

A Good Practice Guide
for Commissioners,
CPA Care Coordinators and
Independent Sector Providers'

To Support Placements
for Mental Health Service Users

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EXECUTIVE SUMMARY

The growth of the independent sector (private and voluntary) has been considerable in recent years and is set to increase further.

In excess of £1bn per annum is being spent on mental health care in independent hospitals, care homes with nursing and care homes.

Links between service providers, Care Programme Approach (CPA) care coordinators and service commissioners are crucial to ensuring that placements remain appropriate, quality is maintained and value for money obtained.

This Guide offers suggestions on how to effectively manage these relationships to the benefit of service users and their families and friends.

A combination of research evidence, advice, practical suggestions and useful resources are given to support service providers, CPA care coordinators and mental health commissioners.


INTRODUCTION

Working with the independent sector to deliver services has been variable across the country in recent years. Some concern has been expressed in relation to out of areas treatments (OATS) (Brindle, 2004; Cooke & Carpenter, 2002; Jaydeokar & Piachaud, 2004; Poole et al, 2002; Royal College of Psychiatrists, 2005). In addition, many services within the area of commissioners are not as integrated into local systems as they could be.

This Good Practice Guide aims to provide support to CPA care coordinators and other practitioners, commissioners and independent sector providers to ensure that service users and their families/carers are supported appropriately and in ways that best meet their needs.

This Guide is not all encompassing and as services and processes change and develop, many new issues will emerge in relation to commissioning placements from the independent sector that are not addressed here. It is intended to enhance existing methods of working and be used as an adjunct to local processes for quality assurance rather than replace them in any way.

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SOME BASIC QUESTIONS ANSWERED

What is meant by placements in the independent sector?

In relation to this Guide, this means placements that require a bed and are in a facility registered with the Healthcare Commission (see www.healthcarecommission.org.uk) as an Independent Hospital or with the Commission for Social Care Inspection (see www.csci.org.uk) as a Care Home with Nursing or a Care Home.

What is meant by the independent sector?

The 'independent' sector is a term often given to non-statutory service providers. For the purposes of this Guide the independent sector has been used as a term to cover both voluntary organisations (charitable or not for profit) and private providers (profit making).

What is meant by a 'commissioner'?

In relation to this Guide the commissioner is defined as 'the person from the Primary Care Trust or Local Authority Social Services Department with financial responsibility for the placement' (they may be at the PCT, LASSD or within a provider Trust with delegated budgetary authority). They undertake the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services irrespective of sector. This is sometimes referred to as 'macro-commissioning'.

What is meant by 'care coordinator'?

The care coordinator is the person overseeing care planning and resource through the Care Programme Approach (CPA). The CPA care coordinator is responsible for keeping in close contact with the service user and for advising other members of the

care team of changes in circumstances which might require review or modification of the care plan (NHS Executive & Social Services Inspectorate, 1999). This is sometimes referred to as 'micro-commissioning'.

What is meant by a 'provider'?

The 'provider' is defined here as a service or organisation in the independent sector that provides placements for individuals or groups of people with mental health needs.

Why have a good practice guide?

It has been estimated that at least £1bn was spent on mental health independent sector beds in 2004/05 in services staffed 24 hours a day (Ryan et al, 2005a, 2005b & 2005c). This figure does not take account of older people with organic illnesses which would indicate even higher levels of cost and numbers of placements.

Studies have shown that many people are placed at considerable distance from their home area (Ryan et al, 2005a & 2005b). There are many reasons for this. These include highly specialised facilities being rarer and therefore not in every commissioner's area; people placed near to relatives at their request and some people have restrictions placed upon them returning to their home area due to offences they have committed. Many however have been placed at distance because of a lack of local capacity or capability in their home area and within this group there will be some people who would like to return 'home'. There is evidence that people placed out of area can become disconnected from their 'home' area services thus reducing the opportunity of them returning (Ryan et al, 2004).

What are the current key issues associated with placements in the independent sector?

A recent report by the Royal College of Psychiatrists (RCP) and several studies of the use of the independent sector have identified a number of key issues (Brindle, 2004; Cooke & Carpenter, 2002; RCP, 2005; Ryan et al, 2005, a, b, & c; Ryan et al, 2004). These cover quality, cost, value for money, monitoring, the impact of distance, contact with families and friends, social inclusion, moving on from services, appropriateness of placements and developing a culture of working with the independent sector.

What is the Care Programme Approach (CPA) and Effective Care Coordination (ECC)?

The Care Programme Approach (CPA) became operational in England in 1990 as the structure for supporting people with mental health needs (DH, 1990). Initially it was targeted towards people who were due to be discharged from in-patient care but now covers anyone in contact with specialist (secondary) mental health services.

The CPA was amended in 1999 and incorporated care management to create a single approach to care coordination (NHSE & SSI, 1999). It applies 'to all adults of working age in contact with the secondary mental health system (health and social care)..... the principles of the CPA are relevant to the care and treatment of younger and older people with mental health problems' (NHSE & SSI, 1999, p.4).

