Fife Health & Social Care Partnership
Supporting the people of Fife together

MENTAL HEALTH AND LEARNING DISABILITY SERVICES

THE CARE PROGRAMME APPROACH

GUIDANCE

2019

Fife Health and Social Care Partnership
A partnership between Fife Council and NHS Fife
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NHS Fife

Fife Council

Please direct any comments or suggestions to the CPA Steering Group

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SECTION 1

THE CARE PROGRAMME APPROACH

1.1 INTRODUCTION

The Care Programme Approach (CPA) model is firmly based on good professional practice. It is a process for organising care for people with complex needs, where those responsible for providing services come together with service users and carers to identify needs and to agree a plan of action for meeting those needs. This agreement forms the basis of the Care Programme Approach.

1.2 AIMS AND OBJECTIVES

The aim of the CPA is to ensure that individuals with severe and enduring mental disorder, dementia and learning disabilities, who also have complex health and social care needs, receive appropriate services in a way that is both planned and co-ordinated.

It should be kept in mind that persons who require care via the CPA may also be at risk of harm. Therefore, all persons involved in their care recognise that Adult Support and Protection is *everyone's business* and all individuals and services have a contribution to make in supporting and protecting adults at risk of harm in Fife.

Every healthcare organisation must adopt the following clinical governance and risk management principles:

- **Person-centred**: Provide care in partnership with people using services treat people using services with dignity and respect, provide care in partnership with other core services.
- **Safe:** Ensure required standards are met identify, investigate, take action on and learn from concerns identify and manage healthcare risks.
- **Effective:** Plan and deliver continuous improvement, and identify, share, learn from and deliver best practice.

The purpose and aims of the CPA are to:

- Ensure that service users with a mental disorder associated with complex health and social care needs receive on-going care support and supervision both in hospital and in the community;
- Ensure structured support for those most in need, or most at risk to themselves or others;
- Ensure that there is effective multi disciplinary agency collaboration;
- Ensure that service users and their families and carers are involved as far as possible with care planning decisions and arrangements;

- Enable systematic arrangements for the assessment and management of health and social care needs; and
- Ensure the appointment of a lead CPA Co-ordinator to monitor and co-ordinate care arrangements.

The objectives of the CPA are to ensure that:

1. Service users and their carers are involved in care decisions and arrangements;
2. There is effective collaboration and joint working between agencies and professionals;
3. Service users and carers receive a full assessment of needs and regular reviews;
4. Service users and carers receive an outcome focused care plan, which strives to meet their needs;
5. The CPA should be subject to regular audit to ensure effectiveness.

1.3 CRITERIA FOR INCLUSION

The CPA is considered to be the most appropriate way of managing the care of people within the Mental Health and Learning Disabilities Services and who meet the criteria below. While not exhaustive; the CPA should always be considered for people who meet these criteria with built-in flexibility to allow for professional discretion.

The CPA is applicable to:

(i) People who have complex care needs and multi-agency involvement; or

(ii) People who are receiving compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, Criminal Procedures (Scotland) Act 1995 or other Supervision Orders.

All persons being included on the CPA **must** give their consent, except those identified in (ii) above – all restricted patients must be managed by the enhanced CPA (see Section 2 of this guide for more information). Nevertheless, even when people are receiving compulsory treatment, it is considered best practice to obtain their agreement as far as possible.

1.4 GOVERNANCE ARRANGEMENTS

An effective clinical governance and risk management infrastructure is essential to the delivery of high quality healthcare and continuous improvement. High performing

organisations are those that have created effective frameworks and systems for improving care that are applicable in different settings and sustainable over time.

The CPA is managed through a Fife-wide Steering Group. The Steering Group is chaired by the Divisional General Manager, Fife-wide Services, Fife Health & Social Care Partnership. It comprises of representatives from:

- Mental Health
- Learning Disability
- Social Work
- The MHO service
- Criminal Justice Social Work Service

The Steering Group has managerial responsibility to:

- Consider the financial and staffing resources required to organise the CPA in Fife;
- Provide service user and carer involvement in the development and monitoring of the Care Programme Approach;
- Provide appropriate information for those involved in the CPA;
- Provide monitoring, evaluation and review arrangements for the Care Programme Approach; and
- Facilitate and develop comprehensive, multi-disciplinary training programmes available to involved staff on an ongoing basis, including training for CPA Co-ordinators and staff involved in the Enhanced CPA.

There are additional responsibilities associated with the Enhanced CPA and the Integrated Joint (Health & Social Care) Board should be able to demonstrate:

- Clarity around governance arrangements and the effectiveness of risk reporting arrangements;
- That they are satisfied with the quality of the operation of the Enhanced CPA and that there are appropriate resources in place;
- Accurate collation of statistical information on the operation of the Enhanced CPA, MAPPA and recording breaches of conditional discharge;
- That a senior manager is identified and that s/he and the relevant RMO meet their responsibilities under MAPPA;
- Regular risk reporting arrangements from clinical teams that register and document the consideration of risks;
- A planned approach to minimising risk; and

- Annual audits on the quality of the operation of the Enhanced CPA are carried out.

1.5 CPA TRAINING

The main aim of training is to ensure that all the agencies involved with the CPA are suitably informed of the aims and objectives of the process. It is important that staff have an understanding of their own and others' roles and responsibilities and that training is multi-agency in nature.

Training should provide staff with the necessary skills to carry out their roles and responsibilities effectively. It should allow all those involved in the CPA to become informed not only with the process, but also with the experience of being part of the CPA, ideally involving both carers and service users.

1.6 ROLES AND RESPONSIBILITIES

Service User and Carer Involvement

The CPA enables service users to be involved in the assessment, planning and implementation of their care. Likewise, carers, nearest relatives and partners, with service users' consent can also be involved.

The practitioner proposing a person's inclusion in the CPA has a responsibility to explain the CPA in full to the service user. It is also important that any carers are familiar with the relevant aspects of the CPA and that they understand what the process involves. Where service users may have impaired capacity and are unable to fully comprehend the CPA, it is essential that advocacy services (including non-directed advocacy) should be offered. Information booklets for service users and their carers have been prepared to explain the CPA process.

Where an individual specifically asks that their carer be excluded from the CPA process, it will be the responsibility of the CPA Co-ordinator to ensure that a carer's views are sought at a CPA meeting and that decisions reached, which have direct implications for carers, are discussed with the carer. It is appreciated that carers play a major role in the provision of care and that their involvement in the process is important within the parameters of current legislation, including data protection legislation.

