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Care Programme Approach

NHS England position statement

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Introduction

1. The NHS Long Term Plan set out a commitment for the NHS to transform community mental health services for adult and older adults by investing almost £1 billion per year by 2023/24 to implement new and integrated models of primary and community mental health services for people with severe mental health problems across every integrated care system (ICS) in England. Since 2019/20, 12 'early implementer' systems have received over £70m to develop new models in line with the national Community Mental Health Framework, and all systems will be implementing new models over the next three years from April 2021 supported by year-on-year growth in new NHS Long Term Plan investment.

2. The Community Mental Health Framework, published in September 2019, proposed "replacing the [care programme approach (CPA)] for community mental health services, while retaining its sound theoretical principles based on good care co-ordination and high-quality care planning." The NHS Standard Contract 2021/22 Technical Guidance document published as part of the Standard Contract consultation stated that "With the publication of the Community Mental Health Framework, the Care Programme Approach has now been superseded." Responses to the 2021/22 consultation were overwhelmingly in favour of this proposed change. Specific reference to CPA from the 2021/22 Contract has therefore been removed. This follows amendment in 2020/21 of a key Standard Contract mental health metric on 7-day follow-up from people on the CPA discharged from inpatient care, to 72-hour follow-up for **all patients** discharged from inpatient care.

3. This CPA position statement has been developed by NHS England in response to queries regarding the national policy position and direction of travel away from the CPA. We have drawn on key points of learning shared by 'early implementer' systems, research evidence, and intelligence from service users, carers and professionals that fed into the Framework. We are publishing the Statement in order to support all ICSs and mental health providers to transform, expand and improve their community mental

health services and implement new models in line with the Framework from April 2021, and not be constrained in doing so by what they believe to be required of them by the CPA.

Background and rationale

4. The CPA was originally introduced to provide greater shape and coherence to local services' approaches to supporting people with severe mental illnesses in the community, based on care co-ordination, care planning and case management. As the Community Mental Health Framework acknowledged, "The CPA has had a central role in the planning and delivery of secondary care mental health services for almost 30 years. The principles underlying the CPA are sound and there has been some excellent work over the years in implementing and in improving it."

5. However, the CPA was originally introduced by the Department of Health 30 years ago, and has not been updated for almost 15 years. Community mental health policy and practice have evolved significantly over this time, along with the introduction of new relevant legislation such as the Care Act 2014, and more recent relevant policy signals such as the government's 2021 Mental Health Act White Paper proposals on statutory care planning. Prior to the NHS Long Term Plan, core community mental health services received negligible additional funding for many years.

6. A number of concerns have been raised by a range of stakeholders in recent years that the continued way in which the CPA is used in community mental health services represents a major barrier to providing the higher quality, more flexible and personalised care that the Framework envisages and that service users need.[1] Following publication of the Framework, it is clear that an altogether fresh approach is needed.

Moving forward

7. The Community Framework makes clear that one of its purposes is to enable services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards **a minimum universal standard of high-quality care for everyone in need of community mental healthcare**. A flexible, responsive and personalised approach following a high-quality and comprehensive assessment means

[1] One example may be seeking to understand and co-productively address the biopsychosocial factors that may have led to someone believing they are at risk of harming themselves, rather than simply labelling the individual as "high risk" in their review meeting notes without further enquiry or a remedial plan of action.

that the level of planning and co-ordination of care can be tailored and amended, depending on:

- the complexity of an individual's needs and circumstances at any given time
- what matters to them and the choices they make
- the views of carers and family members
- professional judgment.

8. We want to make absolutely clear that the shift does not mean taking away any positive aspects of care that someone currently on the CPA is experiencing, and local services need to be equally clear about this in their communications with service users and carers. Those currently on CPA should be gaining access to high quality care through the transformation of services and additional investment. Given the CQC's regular findings in its annual community mental health surveys[2] that people on CPA report relatively better experiences of care than those not on the CPA, **the new system of care envisaged in the Framework should be pulling up the standard for all**.

9. The new approach is based on the following five broad principles, some of which are further outlined below:

    i) A shift from generic care co-ordination to **meaningful intervention-based care** and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care.

    ii) **A named key worker for all service users with a clearer multidisciplinary team (MDT)** approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.

    iii) **High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community**: a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (eg section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure

[2] Recent surveys and information (2018-2020) are available via the following links to the CQC and NHS Surveys websites: Community mental health survey 2020 | Care Quality Commission (cqc.org.uk) and Data library - NHS Surveys.

Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.

iv) **Better support for and involvement of carers** as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.

v) **A much more accessible, responsive and flexible system** in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.

A shift from generic care co-ordination to meaningful interventions

10. Care co-ordination is important work and has often been under-appreciated as a function which should provide high quality care to service users, often within an outmoded and historically resource-constrained system. While many service users find care co-ordination valuable – and while care co-ordination may form a significant part of the overall support that someone with a severe and complex mental health problem receives – care co-ordination is not a meaningful intervention in and of itself.

11. In order to achieve the transformation of community mental health services that we want to see across England, providers and their partners should therefore move away from care co-ordination as an intervention in itself and focus delivering compassionate, meaningful, intervention-based care which has been planned between the service user and their care team (eg timely commencement of a course of psychological therapy). At the same time, the Framework's emphasis on ensuring that flexible, longer-term systems of care are in place for people with severe mental health problems should be maintained. This will allow the easy 'stepping up' or 'stepping down' of care as needed, and will remove the harmful prospect of people in need of long-term care being 'discharged' and left with no support, or having to battle to re-enter services.

A named key worker for all service users with a clearer multidisciplinary team (MDT) approach

12. Continuity of care is something that professionals and service users all want to achieve in community mental health services. Service users and carers should therefore have clarity as to who they can contact via having a named key worker; in most cases we expect this would be the existing care co-ordinator for people already under their care of services. All parties should share clear expectations around communication and best

practice would be a key worker who can form a therapeutic alliance with the service user, and whom the service user trusts and connects with.

13. At the same time, services need to adopt clearer MDT-based approaches by ensuring that named key workers and patients are supported by a robust MDT integrated with social care and the VCSE, which helps to address people's social needs as well as their clinical needs, rather than the system of care relying on a single care co-ordinator coping with an overwhelming workload. The move away from a generic care co-ordinator role is also an important step in supporting all staff to perform the roles they qualified in and went into their professions to undertake, allowing them to apply their unique skills in supporting individuals as part of an MDT, such as in nursing, social work, or occupational therapy.

    This means that services should not respond to this Statement by simply rebadging care co-ordinators as key workers; the purpose of designating key workers is to ensure that a service user can build a consistent, trusted relationship with an individual who understands their history and who can support the service user to engage with the care and support available through a therapeutic alliance. Every member of the MDT should play a prominent role in sharing responsibility for an individual's care and it should be the MDT as a whole playing the co-ordinating role across the various organisations and sectors from which its members are drawn (eg nursing, social care, occupational therapy, employment/vocational support, housing, substance use, VCSE).

14. A fully personalised approach also allows providers and ICSs to take a population health approach by determining what different care spells or care packages look like for different people with different presenting needs and circumstances at a given point in time.

High-quality co-produced, holistic, personalised care and support planning

15. There is little evidence to suggest that the implementation of the CPA has led to high-quality care planning when it is used, and in general there is a need for services across the country to significantly improve the quality and relevance of care planning for people with moderate to severe mental health problems. While the type of plan and the level of support needed will depend on the person and their individual needs, ensuring that all care and support plans are genuinely co-produced, personalised – and Care Act-compliant and integrated with Mental Health Act section 117 plans where necessary – should be a key aim of all new models. This should help to ensure efficiency and minimise the administrative burden on all health and social care staff, as well as improve care.

16. In line with the NHS comprehensive model of personalised care, service users should be encouraged to be owners of the information within their care plan, be familiar with its content and feel confident to request reviews and amendments should circumstances change. Care plans should include the actions that the service user undertake, that carers and/or family members might undertake, and the actions services will undertake to support them. They should include flexible and revisable timescales for review depending on agreement between the MDT, service user and carer / family where appropriate, as opposed to within a long and arbitrary timeframe (currently six or 12 months).

    Plans should reflect the service user's individual needs rather than generic service policies or processes. There should be brief, clear documentation and follow-up of agreed actions, given the centrality of trust to any positive therapeutic relationship. In digitised form they should be live, easily available and accessible both in terms of language and format (to service users, carers, family members and all agencies involved in someone's care), and updated regularly as agreed with the service user. The care planning process and its outputs should be viewed as fundamental parts of the meaningful care that services seek to provide, rather than a box-ticking exercise, and should be linked to routine outcome measurement.