There are two levels or 'tiers' for CPA – Standard and Enhanced – which are managed by individual care coordinators. The former level is intended to support people whose needs are not complex and can be met

by a single agency or professional. The latter relates to people with a complexity of need that requires a number of agencies or professionals to support them safely and can require the facilitation of multi-agency working.


CPA must involve all of the following four key elements:

1. Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services
2. The formation of a care plan which addresses the identified health and social care needs
3. The appointment of a care coordinator to keep in close touch with the patient and monitor care
4. Regular review, and if need be, agreed changes to the care plan

These four principles of assessment, care plan, care coordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Effective Care Coordination relates to guidance on making CPA work although in some areas the term has replaced CPA as the method of describing the process. CPA is central to good practice in working with people placed in the independent sector.

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Where can I find out more about the CPA?

Further detailed information on CPA can be found at the following sites and reference sources:

The Care Programme Approach Association
www.cpaa.org.uk

Department of Health (Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach. A Policy Booklet)
www.dh.gov.uk/PublicationsAndStatistics/Publications

The Institute of Mental Health Practitioners
www.markwalton.net/cpa/index.asp

Sainsbury Centre for Mental Health (Briefing Paper 29)
www.scmh.org.uk and search for 'Briefing 29'

Sainsbury Centre for Mental Health (CPA Brief Audit Tool (CPA-BAT))
www.scmh.org.uk and search for 'CPA Brief Audit Tool'

Sainsbury Centre for Mental Health (CPA literature review)
www.scmh.org.uk and search for 'Literature Review'

KEY ISSUES FOR COMMISSIONERS, CPA CARE COORDINATORS AND PROVIDERS

CPA and placements in the independent sector

Mental health services registered as independent hospitals, care homes with nursing and care homes are regarded as secondary mental health services. Those who are resident in such facilities should be supported through the Care Programme Approach (CPA). The CPA is the cornerstone of practice for placements in the independent sector.

The CPA review

Ideally, although it is not always possible, it is best if the CPA review is chaired by someone who is independent of the case and who can provide objectivity. Often CPA care coordinators can be very passionate about the work they are doing with a person and occasionally this can have a paradoxical effect upon decision making.

The Chair of the review should have obtained all information from individuals and agencies that are not able to attend in advance of the review. They should also have ascertained if the person and their family have been able to adequately relay their views if they are not able to attend. The Chair should also have established if there are any conflicting positions between the service user and their relatives as this can influence how the review is undertaken and how decisions are reached. Any such issues will need to be managed sensitively.

The review should commence by looking at the existing CPA care plan or the draft that is being proposed. The review should aim to establish the person's health and social care needs, identify how these will be met, indicators of this being successful and set a time for the next review. All alternatives to residential or hospital care should be explored so that all other options have been exhausted both in advance of a placement being made and during a placement. The rationale for each placement is particularly useful information for commissioners as this can inform their future commissioning strategy and service development planning.

Care management reviews

Reviews of care can take place outside the formal structures of the CPA. Indeed many CPA coordinators will use the CPA review as a time to examine higher level support areas and medical management issues as the pressure on Responsible Medical Officer (RMO) time often mitigates against covering all aspects of the persons' support needs. Care management reviews often occur more frequently and therefore can go into the care plan in greater depth. This ensures time is available for examining areas such as specific features of the care plan, for example, the person's finances, social aspects of the placement, benefits, ongoing continuing care criteria and so forth. Such reviews often enable the family to be more involved as there is less formality, more time and greater flexibility in respect of the time of day when the review takes place. As a result, the opportunities are greater for developing a good rapport with users and their families.

Deciding on a residential or independent hospital service

Almost everyone who is in a residential placement or independent hospital will have been admitted from somewhere. Most will have come from hospital, another service or their own home. Therefore at some point a decision will have been made to make the placement.

For all involved in the decision making process there are a number of key questions that will need to be addressed of which the main two should be:

- 1 What does the person want?
- 2 What will the person gain from being in the placement?

The service user should be involved in the decision making process. Depending upon their condition (and perhaps also their legal status) the degree to which they can participate and influence decision making may vary. If the person is fully able to participate in the decision making process they should be encouraged and supported to do so in as much as they can. Where they are not able to participate there may be others who can do so; this may be on their behalf or under their instruction. Such a person may be a family member, a close friend or an independent advocate.

Thought should be given to how the person can best be involved in the process of choosing a placement and who is best placed to support them in this. Careful consideration should be given to the views of relatives whilst at the same time ensuring that any conflict of interest or conflicting views between the person and their relatives are accounted for in the process.

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A number of key factors are likely to be important in deciding upon a placement. The first relates to choice and how many services can be considered in the decision making process. All too often service users are placed in services based on a choice of one facility only. If there is a choice between facilities the following questions become particularly significant in informing the decision making process:

- What the services facilities can offer the person?
- What are the facilities available?
- How close are they to their home their relatives or where they wish to live in the future?
- What is access to shops and local amenities like?
- What is the philosophy of the service?
- How long the person be in the placement?
- How much money will they have access to whilst in the service?
- What are the particular needs of other people who they will be living with?