The CPA Co-ordinator

It is recognised that in the CPA no single agency has overall responsibility. A joint agency approach is required to ensure that the process is fully implemented and the co-ordinator can be any member of the CPA team. It is a function of the CPA to

identify the most appropriate person to be the CPA Co-ordinator, and this should be arranged prior to the initial CPA meeting.

The key functions of the CPA Co-ordinator are to, in liaison with the sector administrators, organise meetings, to be responsible for invitations to those involved in the meeting and distribution of CPA documentation. The Responsible Medical Officer (RMO) continues to have overall responsibility for the care of the service user and the CPA Co-ordinator facilitates the CPA.

All the professionals involved in the CPA will retain accountability for their own practice. The CPA Co-ordinator will **not** assume responsibility for other professionals involved in the assessment or the services provided to support the agreed care plan.

It is the CPA Co-ordinator's responsibility to:

- Take responsibility for chairing CPA meetings
- Organise and co-ordinate continuity of care
- Maintain regular contact with the service user
- Ensure members of the CPA team have access to relevant documentation
- Ensure the service user's personal information is up-to-date
- Alert the CPA team members promptly to any matters that impact upon the care plan and take appropriate action
- Advise the CPA team of any changes of circumstances or any matters which may require modification to the care plan between CPA meetings
- Ensure that agencies involved in the service user's care have appropriate access to the CPA care plan and are invited to CPA meetings
- Ensure that every effort is made to facilitate the service user's involvement in the CPA and their continued access to independent advocacy
- Ensure that documentation is updated within specified timescales and distributed accordingly (see section 1.8)
- Maintain contact with the GP, if unable to attend CPA meetings, and advise of all relevant circumstances
- Ensure that appropriate deputising arrangements are made

The CPA Co-ordinator must inform the relevant CPA administrator when:

- The person is admitted to or discharged from hospital;
- The person permanently moves to another sector or;
- The review meeting is altered or cancelled and the reason for this; or
- The person has died.

To assist the CPA Administrator, CPA Co-ordinators should:

- Ensure that all changes are notified to the administrator; and
- Email care plans for formatting within **3 working days** of the review meeting;
- Return the care plan to the CPA Co-ordinator **within 7 working days** for signing off by the service user;
- Enable the CPA Administrator to distribute the document, to the care team within **15 working days after the review meeting**.
- Inform the CPA Administrator of transfers out with locality; and
- Complete the appropriate check list(s).

Should any other person concerned with the CPA wish to make changes to any agreed care plan after the meeting has taken place, e.g. changing dates of further meetings or place of meeting etc, these changes first must be agreed with the service user, carer and the CPA Co-ordinator.

If unable to comply with the above timescales for any reason, the CPA Co-ordinator must write the reason for non-compliance at the bottom of the care plan (e.g. if service user is unable to sign the document, the reason must be documented).

1.7 NOMINATION FOR CPA

1. When it has been established that a service user meets the criteria for the CPA, the initiator - who may be any health care or social work professional - completes a referral form
2. The form is then sent to the CPA administrator in the relevant area.
3. The referral form should contain as much information about the service user as possible. A date, time and venue for the meeting should be included.
4. The referral form should be signed by the service user to show that they are aware of the CPA referral and that they accept it (if able to do so).
5. The form is then signed by the initiator and sent to the administrator.

1.8 CPA ADMINISTRATOR

The CPA Administrators

The sector administrators hold files on all CPA service users. These contain copies of all letters, care plans and any other documents relating to the service user.

CPA Administrators' locations

Mental Health		
North-east Fife	Weston Day Hospital, Cupar	☎ 01334 652163
Central Fife	Dunnikier Day Hospital, Whyteman's Brae Hospital, Kirkcaldy	☎ 01592 643355, ext.23912
West Fife	Phase One, Queen Margaret Hospital, Dunfermline	☎ 01383 627020
Learning Disability		
Fife-wide	Lynebank Hospital, Dunfermline	☎ 01383 623623, ext 35258

CPA Administrators' duties

The CPA Administrators are responsible for carrying out all administrative tasks related to the running of the CPA, including:

- Maintaining a database of service users within each sector (authorised persons may access the central register by arrangement);
- Submitting statistical information to the CPA Co-ordinator monthly;
- Maintaining diaries within the sectors and notifying all relevant parties of meetings within an adequate time scale;
- Formatting, distributing and uploading care plans as required;
- Maintaining files on all service users/clients registered on the CPA; and
- Ensuring information is accessible.

The CPA Administration Process

The following process should be followed after the decision is taken to include a service user in the CPA:

1. A referral form is completed by the nominator and sent to the CPA Administrator in the relevant area.

2. As indicated by the CPA Co-ordinator, calendar invitations (where possible) will be sent out by the CPA Administrator. Where calendar invitations are not possible, agencies involved will be notified of meetings by secure email.
3. CPA information booklets will be sent to the service user and carer(s) with their first invitations.
4. Following the CPA meeting, a care plan will be prepared and emailed by the CPA Co-ordinator to the CPA Administrator within **5 working days** of the review meeting.
5. The care plan is formatted and returned by the CPA Administrator to the CPA Co-ordinator within **10 working days**.
6. The care plan should be signed by the service user and CPA Co-ordinator and returned to the CPA Administrator for electronic distribution (by secure email) to all those involved in the CPA within **15 working days**. Where absolutely necessary, the care plan can be posted to recipients.
7. The care plan will be uploaded to the clinical portal by the CPA Administrator.
8. Dates of subsequent meetings will be notified to the CPA Administrator and a database kept.
9. If a service user refuses to be involved in the CPA or is discharged from the CPA, a form will be completed by CPA Co-ordinator and kept on file by the CPA Administrator. The notification letter of discharge should be sent to the service user and carer and electronic/posted copies will be emailed to all members of the CPA team.
10. Statistical Information is collected at a central point and every month, CPA Administrators in WBH and QMH will inform the CPA Administrator at Weston Day Hospital of the number of CPA admissions and discharges. These statistics will be collated and reports emailed to nominated recipients monthly.
11. The relevant CPA Administrator must be notified of any change of CPA co-ordinator by completing and sending the relevant form.
12. The CPA Administrator will complete administration for the CPA with Learning Disabilities Services.

1.9 ELECTRONIC STORAGE AND ACCESS

There is a requirement for CPA documents to be stored safely and consistently and to be available to all relevant parties, including service users and care givers.

Trakcare and the Clinical Portal have been identified as the routes for electronic alert, access and storage of CPA documents. The process to be used is:

1. An alert will be created on Trakcare (under the current title *Mental Health Alert)* and the user will be directed to the clinical portal to access the CPA document.