Support for and involvement of carers

17. Carers often play a vital role in supporting people with severe mental health problems in the community. While past national CPA guidance laudably set clear expectations around carer involvement – and much of the content in Standard 6 of the National Service Framework for Mental Health regarding carers remains helpful if not outdated – there continues to be variation reported in the extent to which services and statutory organisations understand and act on their legal duties (including promoting the right to a carer's assessment for carers of people with mental health problems), as well as best practice.

18. Carers often face specific inequalities and are protected from discrimination under the Equality Act. NHS England's development of a Patient and Carer Race Equality Framework for use in mental health services is a response to the need to address racial disparities and is part of a wider Advancing Mental Health Equalities Strategy.

19. For this reason, NHS England has asked all ICSs preparing to use new Long Term Plan funding to transform their community mental health services from April 2021 to develop and implement plans for a specific strategy to involve and improve the lives of carers of people with severe mental health problems. Resources to help services and ICSs do so include:

- the Carers Trust's Triangle of Care
- NHS England carers toolkit
- NHS England Supporting carers in general practice: a framework of quality markers
- NICE guideline NG150 on Supporting adult carers
- information on the use of Family Intervention approaches
- specific resources for supporting young carers.[3]

Safety

20. Evidence shows that the safest care is care that is personalised and highly responsive. Clear themes include:

    a) high-quality care planning
    b) an understanding of risk and safety as dynamic within a comprehensive assessment
    c) meaningful engagement with families and carers
    d) communication and information sharing
    e) robust record-keeping; and effective multi-agency working.[4]

21. The National Confidential Inquiry into Suicide and Safety in Mental Health describes how, in order to make approaches to safety personalised and effective, assessments of (changing) personal and individualised risks should not be based on the use of tools and checklists. It is therefore important that assessment of risk forms part of a wider assessment, and that safety planning is built into the wider care planning process rather than being divorced from it. A personalised approach to managing risk is a key part of the personalised care and support planning process. Once risks are identified, through personalised conversations options are explored that are relevant to the individual to help mitigate the risk.

22. There is potential for a misplaced perception in some services that using the CPA in and of itself will keep people safe. This could be due to anxieties on the part of clinical teams that, if people under their care come to harm themselves or others, they will be reprimanded for not using the CPA.

    This can potentially drive unhealthy behaviours, cloud professional judgement within teams and may lead to poor decision-making. It implies that, as they implement new models, in doing so providers will also inevitably need to re-examine the safety cultures

[3] See also The Triangle of Care for Young Carers and Young Adult Carers: A Guide for Mental Health Professionals
[4] See An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day

within their organisations and develop a more progressive understanding of safety as a key aspect of mental health care that is underpinned by providing an accessible, compassionate, communicative and high-quality service.

This was also raised as a major theme in the Independent Review of the Mental Health Act and points to a wider cultural shift needed across all mental health services, which the NHS Long Term Plan and the Mental Health Act reform proposals provide clear opportunities to bring about.

Use of the CPA in other services

Health and justice settings

23. The CPA is also used, albeit inconsistently, within custodial health and justice settings. Eligibility for the CPA has never aligned with prison mental health caseloads and, if followed closely, would likely include the majority of the prison population. The CPA should continue to be used within prisons and will be included within the planned prison mental health specification review during 2021/22.

Learning disability and autism services

24. There will be people with a learning disability and people who are autistic who access mental health services and would be entitled to the same offer as everyone else accessing those services. Services therefore need to be provided in accessible ways and with the required reasonable adjustments. Services should ensure that the changes set out in this Statement are applied for specialist learning disability and autism pathways where people are receiving assessment, care and treatment for their mental health and behaviours that challenge.

25. People with a learning disability and autistic people remain entitled to regular Care and Treatment Reviews (CETRs) in line with existing national policy. NHS England's 2017 Care and Treatment Reviews: Policy and Guidance documentation will be updated to reflect the changes set out in this Statement.