If the person is from a minority group – through their ethnic background, gender, legal status, sexuality, faith or age – it will be important for them to know how their needs will be met in the service.

All of these factors (and others) will need to be considered in order that the person and those around them can make an informed decision.

For the CPA care coordinator, commissioner and provider there are a number of questions that can be addressed prior to the start of a placement that can ensure good relationships which work in the best interests of the service user.

These include:

- What is the purpose of the placement?
- How long it is expected to last?
- What are the expected outcomes from the placement for the person?
- What will be indicative of these outcomes being achieved?

It is of no use to the person in the placement if the all parties all have different views in these areas.

Moving into a placement

In almost all cases placements into residential care and in the majority of independent hospital services the placement should not be a surprise or an emergency. Certainly within independent hospital placements there is a greater chance of people being admitted under sections of the Mental Health Act and therefore in some form of emergency. However, where a home support package is breaking down the preparation for transfer into residential or independent hospital care should be planned in advance. The same goes for transfer from one independent sector facility to another.

Reviews in the placement (CPA and care management)

The placement reviews should operate in much the same way as the initial review that determined the placement. The same questions should be asked as previously as they should still apply:

- 1 What does the person want?
- 2 What will the person gain from being in the placement?

The overarching aims of the review are to determine if the person's needs are being met appropriately and what changes, if any, need to be made to the care plan. The question of whether or not the placement remains the most appropriate place for the person should always be asked at the review and the service user's views on this should be sought.

Location of CPA reviews

Good practice suggests that wherever possible the medical staff (psychiatrists and GPs) review service users in context i.e. at the placement rather than at an out-patients clinic or a GP surgery. Not only does it mean the user is more likely to attend but they will probably be less anxious and the professionals can see them operating in their 'home' environment. It also ensures that the care team supporting the person have a better chance of participating in the review too.

Monitoring the placement and external scrutiny

External scrutiny is part of the review process and can be achieved in a number of ways and cover the individual placement and the overall service. In relation to the individual service user the CPA is the cornerstone of this (see above). It brings together all parties to ensure that the plan of care is coordinated and appropriate. Case management reviews however often afford more time to go into greater depth in relation to the person's needs and how they are being met. CPA care coordinators and case managers are acting (directly or indirectly) on behalf of the commissioners and often their role will be a micro-commissioning one. External monitoring to ensure that the voice of the service user is heard will come from an independent advocacy service. While CPA care coordinators are also acting on behalf of the

service user they do not have the same degree of independence as they are linked to the commissioner and may be influenced by their need to manage finances.

In relation to the facility and the service provider there can be a number of external scrutinisers. These will include either the Healthcare Commission or the Commission for Social Care Inspection who will register and regulate the service see:

www.healthcarecommission.org.uk and

www.csci.org.uk. However, these are primarily

intended to regulate the whole service rather than scrutinise individual placements, which is primarily the role of the CPA care coordinator. Independent hospitals are also likely to come under the scrutiny of the Mental Health Act Commission as most of these services cater for people detained under the Mental Health Act. Other forms of scrutiny that may apply to the service or its provider organisation could include the Charity Commission www.charity-commission.gov.uk which regulates governance arrangements for charitable companies.

Other regulators that may scrutinise in some way include the Housing Corporation www.housingcorp.gov.uk which funds and regulate Housing Associations and the Office of Fair Trading www.of.gov.uk/default.htm which enforces competition and consumer protection rules.

It is crucial that someone external to the care provider participates in service user review processes. "Fair Access to Care Services" (Department of Health, 2003) requires that reviews should be undertaken independently and not by the provider. Under Care Programme Approach this should be a person from a statutory organisation eligible to act in the role of CPA care coordinator.

Links between the CPA care coordinator, provider and the commissioner

Links between these three groups are vital to the success of the placement for the service user. There may be others who play a key role such as psychiatrists, general practitioners, advocates, etc, but the coordination of these three groups are central. Care coordinators are micro-commissioners and will act *de facto* on behalf of the health and social

service funding commissioner. As such, clear reporting arrangements between the two are necessary. Naturally the links between the care coordinator and the provider are central to the placement and under CPA are mandatory. However, it has been shown that these links may not be robust or there may not be a nominated care coordinator (Ryan et al, 2004). This may be due to the placement pre-dating the advent of CPA or when care coordinators move to new posts a replacement has not been allocated to the case.