2. On receipt of a completed and signed CPA, the CPA will be uploaded to the clinical Portal via SCI Store by the CPA Administrator as part of the administration process (see embedded Standard Operating Procedure).

Draft SOP- Manual Doc upload CPA's 31 :

3. When CPA documents are reviewed and updated, the CPA administrator will be responsible for ensuring the expired document has been retired from the clinical portal and the new CPA document uploaded.
4. When service users are discharged from the CPA, the CPA administrator will retire the CPA document from the clinical portal and the Trakcare Alert will be closed.

1.10 CPA MEETINGS

The main approach should be that whenever information can be appropriately shared with the service user and their carer, Named Person or advocate then that information should be shared. Exceptions to this are primarily third party information or information which is likely to cause the service user distress.

CPA meeting

- The service user, carer, Named Person and/or advocate are present;
- There is discretion on who chairs the meeting (see box for suggested competencies for an effective chair), in most cases it will either be the RMO or CPA co-ordinator.
- The first part of the CPA meeting should involve feedback from the various professionals who have had contact with the service user. This should be a verbal summary of written submissions prepared in advance of the meeting and presented by those involved in the meeting. Responsibility for distributing those submissions lies with the CPA co-ordinator.

Competencies for chairing a CPA meeting

1. Be familiar with the clinical case
2. Able to ensure that objectives of the meeting and details of the care plan are set and agreed by members
3. Able to identify, coordinate and steer the meeting
4. Able to ensure that all members of the team fully participate in the meeting
5. Able to ensure that team members remain focussed on the meeting and present information on their objectives
6. Has the skills and attributes to lead a large meeting, keeping focus and the meeting to time
7. Able to adopt a facilitative style to encourage full and frank discussion
8. Know when to be decisive
9. Able to tackle conflict at an early stage
10. Able to communicate effectively orally
11. Able to negotiate and influence others to review and set objectives
12. Able to take sound decisions
13. Has both an analytic and a strategic ability
14. Sensitive to the needs of the patients and carers

1.11 RISK ASSESSMENT AND RISK MANAGEMENT

Risk assessment and management is an overarching principle in the management of any mental health or learning disability service user; it is an ongoing and dynamic process throughout the service user journey.

Risk management for service users under the CPA requires a multi-disciplinary and multi-agency approach. The CPA team will develop, communicate, implement and review the measures adopted to manage risk and teams should be aware of the meaning and impact these measure may have on communication of risk between agencies.

The risk that a service user may present can vary over time and with their condition. The risk of harm to others is an important concern when making decisions about any service user's treatment, care and recovery and those who present such a risk also are likely to be vulnerable to many other forms of risk, e.g. self harm, self neglect or exploitation by others.

Formal assessment of risk should take place at a number of stages in the service user's progress and will be reviewed and updated as circumstances change. It is therefore important that all relevant information is shared with the Mental Health Officer, as well as other members of the CPA team.

Risk Management

In response to the risk assessment, the CPA team will document preventative actions and contingency actions in the risk document and retained in the service user's CPA document. The plan will outline clear lines of accountability and responsibility and timeframes for delivery.

The CPA care plan will set out risk management strategies to:

- address the identified risk factors; and
- support and enhance protective factors.

The contingency action plan will set out planned responses to:

- the appearance of early warning signs;
- the weakening or breakdown of protective factors; and
- the weakening or breakdown of the risk management strategies set out in the treatment plan.

1.12 THE CARE PLAN

- Care will be delivered by means of a multi–agency agreed care plan.
- The agencies involved in the care plan will be directly involved in providing care based on identified need.
- The involvement of the service user and carer is central to devising the care plan.
- The Care plan will identify the individuals responsible for co-ordinating the care plan and how they can be contacted.
- All those involved in the CPA, including the GP, will receive copies of the care plan.
- The care plan will give details of crisis arrangements, for service users, carers and involved agencies.
- The care plan will show the time, date and place for review.

Depending on circumstances, the appointment of a CPA co-ordinator must be arranged **before** the initial CPA meeting. It is ***not*** acceptable for CPA co-ordinators to be identified without their permission.

Once the CPA co-ordinator is appointed it is their responsibility to complete the care plan. This will set out the objectives of care and the nature and range of services to be provided. It should be completed as a strength-based approach and identify for each agency and the service user:

- The frequency and nature of contact care and support to be provided by the CPA co-ordinator and the others involved in the care programme;
- How the CPA co-ordinator can be contacted;
- What services will be provided and by whom, including unmet needs;
- Time scales and the names of staff responsible;
- A clear statement of the action to be taken in a crisis;
- A clear statement about “out of hours” support available; and
- Details of date, time and place of next review.

The procedure for completing and submitting Care Plans should be followed at every meeting using the checklist, ensuring a consistent approach throughout Fife.

1.13 DISCHARGES AND REFUSALS

Discharges

People who no longer require the CPA should not remain on it any longer than necessary. Risk assessment will inform a discharge decision and must have overall agreement from all agencies involved, including the GP. Services users must be notified immediately of their discharge and appropriate arrangements made for continuing support to ensure sustainable discharge.

On discharge from the CPA, the appropriate form should be completed and sent to the relevant CPA administrator. This form should be signed by the service user and include the reason for discharge.

Refusals

Should a service user refuse the CPA, this must be noted on the referral form and where possible signed by service user and sent to the CPA administrator to be kept on file.

In all cases, the CPA administrator will notify the relevant parties.

1.14 CPA Audit

Regular audit of CPA documentation aims to find out if the CPA is being followed in line with this guidance. It shows where there could be improvements, where those improvements will be most helpful for patients using the CPA and ultimately improve outcomes for patients.

A CPA audit tool has been designed to be used throughout Mental Health and Learning Disability services.

SECTION 2

THE ENHANCED CARE PROGRAMME APPROACH FOR RESTRICTED PATIENTS

2.1 USING THE ENHANCED CPA WITH RESTRICTED PATIENTS

The CPA is a well-established model of joint working and care delivery, which delivers the day-to-day management of patients with complex needs. Extension to this working model introduced the *Enhanced Care Programme Approach* to manage the care of Restricted Patients in Scotland, ensuring consistency through the use of standardised processes and documentation in care planning and risk management plans.

Public protection is at the core of the decision making in respect of Restricted Patients' rehabilitation. The new Management of Offenders etc (Scotland) Act 2005 (the 2005 Act) and the introduction of Multi-Agency Public Protection Arrangements (MAPPA) led further impetus to establish joint arrangements for effective risk management.

