform on local out-of-area placements, CPA monitoring and evaluation arrangements? Do care co-ordinators actively case-manage out of area placements?

Appendix 3

Audit Schedule

Caseload Audit		
Organisation	**Audit Date**	**Number of records reviewed**
ABM. Swansea Audit – Cefn Coed	20/01/09	20
ABM. Bridgend Audit – North East Ogwr	23/01/09	20
ABM Neath/Port Talbot – The Forge	26/01/09	20
C&V Cardiff Audit	02/02/09	20
C&V Vale of Glamorgan	04/02/09	20
Gwent – Newport, Gold Tops	11/02/09	20
Gwent – Newport Park Square	13/02/09	10
Gwent - Caerphilly, Ty Siriol	18/02/09	10
Gwent – Aberbargoed,Bryn Golau	20/02/09	12
North West Wales - Bangor	23/02/09	20
North West Wales – Llangefni	24/02/09	20
Powys – Newtown	25/02/09	20
Powys - Brecon	27/02/09	20
North Wales Central – Rhyl	02/03/09	21

Care Co-ordinator Meetings	
Meeting Date	**Meetings with Care Co-ordinators**
ABM Bridgend	27/01/09
ABM Swansea Central	20/01/09
ABM Swansea West	30/01/09
C&V Cardiff	04/02/09,
C&V Vale of Glamorgan	10/02/09
ABM Neath Port Talbot	16/02/09
Gwent Newport,	13/02/09,
Gwent Caerphilly	18/02/09
NW Wales Bangor	23/02/09
NW Wales Anglesey	24/02/09
Powys Newtown	25/02/09
Powys Brecon	27/02/09
North Wales Wales Rhyl	02/03/09
North Wales Landudno	03/03/09, 18/03/09

Appendix 4

DELIVERY AND SUPPORT UNIT
UNED CYFLENWI A CHYMORTH

National Leadership and Innovation Agency for Healthcare
Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd
Supporting NHS Wales *to deliver world class healthcare*
Cefnogi GIG Cymru *i gyflwyno gofal iechyd o safon fyd-eang*

Dear Chief Executive

Re: Care Programme Approach – Review

In July 2008 Mrs Anne Lloyd, Chief Executive, Welsh Assembly Government requested that the DSU and NLIAH review the Care Programme Approach (CPA) within Wales, taking into account current practise. Subsequently, the Welsh Assembly Government Mental Health Performance Group endorsed the review and supported the undertaking of a pilot project on CPA implementation, focussing on "care co-ordination".

The pilot project involved three NHS Trusts in Wales and is now complete. For completeness and in order to achieve an informed view across Wales Mrs Lloyd has requested that the remaining NHS Trusts within Wales who were not involved in the pilot project have a similar review.

The methodology for the review is two fold and involves a sample audit of patients' notes (audit tool attached) and a semi structured interview schedule with care coordinators on the process of 'care coordination'.

You have our assurance that all data emerging from the review will be anonymised and un-attributable to any individual organisation; the outcomes will facilitate the ongoing implementation of CPA across Wales.

We hope to undertake this work during January and February 2009, and aim to have draft results to share with you by the end of March. Following your feedback, we will then present the results from the pilot site to the Welsh Assembly Government leads in April.

We hope that you will be content with the proposed approach and look forward to your participation in the reviews. If you have any questions, or need any additional information at this stage, please do not hesitate to contact either:

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Liz Singer, NLIAH (01443 233457) mailto@liz.singer@nliah.wales.nhs.uk

Yours sincerely

Signature:
Andrew Lewis
Acting Chief Executive, NLIAH

Signature:
Richard Bowen
Director, DSU