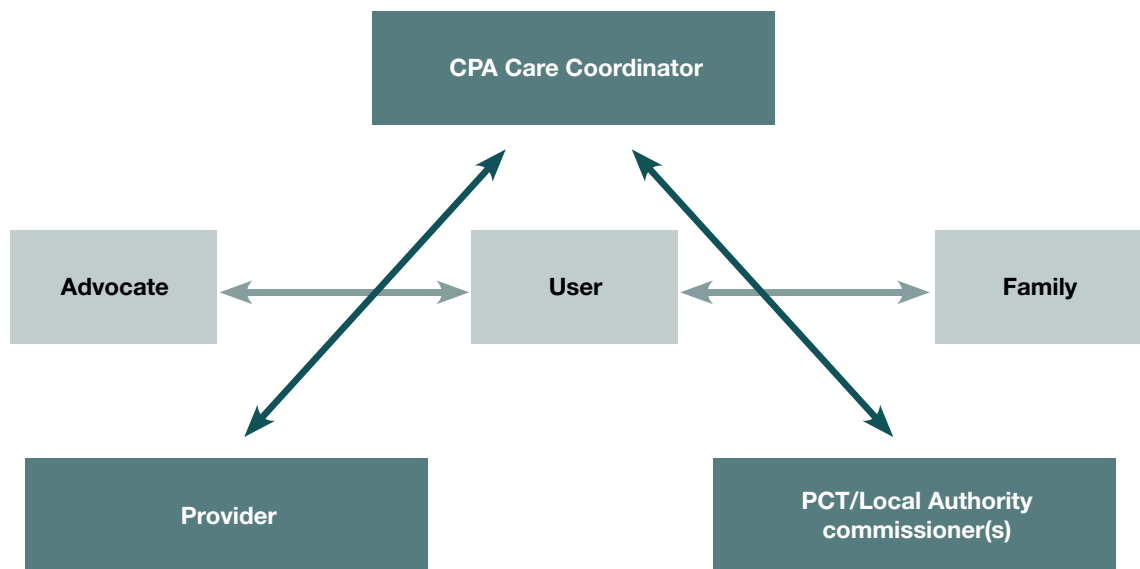


Figure 1 – Key placement links

In some circumstances a CPA care coordinator may be identified but monitoring is not effective. This may be due to the care coordinator having a large caseload that requires significant crisis management work and the placement coming low down on the list of priorities. Such circumstances highlight the need for links between the service commissioner and the provider as this can act as a safety net.

Moving between services in the independent sector and contingency planning

Occasionally there is a need for a person to move from one placement to another. This could be part of the logical progression in the service user's care pathway and as such should occur in a planned manner rather than in haste and without forethought.

Less rarely, although common enough to warrant thinking about in advance, there may be the need for a person to move at short notice (see Table 1). Usually this is due to a sudden change in their needs or a sudden change in the needs or provision of the service, for example if there has been a problem with the property. Good practice would dictate that both

the CPA care coordinator and the commissioner are notified in advance of any sudden move and are, along with the service user, involved in the process of choosing where the person moves to. In only the most extreme circumstances this may not be possible. In such circumstances the provider should discuss this with the CPA care coordinator and the commissioner at the earliest opportunity and follow this up with a formal letter detailing the circumstances surrounding the move. A CPA review should be set up as soon as possible to respond to the issues that have arisen.

It is helpful for providers to have the full contact details for the commissioner and the CPA care coordinator as well as the person who the service user regards as closest to them for just such an emergency. There are a number of circumstances where the arrangements for providing support in a placement may change; some of which may necessitate a move into other services, whether temporary or permanently. Most of these circumstances can be grouped into one of the areas in Table 1

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Circumstance	Example(s)	Responsibility for Contingency Planning	Issues
Clinical mental health changes	Acute psychosis Suicidal intent	Provider service clinical team	Need to alert the commissioner and CPA care coordinator if there is a need to move the service user or increase levels of clinical input e.g. high intensity nursing
Clinical physical health changes	Fracture Contagious illness	Provider service clinical team	Need to alert the commissioner and CPA care coordinator if there is a need to move the service user or increase clinical input
Changes to social situation	Threats against the person from others outside the facility Family moves from the area	Provider service clinical team and CPA care coordinator	Need to alert the commissioner if there is a need to move the service user
Changes to the service users' legal status	Mental Health Review Tribunal discharges the person from a Mental Health Act section	Provider service managers, service clinical team and CPA care coordinator Multi-agency Public Protection Panel (MAPPP)	Contingency plans of this nature could be included in the person's care plan if they are subject to the Mental Health Act
Changes to the property	Fire Flood	Provider	Contingency plans of this nature could be included in the placement contract Implementation should immediately involve the CPA care coordinator and the commissioner should also be made aware
Changes to the registration	Facility stops taking people detained under the Mental Health Act	Provider	Need to alert the commissioner and CPA care coordinator immediately
Regulator closes the home		Provider	Need to alert the commissioner immediately

Table 1 – Contingency issues

Situations where service users move precipitously into or between placements

There are a number of situations that may result in the sudden need for a person to move from one facility to another. These include:

- When the service user becomes extremely challenging and can no longer be supported in the placement
- Service closure
- Changes in registration of the facility
- The facility suddenly becomes unfit for purpose e.g. due to fire damage

Such circumstances are thankfully rare. Effective and well planned CPA will minimise the need for a person to move abruptly, particularly if there is a contingency plan built into the care plan. It may also be possible to predict which service users are at greater risk of needing to move suddenly. Factors that can result in a service suddenly being unable to cope with a service user include:

- Past history of the user not adequately considered when making a placement
- Provider being overly optimistic about the placement
- History of placement failure when moved
- Lack of access to risk information
- Lack of information that is digestible at the point of assessment (for example a three to four page summary of the care history as part of the CPA)