Recommendations by the Forensic Network in Scotland were endorsed by the Scottish Government leading to the Enhanced CPA being adopted as the mechanism for regular review for all patients subject to Compulsion Order with Restriction Order (CORO), Hospital Direction (HD), Transfer for Treatment Direction (TTD) and Interim Compulsion Order (ICO). Under *Delivering for Mental Health* and the MAPPA Guidance, all Restricted Patients from 30 April 2008 must be managed under the new Enhanced CPA arrangements.

2.2 THE MANAGEMENT OF OFFENDERS ETC (SCOTLAND) ACT 2005 AND OPERATION OF THE ENHANCED CPA

The 2005 Act gives Health Boards[1] a statutory responsibility for the management of Restricted Patients. As a *Responsible Authority* the Health Board must establish joint arrangements for assessing and managing risk of Restricted Patients and effective information sharing between agencies. These arrangements will be supported by the operation of the Enhanced CPA which is **mandatory** for Restricted Patients. The Enhanced CPA care plan forms the template for admission, through-care, discharge and aftercare arrangements and specifies individual and agency responsibilities.

[1] The Scottish Prison Service, Local Authorities and the Police, are the *responsible authorities* for sex offenders and they must jointly establish arrangements for the assessment and management of risks posed by those offenders.

2.3 MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA) AND THE ENHANCED CPA

The introduction of Multi Agency Public Protection Arrangements (MAPPA) for Restricted Patients reinforces the requirement for multi-agency information sharing.

MAPPA and the Enhanced CPA for Restricted Patients have a common purpose of maximising public safety and reducing serious harm. Although the same underlying principles of gathering and sharing of relevant information in relation to risk apply, the Enhanced CPA focuses on the care and treatment likely to minimise the risk posed, whilst MAPPA focuses on multi agency management of risk. Within the MAPPA framework, the Enhanced CPA process will oversee planning a person’s care and treatment and for risk assessment and management planning.

Decisions on how and when to share information outside of the Enhanced CPA and MAPPA meetings, and who with, will be taken on a case-by-case basis and should take account of patient confidentiality considerations.

- MAPPA provides systems and processes for relevant agencies to share information about people who pose a risk to the community
- Ensures agencies co-operate in plans to assess and manage risk
- Oversees management of the most concerning cases and ensures that risks are being assessed and managed appropriately
- Scrutinises risk assessment, information sharing and risk management plans
- MAPPA does **NOT** become involved in direct case management or case conferences

Individuals are allocated a risk level, depending on the nature of the risk and how it can be managed. These levels are:

Level 1 – Ordinary risk management
Cases are managed by one agency without actively or significantly involving other agencies. Cases are notified to MAPPA but no active involvement is sought. Most Restricted Patients in hospital or on conditional discharge will be in this category.

Level 2 – Local inter-agency risk management
Higher level of risk or more complex management needs. Cases are discussed by more than one agency at regular MAPPA meetings. Restricted patients who are referred to MAPPA before unescorted suspension of detention, unescorted ground leave or conditional discharge will be in this category until discussed at the MAPPA

meeting. The MAPPA group may retain the patient at level 2 or may designate the patient as level 1 or level 3 (MAPPP).

Level 3 – Multi-Agency Public Protection Panel (MAPPP)
Deals with the critical few cases where there is a high likelihood of serious harm or which are very complex. Cases with a high media profile will also fall into this group. Very few Restricted Patients will fall into this category, but it may be appropriate in certain circumstances, e.g. where a patient no longer has a mental disorder and would be entitled to have the MHA order revoked.

Individuals can move up or down between MAPPA levels if risk management needs change.

2.4 AIMS AND OBJECTIVES OF THE ENHANCED CPA

The aims and objectives of the Enhanced CPA are to ensure:

- That patients with a mental disorder associated with complex health and social care needs receive on-going care support and supervision throughout their detention in hospital and rehabilitation into the community
- The availability of structured support for those most in need, or most at risk to themselves or others
- That there is effective multi-disciplinary agency collaboration
- That patients, their families and carers are involved as far as possible with care planning decisions and arrangements
- That there are enable systematic arrangements for the assessment and management of health and social care needs
- The appointment of a lead CPA Co-ordinator to monitor and co-ordinate care arrangements
- That the policy is compatible across Scotland.

2.5 CRITERIA FOR INCLUSION

The fundamental reason for making someone a Restricted Patient is to protect the public from serious harm. All Restricted Patients must be managed via the Enhanced CPA.

A Restricted Patient is someone who is subject to special restrictions as a result of an order made under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995 and who is subject to Multi-agency Public Protection Arrangements.

Only persons who have been sentenced by the Sheriff Court or the High Court and who also have a mental disorder will become subject to special arrangements under MAPPA. These sentences are:

i. **Compulsion Order and Restriction Order** (**CORO**) (s57A Criminal Procedure (Scotland) Act 1995) a Compulsion Order with a Restriction Order (s59 Criminal Procedure (Scotland) Act 1995). The person is convicted on grounds of diminished responsibility due to mental disorder and the measures are without limit of time. The person is detained in hospital until s/he is conditionally or absolutely discharged by the Tribunal

   When the court imposes special restrictions on the person in the form of a CORO, this is always done in the interests of public safety. It might be because of the nature of the crime committed or because of medical evidence about the risk the person may pose in the future. There should be a **serious risk** to the public and a **significant link** between the mental disorder and the offence and/or the future risk posed.

ii. **Hospital Direction** (**HD**) (s59A, 1995 Act) authorises removal to, and detention in, a specified hospital along with a prison sentence. It may be imposed in serious cases where there is **not** a close relationship between the mental disorder and the offence **or** where treatment of the mental disorder may not address the risk of further offending.

   The Hospital Direction allows the person to receive the appropriate medical treatment in hospital under Part 16 of the Mental Health (Care and Treatment) Scotland) Act 2003 (2003 Act) and then to be transferred to prison to complete the prison sentence. The time spent in hospital counts as time served in relation to the sentence.

iii. **Transfer for Treatment Direction** (**TTD**) (s136, 2003 Act) authorises transfer of prisoners to a specified hospital for treatment of a mental disorder. The order lapses when the prison sentence expires and continued detention in hospital is only possible if the person's case is brought before the Tribunal and would be considered on the same basis as an application for a Compulsory Treatment Order.