Specialised Commissioning Mental Health, Learning Disability and Autism Services

26. The CPA will continue to be used in adult secure services and is included in published service specifications. A review of CPA within these setting will be undertaken with key stakeholders (including service users and families) during 2022/23. We will look to ensure people who may be moving between community mental health, learning disability and autism services, the Criminal Justice System and adult secure services

are supported in a consistent way under the principles set out in this Position Statement and this will be agreed and co-produced with all relevant stakeholders.

27. The CPA will continue to be used in the following services:-

    a) *Adult Eating Disorders*

    b) *Deaf Mental Health Services for Adults*

    c) *Obsessive Compulsive Disorder & Body Dysmorphic Disorder*

    d) *Perinatal Mental Health*

28. The CPA is currently included in each of the published service specifications for the above service lines. The CPA will remain for each as NHS England retains commissioning responsibility for these services at present.

29. For all patients accessing any of the inpatient services/settings listed above, we will continue to provide support to them when moving through or transitioning from community mental health settings to specialist mental health inpatient settings in line with the principles detailed within this position statement.

30. Any future review of the use of the CPA in the services listed above will involve service users, experts by experience, family/carers alongside other key/relevant stakeholders to take an informed and co-produced approach.

Next steps

31. NHS England is committed to supporting services and systems to implement new models in line with the Framework supported by new NHS Long Term Plan funding from April 2021. We expect that mental health providers, clinical commissioning groups (CCGs) and ICSs will review and begin to update their local policies and procedures related to provision of community mental health services, and associated reporting requirements,[5] in 2021/22 to reflect these changes. Local partners will wish to retain the positive aspects of CPA whilst ensuring their processes align with the five key principles set out above.

32. We will work closely with services to understand how providers are adapting over 2021/22, which will be a transitional year, and what further guidance and support may be required to help services to adopt the new approach outlined in this Statement and

[5] See Annex A below for further detail.

in the Framework. As local approaches evolve and as implementation accelerates, we will seek and share practical examples from services on areas such as assessment and care planning approaches to promote learning between providers. We will also share examples to illustrate more clearly how this minimum universal standard of care described in the Framework and in this Statement can be measured.

33. We will also continue to work with partners at the Department of Health and Social Care and its arm's length bodies to undertake the steps outlined in Annex A regarding other metrics and guidance relating to the CPA.

Annex A: National metrics and related guidance

1. The Statement has been endorsed by the Department of Health and Social Care, and by other national arm's length bodies including the Care Quality Commission (CQC) and NHS Digital.

2. As well as the Standard Contract metrics referred to above, NHS England is working with NHS Digital to amend the data currently collected in the Mental Health Services Data Set (MHSDS) and the measures published relating to the CPA as part of NHS Digital's routine data set change process. Subject to the NHS Digital public consultations that accompany all dataset change processes, we are proposing that existing measures around CPA are decommissioned and that the settled accommodation and employment status measures are amended to apply to all working age adults under the care of community mental health services, not just those on the CPA. At the next available opportunity, we intend to remove the CPA tables from the MHSDS entirely.

3. This will reflect proposed changes to mental health metrics in the Department of Health and Social Care Adult Social Care Outcomes Framework, which is currently being refreshed.

4. NHS England has been in active discussions with the CQC about the amendments needed to the CQC's community mental health survey in light of this move away from the CPA, and the implications for its use of MHSDS metrics. The CQC is supportive of the direction of travel set out in the NHS Long Term Plan and Community Mental Health Framework, and this will be taken into account in relation to its collection and use of national data and metrics.

5. There are no national requirements for providers to use the CPA, nor are there any remaining metrics within national datasets relating to the CPA that are reported on or used for any purpose, including in the NHS Oversight Framework. It is clear that some providers believe to the contrary, most likely as historically they have been asked or are contractually obliged by clinical commissioning groups (CCGs) to report CPA metrics. As well as over time creating new internal policies in line with the transformation of services, Provider Boards, CCGs and other local governance groups including ICSs should review the metrics they hold and report relating to the CPA with a view to stopping their collection and reporting, thereby reducing the unnecessary administrative burden on provider staff.

6. Following publication of the government's White Paper in response to the Independent Review of the Mental Health Act, it is expected that legislation will be introduced in Parliament in 2021 to amend the Mental Health Act, necessitating an update to the Mental Health Act Code of Practice. The next version of the Code will therefore include updated content setting out the relationship between the Community Mental Health Framework and the Mental Health Act, replacing the chapter in the current Code on the CPA.