- Lack of information about the placement for the service user
- Lack of certainty for the user about the longevity of the placement
- Poor systems for involving families and friends of the service user in the transfer plans
- Service taking users whose needs are beyond its capability to support

Links between clinical teams (provider and area of origin)

A crucial issue for service providers will be the link with the team who have had clinical responsibility for the person previously. This is particularly the case if the placement is expected to be relatively short term and it is planned for the person to return. Connections will usually occur through the CPA care coordinator although they should not be the sole contact, especially if the needs of the person are complex. In such cases the area of origin Responsible Medical Officer (RMO) needs to be kept engaged. This is not simply to plan for the return, but also because they are likely to have useful additional knowledge of the person. Attendance at reviews is particularly helpful. A key benefit of this will be that both clinical teams (at the provider service and the area of origin) will be jointly planning care, and the service user, their relatives or friends do not receive mixed messages.

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If there are no plans for the person to return to the area of origin the RMO should be identified to liaise with for a transitional period at least. They will have information that the provider does not have, even if the case has been formally passed on to an RMO in the provider area.

Providers can to support links with CPA care coordinators attendance. For example, they can set dates for CPA reviews around their availability. They can also undertake practical administration tasks such as sending out invites to the review as this helps to develop a sound working relationship. Care coordinators and the “home” RMO can be engaged on an ongoing basis and not just at reviews. This can be done through telephone contact, email, text and post.

If there are plans for the person to go to another area or stay in the facility indefinitely the area of origin clinical team should stay involved until they have formally handed the person over to another team in the provider area and a local RMO. In relation to situations where the person is going on from the provider to an area that is new to them there should be early engagement with the local clinical team in the new area. Engagement with local clinical teams occurs through the CPA process being carried out correctly and not simply as a “get together”.

Ongoing engagement with commissioners is also particularly important and especially in relation to high cost or controversial placements and placements that require fluctuating clinical inputs that create financial variances in charges.

Organising CPA reviews

When organising the CPA review there is a need for agreement between commissioners, care coordinators and providers about who will do this. Where the

provider takes administration responsibilities effectively this can significantly assist in developing a good rapport with the other parties. It is important to agree timescales for reviews so that they are not held at short notice. This maximises the chance that everyone can attend. However, the CPA must operate as an active and dynamic process where any party can call for a review at any point in time.

Developing good professional working relationships

It can be very helpful for providers to take the time to get to know their main commissioners and associated clinical teams. Develop trusting relationships and being able to empathise is important. As part of this it will be regarded positively by commissioners if a provider understands what services they are capable of delivering and what they cannot do. An awareness of limitations will increase confidence in them as a provider.

For providers it is important that there is an etiquette established. For example, the provider knows the key members of the clinical team (CPA care coordinator, RMO), the commissioner, close relatives and advocates. It is important to generate a respectful and courteous atmosphere between all parties and to acknowledge each others' position and their difficulties.

It is also useful to agree at the outset what the goals of the placement are and what will happen if things are not going according to plan. In cases of dispute it is helpful to have agreed in advance how they will be handled and any protocols for obtaining a second opinion rather than set 'ground rules' when a disagreement has developed.

Feedback to commissioners

Some commissioners have found it useful to have good summary information on each person they are funding. For example, where they are in their mental health service history; their current and anticipated future needs; a brief and current overview of their history and what the person wants from the placement. It is helpful for commissioners to know if the longer term aim of the person is to remain in the placement, return to their 'home' area or move on elsewhere. This type of information can easily be provided by the care coordinator or the provider service. It is better if it comes from the former, as the latter can be seen as having a vested interest in maintaining the placement, whilst the care coordinator can provide the independence necessary for commissioners.

Operating a Placement Panel and coordinating the allocation of resources

Many areas now operate 'Allocation' or 'Placement' Panels to allocate resources, determine funding decisions and oversee placements. Usually they involve commissioners and in many cases also engage clinicians or practitioners, either on a case by case basis or as full members. In some areas the Panel also includes local providers, which is extremely useful when developing a systems approach to delivering local services.

Although many Panels have well developed roles and membership as a minimum they should ensure that:

- All paperwork is up to date in relation to placements
- A CPA care coordinator is allocated in every case
- The care coordinator is in contact with the service user and the service provider

- Reviews are occurring as planned
- Dates are set for future reviews
- There is a contract in place with the provider
- The person remains appropriately placed
- Funding arrangements are clear and agreed (particularly if the placement is jointly commissioned)

Feedback to commissioners (and Panels) may vary depending on the type of placement and the resources available to undertake the monitoring. Many commissioners will require more feedback for placements with high costs and complexity. In addition, commissioners are likely to require more feedback on placements where there are additional and variable inputs, particularly if there are related costs such as through "specializing" (high intensity nursing) or escort duties.

It is good practice to ensure that the care coordinator receives a copy of the contract or service level agreement, particularly if it has built in performance measures that they will be required to monitor. For many high cost placements regular reports will be built into the contract and linked to funding payments.