2.6 ENHANCED CPA TRAINING

The main aim of training is to ensure that all the agencies involved with the Enhanced CPA are suitably informed of the aims and objectives of the process. It is important that staff have an understanding of their own and others' roles and responsibilities and that training is multi-agency in nature. Training should provide staff with the necessary skills to carry out their roles and responsibilities effectively. It should allow all those involved in the Enhanced CPA to become informed not only with the process, but also with the human experience of being part of the Enhanced CPA, ideally involving both carers and service users.

2.7 ROLES AND RESPONSIBILITIES OF THE ENHANCED CPA TEAMS

There is a mandatory Enhanced CPA process for Restricted Patients and teams have the following responsibilities:

- To maintain accurate records on Restricted Patients through completion of the Enhanced CPA care plan; undertaken by the CPA Co-ordinator with input from the whole of the Enhanced CPA team
- Develop risk management plans for the Restricted Patient ensuring that public protection is paramount
- Ensure notification and referral of Restricted Patients to the MAPPA co-ordinator, including any proposed changes of circumstances and any significant events
- Conduct regular multi-disciplinary/multi-agency review meetings
- Use standardised documentation for care plans that incorporate risk issues and contingency plans (Enhanced CPA Care Plans)
- Police and other relevant agencies **must** be involved in the Enhanced CPA process

The Health & Social Care Partnership must be able to demonstrate the effective establishment and implementation of the arrangements between agencies for the

management of offenders who are subject to MAPPA arrangements. There should be an identified a senior manager responsible for providing assurance on the quality of the operation of Enhanced CPA and any statistical information required by the MAPPA coordinator.

2.8 REFERRAL

For Restricted Patients

Restricted patients will automatically be placed on an Enhanced CPA. The Forensic Community Mental Health Team (FCMHT) will be made aware of the patient's transfer date to NHS Fife and an initial Pre-Enhanced CPA and Enhanced CPA meeting will be arranged within 4-10 weeks of transfer.

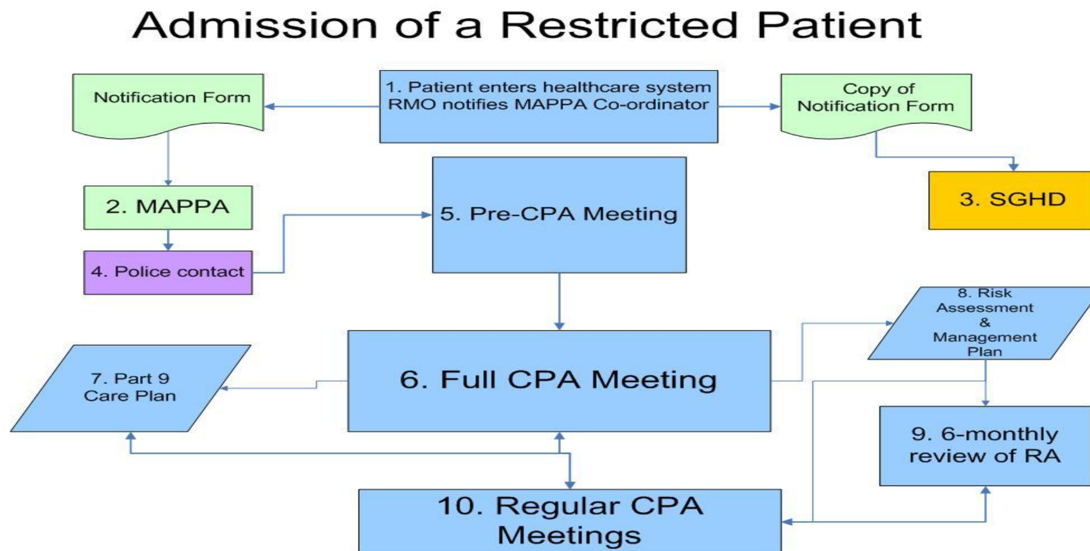
For non-Restricted Patients;

Any patient whose CPA Co-ordinator is a member of the FCMHT will be placed on an Enhanced CPA, providing that patient gives consent. The CPA Co-ordinator sends the Enhanced CPA referral form to Team Administrator who will record and copy to Enhanced CPA Administrator at Weston Day Hospital. The referral form should contain as much information about the service user as possible. A date, time and venue for the meeting should be included.

The referral form should be signed by the service user to show that they are aware of the CPA referral and that they accept it (if able to do so).

CPA Administrator should be informed of any transfers out with the locality

2.9 ADMISSION OF A RESTRICTED PATIENT



1. Restricted patient enters the healthcare system
2. RMO notifies the MAPPA co-ordinator before Enhanced CPA meeting to provide details of the patient
3. Copy of the notification sent to SGHD
4. MAPPA identifies police contact
5. Police contact attends pre-Enhanced CPA meeting to enable intelligence gathering in relation to risk
6. Convene Enhanced CPA meeting within 4-10 weeks
7. Enhanced CPA team compiles Part 9 care plan (written by CPA Co-ordinator)
8. Risk assessment and management plan prepared that includes addressing the risk of and likely outcome should the patient abscond
9. Regular Enhanced CPA meetings held
10. Risk management plan reviewed 6-monthly or more frequently if necessary

2.10 IMPLEMENTING THE ENHANCED CPA

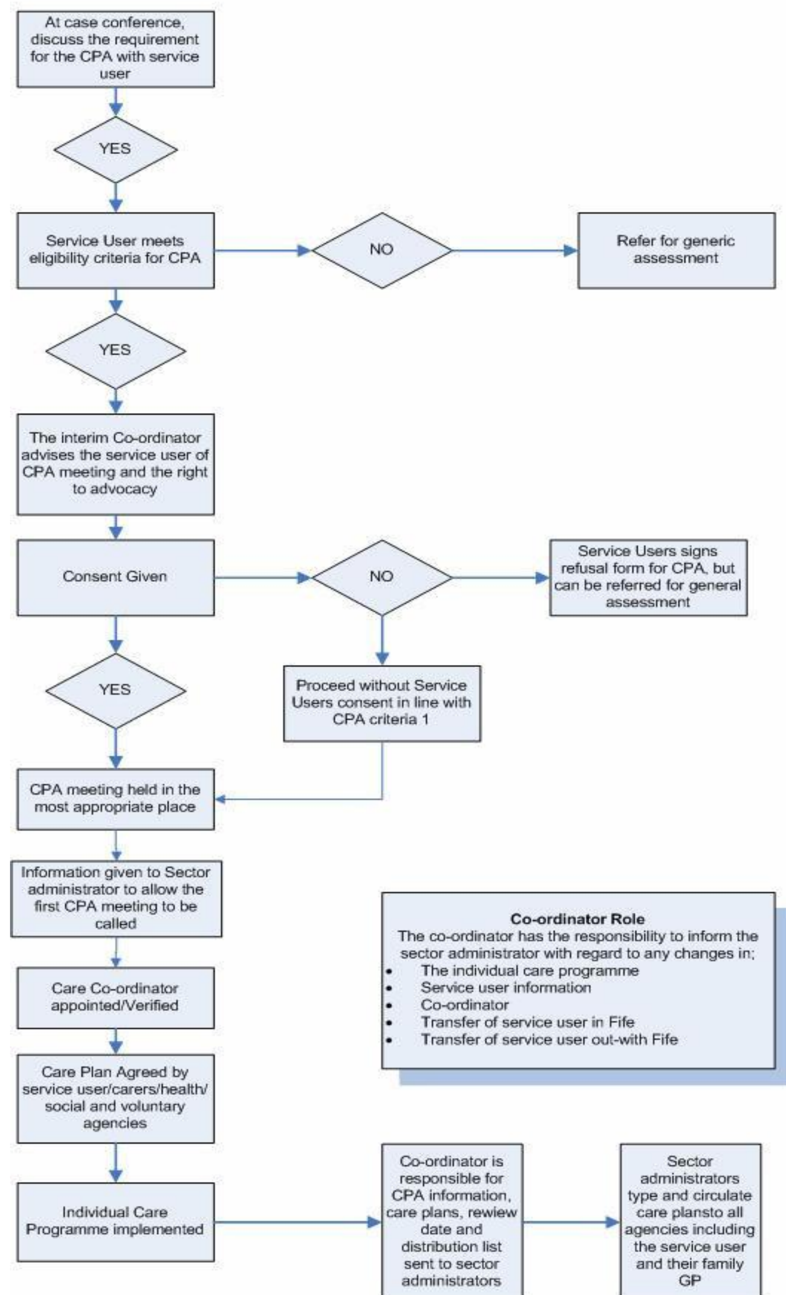
Guidance on the implementation of the Enhanced CPA states that the Enhanced CPA is the appropriate tool for all Restricted Patients.

Enhanced CPA Meetings

The Enhanced CPA is the method of management and review for all Restricted Patients in Scotland. An initial meeting should be held approximately 4 - 10 weeks after admission to hospital and review meetings should be held at least every 6 months. More frequent meetings will be necessary when situations change, especially those that influence risk.

The main approach should be that whenever information can be appropriately shared with the patient and their Named Person or advocate then that information should be shared. Exceptions to this are third party information or information which is likely to cause the patient distress.

In appropriate cases the Enhanced CPA process will have two stages:



Pre-Enhanced CPA meeting

- The patient will not be present.
- The meeting focuses on third party information, sensitive information or material that members of the multidisciplinary team feel uncomfortable in sharing in front of the patient.
- It is vital that the Pre-Enhanced CPA meeting determines whether it is appropriate that this information is shared with the patient and should be included in the Enhanced CPA Meeting.
- It is up to the chair to decide whether this is so.
- The pre-Enhanced CPA meeting will be briefly minuted.
- This will be considered third party information and not shared with the patient along with the rest of the Enhanced CPA documentation.
- Where Police are involved they will take part or contribute information that will be considered in the pre-Enhanced CPA meeting.
- The Police acknowledge the need to cooperate in this process; however, they should not be invited to attend every Enhanced CPA meeting.
- Police will only attend at the key stages listed below:
  a. At the point of admission, to allow a suitable police liaison officer to be identified, and to assist with the gathering information for the risk assessment process
  b. When the patient is being considered for escorted leave within the community or in certain circumstances escorted leave within hospital grounds
  c. When unescorted leave is being considered
  d. Prior to the patient being referred to the Mental Health Tribunal for conditional discharge
  e. When a breach of condition(s) occurs and/or a patient is recalled
  f. Any other occasion when it can be demonstrated that a police officer's presence is essential

Enhanced CPA **meeting**

The Patient, Named Person and/or advocate are present. There is discretion on who chairs the meeting (see box for suggested competencies for an effective chair). In most cases it will either be the RMO or CPA Co-ordinator.

The first part of the Enhanced CPA meeting should involve feedback from the various professionals who have had contact with the patient. This should be a verbal summary of written submissions prepared in advance of the meeting and presented by those involved in the meeting. Responsibility for distributing those submissions lies with the CPA Co-ordinator.

There need not be a full repetition of the patient's past history at every Enhanced CPA, but the care plan should state where a historical summary can be. This should include the normal information contained within a past psychiatric history summary and also a summary of the information of particular relevance to risk assessment. It may be that in part of the Enhanced CPA meeting or pre-Enhanced CPA meeting a presentation of the past information is given, either because it is the first Enhanced CPA in that particular setting following a transfer or because of the inclusion of new members into the Enhanced CPA process.

Following the presentations there should also be an opportunity for the patient or Named Person to state their hopes for the next stage of their journey.

There should then be a review and updating of care plan objectives. Risk assessment should inform those aspects of the care plan which can reduce risk. The care plan for patients on compulsion orders with restriction orders should fulfil all the requirements of a part 9 care plan (section 137 of the Mental Health (Care and Treatment) (Scotland) Act 2003). **Where a more detailed care plan exists there should be a cross reference to that documentation.**

Summary of the Enhanced CPA Meeting

1. Feedback for professionals (verbal summary of written submissions)
2. Presentation of past history if meeting follows a transfer or new members to the meeting
3. Opportunity for patient and/or Name Person to express views
4. Review and update of care plan objectives including aspects of risk assessment which can reduce risk
5. Clear reference to Risk Management documentation
6. Identification of particular risk factors including relapse of symptoms and use of alcohol or illicit drugs
7. Decide practical contingencies in relation to risk factors using ‘traffic light’ approach
8. Review of any amber or red alert
9. Opportunity for comments on any gaps in treatment or contingency plans
10. Opportunity for patient and/or Named person to comment on the plan
11. Dissenting views from team members should be documented
12. Set date and time of next meeting

2.11 CARE PLANS

Restricted Patients must have standardised care plans containing a number of core documents:

- Key demographic information
- Legal status
- MAPPA status
- Historical summary
- Parties involved in Enhanced CPA
- Compulsory treatment details
- Advance Statement
- Multidisciplinary reports
- Identified needs
- Review of previous objectives
- Professional care plan
- Contingency plan
- Risk assessment
- Risk summary
- Minute of previous meeting
- Patients' views/comments on care plan

2.12 TRANSFERS

All transfers of Restricted Patients must have the Scottish Ministers' approval (section 218(3), 2003 Act) in addition to securing the consent of the hospital managers in the receiving hospital, whether to higher, lower or equivalent levels of security. The patient and their named person must normally be given 7 days notice of the transfer. However, where this is not possible, transfer may still take place in urgent cases and notification completed afterwards. No notification is required if the patient consents to transfer.