The Panel is an ideal central point for storage of information from commissioners and care coordinators. A database of all funded placements, both local and out of the area can be maintained and scrutinised at this forum. If the data is managed as an operational database and collected and saved over time (e.g. monthly) it will also show trends in the needs of service users and use of resources. This will provide significant strategic information to inform the development of local services.

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Ideally, commissioners should also maintain a database of services that are available in their locality. This can serve as a directory to commissioners, care coordinators, service users and their families. Any fine grain details that are recorded can also be useful, for example, whether or not the service will work with people with a dual diagnosis; if the service can support service users with rare conditions; what the staffing levels are; whether there is 24 hour support; if the service can work with people subject to legal restrictions; and so on. In essence, if it is well developed, such a resource will serve both operational and strategic management needs. It can also provide a method for proactive support to CPA care coordinators by flagging visits and highlighting when to expect feedback.

'Block' and 'spot' contracts

Most block contracts (when a number of places are commissioned together) have been established to meet the needs of a known group of service users (for example from a hospital closure programme) or for a specific population of unknown individuals (for example who require a specialist type of service). It can often be difficult for a commissioner to tailor a service to an individual through a block contract and consequently the CPA care coordinator will have the role of achieving this on a day-to-day basis with the care provider. The role of the commissioner is more likely to be strategic and concerned with the performance of the service as a whole. Spot contracts (single case placements) are more likely to be individually tailored and can be developed by the CPA care coordinator, the commissioner or they can do this jointly.

A block contract for a number of placements in a facility is best managed by a single care coordinator

rather than a number of care coordinators each managing a single placement. This provides an opportunity to build up a rapport with the service in ways that otherwise would be difficult, if contact in relation to the placements were spread across a range of individuals.

Managing change in block contracts

Many services were developed on the back of the hospital closure programme during the last three decades. However, most of these services have (or are experiencing) the need to change as they move from supporting people with long term care needs to younger people with more complex needs. One model for supporting this transition (which also personalises the service being commissioned) is to provide 'top-up' funding to an existing block contract but link this to individuals rather than the whole service. The block contract acts as the core grant and additional client-specific monies are used to support changes to the service as the client group changes.

Differing relationships with providers

Whilst not exclusively so, the relationship between the private sector and commissioners often contrasts with that of the voluntary sector. Voluntary sector services have often been block contracted whilst the private sector placements are often made through spot contracts. Private sector providers can often use venture capital to fund the development of services and therefore do not necessarily have to be 'commissioned' in advance to develop the service. Voluntary providers however almost always have to be requested to provide services by their commissioners, as they are rarely able to fund schemes at risk in the same way as private companies can.

Close working between commissioners and providers

It is useful for commissioners and their main providers to meet regularly, along with the care coordinators who are monitoring placements. This is best done at the service and should occur outside the usual round of CPA reviews or other clinical forums, as it gives each the chance to review things strategically. Some commissioners may do this as part of a general 'contract review'. The commissioner can learn about the issues facing the provider in running the facility, their plans for service and practice development and other issues that may affect the service for their service user(s). Similarly it provides the CPA care coordinator with the opportunity to see the strategic picture beyond the individual service users they are supporting. It also gives the provider the opportunity to raise issues that are important to them. Collectively such meetings also allow for the three parties to undertake work on areas such as care pathways, changing referral patterns, changing needs of users and so forth. Such meetings will provide the opportunity to tighten liaison processes between the parties.

In advance of such meetings the commissioner would be wise to spend time with the care coordinators concerned and also to review any Healthcare Commission and Commission for Social Care Inspection reports on the facility. If it is an independent hospital taking people subject to the Mental Health Act then recent reports of visits by the Mental Health Act Commission should be accessed.

The RMO and other medical colleagues

Responsible Medical Officer (RMO) and other medical staff involved in supporting the person need to be clear about their respective roles. Questions such as, 'Who

is ultimately the RMO?' 'How and when is responsibility transferred?' and 'Are there areas for potential confusion?' There is considerable opportunity for miscommunication with the provider clinical team and the 'home' area of origin team. Clarification between the two parties over roles and who should do what, would be considered good practice.


Continuity of care post-transfer

There is often a window of opportunity for therapeutic change early on in the stay, in a new facility. This often requires services to take on and continue with the existing care plans rather than assess the person's needs again. This requires both a continuity of information along the care pathway between 'home' and provider clinical teams, and ongoing contact with CPA care coordinator after the point of transfer.

Accessing services outside the facility

Day time occupation can be variable within facilities and often it is not appropriate to be undertaken within a service, especially if the aim of the placement is progression, recovery and social inclusion. However, some people living within independent sector facilities are excluded from accessing statutory services of various forms simply because of where they are located. Ensuring access to local mainstream and mental health services is primarily the role of the provider, but the CPA care coordinator has a duty to see that this occurs. Ensuring access to appropriate external services may be written into the contract with the provider.