Where service users move between Local Authorities or Health Boards, there should be clear arrangements for the transfer of responsibility. No transfer should take place until arrangements for care and support are firmly in place.

In the case of a service user moving between sectors in Fife, or moving to a new address out with Fife, the CPA Co-ordinator is responsible for ensuring that the necessary arrangements are made and documentation completed (blue form). Once the new arrangements have been agreed, these should be notified to the administrator of the new and original sector.

There are other types of transfer that an RMO may encounter. For instance, the transfer of a restricted patient on conditional discharge, the transfer back to the home country of a person held in hospital and transfer from hospital back to prison of a TTD patient. Further advice is available from the Scotland Government Health Directorate ("SGHD") officials.

The RMO should contact SGHD officials for specific advice about any planned transfers and must notify the local MAPPA Co-ordinator of same.

For further information; specific guidance is given in chapter 9 of the *Memorandum of Procedure on Restricted Patients* regarding the following types of transfer:

- Transfer to another ward within the same hospital;
- Transfer to another hospital with equivalent level of security;
- Transfer to another hospital involving a reduction in the level of security;
- Transfer to the State Hospital from conditions of lower security;
- Transfer to Scotland; and
- Transfer from Scotland.

2.13 DISCHARGE OF RESTRICTED PATIENTS

Conditional Discharge

Conditional Discharge applies to CORO patients only; there is no possibility of a patient subject to a Transfer for Treatment Direction or Hospital Direction being conditionally discharged from hospital under the Mental Health (Care and Treatment) (Scotland) Act.

Once a CORO patient has reached the stage of overnight suspension of detention from hospital (granted under section 224 of the 2003 Act for Restricted Patients) to accommodation where it is anticipated they will ultimately reside on conditional discharge, a MAPPA referral should be made by the RMO on the appropriate form. The consideration by the MAPPA will help inform the Scottish Ministers Position Statement to the Tribunal following a recommendation by the RMO for conditional discharge.

A CORO patient’s discharge from hospital is subject to certain conditions set by the Tribunal, the exception being those Restricted Patients who are also life sentence prisoners. The conditions imposed normally relate to residence, supervision by RMO, MHO and Forensic CPN. However, additional conditions may be recommended either for the protection of the public or of the patient. Under the 2003 Act, Scottish Ministers may vary these conditions at any time, and Scottish Ministers have power to do so if they consider variation is necessary.

Multidisciplinary teams should make any plans for Conditional Discharge via the normal Enhanced CPA procedures and in response to needs assessment and risk assessment (including the risk of harm to others).

Conditions of discharge must be stringently adhered to by the patient and monitored closely by the supervising team. Where there is a breach of any of the conditions of discharge, this will automatically trigger a formal consideration of whether recall is appropriate via an Enhanced CPA meeting. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SGHD immediately.

Absolute Discharge

For CORO patients, the Tribunal can order revocation of the Compulsion Order part; or revocation of the Restriction Order part,

Where the Compulsion Order is revoked the Restriction Order also ceases to be in place; this has the effect of ending the special restrictions and patient is absolutely discharged.

It should be noted in relation to a Restriction Order that the "risk of serious harm requiring detention in hospital" test is a quite separate test from the "necessity for a restriction order" test. A recommendation for revocation of a restriction order will only be appropriate where the RMO is satisfied that ***both*** tests are not met.

Revocation of the restriction order will leave the patient as a compulsion order patient, subject to Part 9 of the Act instead of Part 10, whose management is now solely at the discretion of the RMO, subject to the power of the Tribunal to order discharge.

When it is not appropriate to recommend revocation of the compulsion order, it would normally be appropriate to lift the Restriction Order when:

- A patient continues to be detained in hospital with little prospect of conditional discharge due to the severity of their illness but has become frail, particularly due to age, and will never pose a threat of serious harm to others. **NB** look at offending behaviour as not all dangerous offences require strength, e.g. fire-raising or assault/attempted murder by poisoning; and
- The patient's management is almost entirely to protect his or her own health and safety needs rather than those of others.

In most cases, the CORO patient will have been under supervision in the community on conditional discharge for several years without incident before a decision about revocation of the compulsion order will be taken.

For further information see Chapters 11-13 of the [Memorandum of Procedure on Restricted Patients]() (2010) which includes guidance on:

- *When conditional discharge may be appropriate*
- *Pre-Discharge Procedures*
- *Roles of the care team*
- *Changes*
- *Recall to Hospital*
- *Reasons for lifting restrictions*

2.14 RISK ASSESSMENT AND RISK MANAGEMENT

Risk assessment is an overarching principle in the management of Restricted Patients; it is an ongoing and dynamic process throughout the patient journey. The risk that a patient may present can vary over time and the patient's condition. Good clinical care should involve a multidisciplinary approach of structured risk assessment and management within the Enhanced CPA. The Scotland Government Health Directorate expects reassessment of the risk that a patient might present at six-monthly intervals or at appropriate points and, in particular:

- Before transfer involving a drop in the level of security;
- Prior to a MAPPA referral and
- Prior to consideration by the Tribunal.

Formal assessment of risk should take place at a number of stages in the patient's progress and will be reviewed and updated as circumstances change. It is therefore important that all relevant information on a patient is shared with the Mental Health Officer and other members of the multidisciplinary team and the dissemination of information may be extended to include external agencies such as local authority housing departments, care providers and the police. Similarly, the Enhanced CPA process may offer opportunities for gathering additional information, e.g. local police intelligence at pre-Enhanced CPA meetings.

In response to the risk assessment, the multidisciplinary team will document preventative actions and contingency plans in the Enhanced CPA documentation, alongside mental health considerations that may or may not be linked to the risk to others. The plan will outline clear lines of accountability and responsibility and timeframes for delivery.

Risk Management for Restricted Patients requires a multi-disciplinary and multi-agency approach and the multidisciplinary team must develop, communicate, implement and review the measures adopted to manage risk. Management with

MAPPA for Restricted Patients makes the police an integral part of the process. There also may be separate risk assessments undertaken by Criminal Justice agencies; teams should be aware of these, their meaning and impact on communication of risk between agencies.