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Input to independent sector facilities by mental health teams and care coordinators

Some providers have on occasion described inconsistencies in having a number of clinicians dealing with a single facility. Good practice would suggest that where several service users are placed in the same facility (particularly if it is in close proximity to the area of origin teams or within their geography) that the number of CPA care coordinators, RMOs and other clinicians are kept to a minimum. That way providers and clinicians have an increased chance of developing effective working relationships and a better understanding of the issues they each face in delivering support services.

Monitoring placement at distance

For a wide range of reasons some service users can be placed at considerable distance from the area where they come from and their area of origin clinicians. It can create major difficulties for providers and area of origin services, in maintaining effective contact and discharging CPA responsibilities, particularly if there is no intention to transfer these responsibilities to clinical teams in the area of the provider service. In some cases the required level of CPA input is not delivered and monitoring can be extremely time consuming for the commissioner and CPA care coordinator. It is not uncommon for people in such roles to take two days travelling time to review a placement.

Some commissioners and CPA care coordinators have developed relationships with statutory agencies in the area where the service is located and contracted with them to provide CPA care coordinator and local management on their behalf. This is particularly helpful if the placement is at considerable distance and the local

statutory service already has an established relationship with the provider. This can improve monitoring arrangements and reassure the funding commissioners that the support being provided is appropriate.

Multiple assessments and the impact upon service users

Some service users complain (along with the clinicians working with them) that they receive many assessments from providers who then turn them down. This can often be counter-therapeutic, despite the fact that it may be with the best of intentions, as it leaves users with the feeling they have been rejected. Clinicians and commissioners (depending who is involved) should question why this occurs, particularly if there is sufficient information given in the first place. It may however, be the case that the CPA care coordinator or commissioner does not know enough about the service and what it is capable of providing, thus leading to inappropriate referrals. Placement Panels can often be an excellent arena for ensuring that referrals are made to the most appropriate agency, rather than those that are known to the service currently working with the person (e.g. acute in-patient ward). Working with providers through Panels or local forums can help to develop relationships and improve trust. Providers can at times feel 'out on a limb' and concerned that they will not receive the necessary support if there are problems. Open dialogue prior to a referral becoming an assessment through such as forum is also likely to reduce the possibility of inappropriate referrals being made. Additionally, this can allow for outline contingency plans to be agreed in advance where services are undertaking positive risks to support people. Ideally, local systems of providers and clinicians would have a method (and trust) that allows for agencies to accept each others' assessments.

Top-up fees

Although not always exclusively so, the voluntary sector tends to have a single cost price with all services included for an individual placement within a service. The dominant model in the private sector is one with a baseline cost and 'add-ons' for additional services such as high intensity nursing (also known as specialising), escort duties and so forth. Good practice for providers would suggest that they share their tariff of add-on costs with the commissioner at the start of the placement, along with a protocol for applying the add-on services and methods of evidencing their use of these additional inputs.

Involving service users and their families

CPA care coordinators can build up a rapport with the user and their family (subject to the persons' wishes) outside formal reviews, in order to encourage them to participate as fully as possible in care planning processes. This can involve encouraging the service user and relatives to ask questions, modelling questions for them to ask, informing them about care review processes, answering questions they may have and so forth. After the review it is important that the service user, their relatives and anyone else who has supported them at the meeting gets a copy of the review document.

It may also be possible to follow up relatives who have not been in contact for some time. An invitation to a CPA review can act as a catalyst for some people to re-establish contact with relatives.

Advocacy

Many providers will have established systems that ensure access to independent advocacy services for people who use their services. Both the CPA care coordinator (at micro case management level) and


commissioner (at a broader contracting level) should be able to ensure that providers have robust systems in place for accessing independent advocacy.

Working with providers and improving standards

Developing a rapport with the facility and its staff is essential in order to be able to give constructive criticism, particularly if the CPA care coordinator (or commissioner) is working with a number of users in the service. This can be done through attendance at regular case management reviews and CPA reviews. It can also occur through less formal means such as phone and email contact or simply over a coffee after a review has taken place. In the case of commissioners who have a block contract with the provider regular contract reviews may provide an opportunity to assist the provider in developing their service. This can be done through constructive feedback, giving them information about future commissioning plans and listening to their plans for practice and service development.

Sometimes CPA care coordinators can draft care plans for providers as a method of educating them in respect of what they require from the service. Also using CPA and care management as regularly as possible can assist in improving standards in services where the quality is not as the commissioner or CPA care coordinator might wish. It is possible to set goals and implementation expectations through attending the reviews and evaluating service user goals until standards improve. Whilst it may be desirable to move a person to another service with better standards it may not always be in their best interests as they may have developed good friendships and social networks, which could be lost. In such circumstances a move may be therapeutically counter-productive.

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OATS (out of area treatment) teams

Several areas now have individual workers or small teams of CPA coordinators who take responsibility for facilities within the area of the commissioner, or who work solely on OATS cases. This means that services have a single point of contact and can develop working relationships easier than if they have a number of different CPA care coordinators to liaise with. Such teams can also build up useful knowledge of the capabilities of the providers they work with and act as a point of information for Placement Panels, CMHTs and other local services, enabling them to be better informed when making referrals.

CPA care coordinators taking on a service user who is already in a placement

For CPA care coordinators it would be regarded as good practice for them to visit the person in advance of any formal review. In some cases this may not be feasible, for example where the placement is at a considerable distance, in such circumstances the minimum that should be expected by the service user and their family is that the CPA care coordinator spends some time with them prior to the CPA review when it is scheduled.

Provider requirements and CPA

In 2002 the Department of Health published Independent Health Care: National Minimum Standards Regulations (DH 2002). This policy document placed a requirement upon mental health care provider organisations to have policies and procedures that enabled the full operation of CPA. There is a requirement that such policies and procedures are reviewed and updated at least every three years. There are specific expectations within this that cover planning, care reviews and implementing effective discharge.

SUMMARY

The 'macro' and 'micro' commissioning of placements within the independent sector has taken place for several decades and is an area which will see significant activity in the future (DH 2005; DH 2006). The relationships between providers, 'macro' commissioners (PCT and local authority commissioners) and 'micro' commissioners (CPA care coordinators) will continue to be central to providing appropriate and effective support to people requiring placements in the independent sector. Maintaining effective contact between these three key groups (along with the service user and their significant others) can be challenging, particularly given the physical distance that often exists between these parties, high workloads and sometimes ineffective processes. The issues raised in this Guide are not exhaustive but it is hoped that the good practice described here provides useful guidance for key people struggling with the complexities of this area.

APPENDIX 1: TERMINOLOGY

Block contract

When a service is commissioned for a group of people (usually unspecified) rather than for a specific person.

Independent sector

The 'independent sector' is a term often given to non-statutory sector service providers. A range of terminology is used to describe this area, sometimes confusingly. For the purposes of this Guide the independent sector has been used as a term to cover both voluntary (charitable/not for profit) and private (profit making) sectors.

Out of sector placement

A placement into the independent sector made by commissioners' of secondary mental health services.

Out of area treatments (OATS)

A placement outside the geographical boundaries of the commissioners or statutory service provider.


Spot contract / spot purchase

This refers to a placement that is funded for a single individual rather than part of a block contract.

APPENDIX 2: REFERENCES AND FURTHER READING

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- RYAN T, HATFIELD B & SHARMA I (2005c) *A census day audit of Social Services and NHS non-statutory sector placements and 'Spot purchase NHS placements' for the County Durham & Tees Valley Strategic Health Authority area*. HASCAS & University of Manchester.

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APPENDIX 3: USEFUL RESOURCES

The Care Programme Approach Association
(The Care Programme Approach)

www.cpaa.org.uk

National Primary Care and Trust Development
Programme (NATPCT) (The Commissioners
Friend for Mental Health)

[www.natpact.nhs.uk/uploads/2005_Jan/MH_Screen_ Version.pdf](http://www.natpact.nhs.uk/uploads/2005_Jan/MH_Screen_Version.pdf)

Department of Health (Effective Care Coordination in
Mental Health Services: Modernising the Care
Programme Approach. A Policy Booklet)

www.dh.gov.uk/PublicationsAndStatistics

The Institute of Mental Health Practitioners

www.markwalton.net/cpa/index

Sainsbury Centre for Mental Health (Briefing Paper 29:
The Care Programme Approach – Back on Track?;
CPA Brief Audit Tool (CPA-BAT) and CPA literature
review)

www.scmh.org.uk

Care Services Improvement Partnership
Commissioning
eBook (Developing and managing the market:
Reducing
the need for out of area placements through managing
local whole service systems)

www.cat.csip.org.uk/index.cfm?pid=365

Guidance on choosing a care or nursing home:

www.bupacarehomes.co.uk/asp/guidance/choose_home.asp

www.time4care.co.uk/key/choosing_a_care_home.html

www.mssociety.org.uk/what_is_ms/publications_shop/choose_care_home.html

www.helptheaged.org.uk/en-gb/AdviceSupport/FinancialAdvice/CareHomeFunding/

www.nursinghomeguide.org/NHG/nhg_txt_howtochoose.lasso

APPENDIX 4: USEFUL CONTACTS

Care Programme Approach Association

Walton Hospital
Whitecotes Lane
Chesterfield
S40 3HW
Tel: 01246 515 975
Fax: 01246 515 976
Email: cpa.association@chesterfieldpct.nhs.uk
Web: www.cpa.co.uk

Health Care Commission

Finsbury Tower
103-105 Bunhill Row,
London
EC1Y 8TG
Tel: 020 7448 9200
Web: www.healthcarecommission.org.uk

Health Care Commission Regional Offices

Leeds

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF
Tel: 0207 448 8179

Bristol

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR
Tel: 0207 448 8158

Manchester

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX
Tel: 0207 448 9100

Nottingham

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BG
Tel: 0207 448 8188

Birmingham

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG
Tel: 0207 448 9200

Commission for Social Care Inspection

33 Greycoat Street
London
SW1P 2QF
Tel: 020 7979 2000
Fax: 020 7979 2111
Web: www.csci.org.uk

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Care Services Improvement Partnership **CSIP**

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