The Enhanced CPA care plan will set out risk management strategies to:

- Address the identified risk factors; and
- Support and enhance protective factors.

The contingency action plan will set out planned responses to:

- The appearance of early warning signs;
- The weakening or breakdown of protective factors; and
- The weakening or breakdown of the risk management strategies set out in the treatment plan.

The Enhanced CPA Documentation must:

- Set out the arrangements for the supervision and monitoring of the patient;
- Detail the treatments or interventions to be carried out; and
- Address victim safety planning.

An essential part of the Enhanced CPA is Risk Assessment and Management and the care plan for a restricted patient must include measures to manage the risk that the patient poses to others. During the Enhanced CPA meeting there should be clear reference to whatever Risk Management document has been produced and there should be an identification of the particular risk indicators relevant to the patient. In many cases this will include the relapse of symptoms of mental disorder and the use of illicit drugs or alcohol. The Enhanced CPA should then include what practical contingencies should be put in place in relation to the risk indicators using a *traffic light approach*.

The risk assessment will demonstrate a thorough review of the following information:

- Personal and family history
- Criminal history and history of violence
- Substance misuse
- Psychiatric history
- Assessment of personality
- Other relevant risk factors

It involves the use of appropriate risk assessment tools and the risk assessment will clearly document:

- The likely impact of the harm posed by the patient
- An indication of those to whom the patient poses a risk of harm
- All relevant risk factors
- Active protective factors
- Early warning signs and relapse indicators

The Traffic Light Approach
For each risk indicator the factors which suggest continuing the current treatment plan should be identified as a **green** light. For example, in the case of recurrence of symptoms of major mental illness, a green light would be identified where there is no evidence of recurrence of major mental illness.

If the clinical team identify factors that might signify the early return of symptoms, this would be identified as an **amber** light. An amber alert should always be reported to the Scottish Government Health Department (SGHD) and there should always be an early review by the clinical team.

A **red** light would be the presence of a major risk factor and would trigger emergency action such as urgent recall to hospital for conditionally discharged patients.

Enhanced CPA documentation will be used to record risk assessment, multi-disciplinary reports and management plans as well as the ongoing care and treatment of the patient. The traffic lights system is an integral part of the Enhanced CPA documentation and clearly highlights risks, relapse signs and crisis planning. It is also used to provide the risk management information necessary to support requests for escorted and unescorted suspension of detention.[2]

Review
Reviews will be carried out at least every 6 months. Meetings can be held more frequently if required, for example when a Restricted Patient is initially granted conditional discharge to allow close monitoring during the transitional period from hospital to community.

[2] http://www.sehd.scot.nhs.uk/mels/CEL2007_13.pdf

EXAMPLE : Mr Bloggs is a restricted patient on conditional discharge in the community		
	Contingency Planning	**There may be circumstances that do not appear on this list that require action. Any professional with any concerns about this patient's circumstances or behaviour should contact the clinical team.**
Category	**Early Warning Signs (Relapse Indicators)**	**Contingency Actions**
Symptoms of Mental Illness	**Green**: No evidence of symptoms of psychosis or depression **Amber**: Prolonged periods of anxiety, suspiciousness, pre-occupied or withdrawn **Red**: Command hallucinations, delusions regarding aliens	• Continue current treatment • Review by Clinical Team, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) • Emergency Recall - Inform Duty RMO immediately (tel: 032164 16548241)
Substances	**Green**: No positive urine drug screens despite regular monitoring **Amber**: empty can or missed drug test **Red**: Clear evidence intoxicated with illicit substances positive test.	• Continue current treatment • Alco meter test. Inform RMO by end of next working day (Dr J Smith, tel: 03256 2561479) • Emergency Recall - Increase observation levels, stop access to sharp instruments - Inform Duty RMO immediately (tel: 032164 16548241)
Engagement with Team	**Green**: Compliant with medication and keeping all appointments **Amber**: Suspected non-compliance with medication, missed appointment(s) **Red**: Refusing medication, refusing to attend appointments	• Continue current treatment • Inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) • Emergency Recall - Inform Duty RMO immediately (tel: 032164 16548241)

2.15 ENHANCED CPA AUDIT

The concept of clinical governance was introduced to NHS Scotland in 1997 and was described as corporate accountability for clinical performance. More recently, it has been described as the system for making sure that healthcare is safe and effective, that care is patient-centred and that the public are involved. Health Boards must be able to demonstrate clarity around governance arrangements for Restricted Patients and the effectiveness of risk reporting arrangements.

Health Boards also have to demonstrate that they are satisfied with the quality of the operation of the Enhanced CPA and that there are appropriate resources in place. They will be responsible for collating statistical information on the operation of Enhanced CPA, MAPPA and recording breaches of conditional discharge.

It is essential that a senior manager is identified for each Health Board and that s/he works with the relevant RMO in order to meet their responsibilities under MAPPA. It is recommended that an audit be carried out on the quality of the operation of Enhanced CPA on an annual basis.

FURTHER READING

Adult Support & Protection (Scotland) Act 2007
Criminal Procedure (Scotland) Act 1995
Memorandum of Procedure on Restricted Patients 2010
Mental Health (Care and Treatment) (Scotland) Act 2003
Mental Health Law website

Multi-agency Public Protection Arrangements, version 4 (MAPPA)

TRANSLATION AND INTERPRETATION

You can obtain the service of an interpreter or have this document translated into your own language by contacting the Fife Community Interpreting Service on 01592 611745

مرحبا بكم
للحصول على أية معلومات من الموقع الإلكتروني بلغة أخرى أو بصفة مختلفة، فالرجاء الإتصال على قسم الإتصالات في الخدمات الصحية في مقاطعة فايف. هاتف رقم: 01592 647971

W celu uzyskania informacji ze strony internetowej w innym języku lub w innym formacie prosimy dzwonić do *Communications Departament* przy *NHS Fife.* Numer telefonu 01592 647 971

خوش آمدید
ویب سائیٹ سے دوسری زبان یا فارمیٹ (شکل) میں کسی قسم کی معلومات حاصل کرنے کے لئے براہ کرم کمیونیکیشن ڈپارٹمنٹ ، این ایچ ایس فائف (Communication Department, NHS Fife) سے فون نمبر **01592 647971** پر رابطہ کیجئے۔

歡迎

如欲取得網頁上任何資料的其他語言或型式的版本，請與快富國民保健服務的通訊部門(**Communications Department at NHS Fife**)聯絡，電話：**01592 647971**。

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