

In light of the COVID-19 outbreak it has been necessary to make temporary changes to this Policy Document. Therefore when reading the policy document please take account of the changes highlighted in Part B and C of this form.

PART A – INFORMATION ABOUT THIS POLICY DOCUMENT

Policy Name	Care Programme Approach	Reference No	SD21			
Executive Lead <i>(Trust-wide policies)</i>	Executive Director of Nursing and Operations					
Chief Operational Officer <i>(Clinical Division policies)</i>						
Policy Document <i>(Tick only one)</i>	Trust-wide (Board approved)	<input type="checkbox"/>	Trust-wide (Executive Director approved)	<input checked="" type="checkbox"/>	Secure & Specialist Learning Disabilities Division	<input type="checkbox"/>
	Community Division	<input type="checkbox"/>	Local Division	<input type="checkbox"/>		
Type of Policy <i>(Tick only one)</i>	Clinical Policy		<input checked="" type="checkbox"/>	Non-clinical Policy		<input type="checkbox"/>
Clinical Policy Only <i>(Tick only one)</i>	Minor Change <i>(Not referred to the Clinical Cell)</i>		<input checked="" type="checkbox"/>	Major Change <i>(Referred to Clinical Cell, then to SCG for approval)</i>		<input type="checkbox"/>
Approving Body <i>(Tick only one)</i>	Board of Directors	<input type="checkbox"/>	COVID-19 Strategic Coordination Group	<input type="checkbox"/>	Community Division Tactical Coordination Group	<input type="checkbox"/>
	Corporate Division Tactical Coordination Group	<input checked="" type="checkbox"/>	Local Division Tactical Coordination Group	<input type="checkbox"/>	Secure & Specialist LD Division Tactical Coordination Group	<input type="checkbox"/>

PART B – CHANGES TO THE POLICY DOCUMENT

Section / Paragraph No	Outline of the information that has been amended in this policy document
6.7.2	<p>... It is imperative that all service users are subject to a 48 hour follow up after discharge from inpatient admission. (This includes service users on CPA, non-CPA and those discharged back to primary care. Ward staff will refer to the relevant community team within Mersey Care who will arrange and carry out the follow up visit within 48 hours. This should take place face to face and any deviations from this should be risk assessed, discussed by the MDT and details noted in RIO.</p> <p style="color: red;">In the case of discharge to Care Homes and Acute hospitals, 48 hour follow up will be undertaken via telephone contact.</p>
6.7.3	<p>It is good practice for the Care Co-ordinator to meet make telephone contact with the Service User prior to the formal review</p>
Appendix 5	<p>To ensure that regular telephone contact is made with the service user directly or via named people on the care plan. (If it is not possible for a virtual consultation to be undertaken, ie. due to disability, lack of technology/equipment, high risks, etc., then the service user will continue to be seen on an individual basis.)</p>

PART C – RATIONALE FOR CHANGES

Please explain why this document needs to be amended during the COVID-19 outbreak
<p>The Policy needs amending to enable staff wherever possible to adhere to the Government's advice to social distance.</p> <p>The author of the Policy has been consulted with prior to submission of the Change Form. They have recommended that the temporary changes remain highlighted in red within the policy with a marker that, “the changes noted in red will be temporary for the duration of the current COVID crisis and will be subject to review.”</p>

COVID-19 DOCUMENT CHANGE FORM

PART D – APPROVAL (for completion by officer loading policy document onto intranet / website)

Date Referred to the Clinical Cell <i>(Clinical Policies only)</i>	
Date Referred by the Clinical Cell to the SCG <i>(Clinical Policies only)</i>	
Date Approved by the Approving Body	29 April 2020
Date Circulated to Relevant Staff	29 April 2020
Date Published on the Divisional Intranet / Trust Website	29 April 2020

Note – the Approving Body to send this form to the appropriate divisional officer (for divisional policies) or the Corporate Governance Team (for trust-wide policies) who will be responsible for adding this form to the front of the existing policy and then uploading these onto the intranet / trust website.

TRUST-WIDE CLINICAL POLICY DOCUMENT

CARE PROGRAMME APPROACH

Policy Number:	SD21
Scope of this Document:	All Staff
Recommending Committee:	Perfect Care and Wellbeing Board
Approving Committee:	Executive Committee
Date Ratified:	February 2019
Next Review Date (by):	February 2022
Version Number:	2019 – Version 4
Lead Executive Director:	Executive Director of Nursing and Operations
Lead Author(s):	CPA Project Lead

TRUST-WIDE CLINICAL POLICY DOCUMENT

2019 – Version 4

Striving for Perfect Care for
the People We Serve

TRUST-WIDE CLINICAL POLICY DOCUMENT

CARE PROGRAMME APPROACH

Further information about this document:

Document name	SD21 Corporate Policy And Procedure For The Care Programme Approach
Document summary	<p>The objective of this policy is to describe the framework for assessment, care, support, planning and review of people referred to secondary care mental health services provided by the Trust.</p> <p>It highlights the CPA has been extended to Olders Adults, CAMHS, Learning Disabilities and Substance Misuse Services under the Refocusing Guidance. It describes:-</p> <ul style="list-style-type: none"> • The duties of all parties within Mersey Care NHS Foundation Trust • Non-CPA • CPA process • The process for monitoring compliance with the standards of the policy
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Published by Copies of this document are available from the Author(s) and via the trust's website	<p>Mersey Care NHS Foundation Trust V7 Building Kings Business Park Prescot Merseyside L34 1PJ</p> <p>Your Space Extranet: http://nww.portal.merseycare.nhs.uk Trust's Website www.merseycare.nhs.uk</p>
To be read in conjunction with	<p>Risk management strategy SA02 Clinical risk assessment tools SA10 Health Records IT06 Confidentiality and Data sharing IT10 Safeguarding and protection of children SD13 Safeguarding Adults SD17 Zero Suicide SD38 Carers SD39 Divisional Discharge/Transfer Policy Divisional Transfer of Care Policy</p>

This document can be made available in a range of alternative formats including various languages, large print and braille etc

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Version Control:

Version History:		
Consultation Draft Version 1	Policy Group Meeting	23.02.2016
Consultation Draft Version 2	Executive Committee	24.03.2016
Version 3	Executive Committee	30.03.2016
Version 4	Policy Group Meeting	26.02.2019

SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **Fairness, Respect, Equality Dignity, and Autonomy**

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1. PURPOSE AND RATIONALE

- 1.1 This Care Programme Approach (CPA) Policy has been updated to reflect best practice and a recovery-focus approach. It provides a framework for the assessment, care, support, planning and review of people referred to secondary care mental health services provided by the Trust. The principles of personalisation, choice and recovery underpin the approach supported by this policy.
- 1.2 It aims to promote effective liaison and communication between agencies, carers and service users, thereby meeting a person's recovery aspirations and ensuring all aspects of safety are addressed by good collaborative risk assessment and management.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

- 2.1 The CPA policy has been developed to ensure that CPA and Non-CPA are fully implemented across MCFT. Non-CPA will involve the allocation of a Lead Professional, rather than a Care Coordinator as is required for CPA Care, and can also utilise any aspects or tools within CPA that are thought to be useful.

3. SCOPE

- 3.1 This policy applies to all practitioners throughout the Trust's Secondary Mental Health Services and excludes IAPT and Primary Mental Health Care. It is important to note that the provisions of the policy are the National Good Practice Guidelines and should be adhered to by all Practitioners.
- 3.2 Whilst CPA has always been applicable to all adults of working age in contact with Secondary Mental Health Services, under the Refocusing Guidance it has been extended to Older Adults, CAMHS, Learning Disabilities and Substance Misuse.

4. DEFINITIONS

- 4.1 The Care Programme Approach (CPA) was introduced in April 1991, as the cornerstone of the government's mental health policy, to provide a framework for effective mental health care to all Service Users and Carers regardless of age, gender, ethnicity, culture, spirituality, disability or sexual orientation. At the heart of the Care Programme Approach are the **seven key principles** that underpin effective care planning processes and standards:

- The person is at the centre of planning
- The role of families and carers is actively supported
- There is good communication and active partnership
- Services are underpinned by recovery and social inclusion
- Good quality services are fair, open and easy to understand
- Information will be shared, but confidentially respected
- People will be treated with dignity and respect

Each Service Users' needs and goals will be unique to them.

- 4.2 The original guidance was updated by the publication of 'Effective Care Co-ordination in Mental Health' in October 1999. This guidance set out to integrate care management and care programme approach.

- 4.3 In March 2008 'Refocusing the Care Programme Approach' was issued. This updated guidance highlights good practice, keeping recovery at the heart of the person centred approach. It also sets out how CPA and Non-CPA should be used. The guidance provides a Statement of Values and Principles (Appendix 1).
- 4.4 The Care Programme Approach is designed to ensure that the services provided by Mersey Care NHS Foundation Trust (MCFT) are Service User focused and driven. CPA prompts professionals to take a wider view that considers a person in their life rather than a patient in the service. CPA is endorsed by MCFT's Recovery Strategy, which highlights the need for true collaborative care planning and links to the Triangle of Care.
- 4.5 The term 'Service User' will be used throughout this policy to refer to those individuals who receive a service from MCFT, Liverpool City Council Department of Social Services, Sefton Borough Council Department of Social Services and Knowsley Borough Council Department of Social Services.

5. DUTIES

5.1 Executive Director of Nursing & Operations

The Executive Director of Nursing and Operations has delegated responsibility to ensure that a Policy & Procedure on the management of CPA is in place; that it is implemented effectively and systems are in place for the effective monitoring of the standards contained within the policy.

5.2 Operational Manager

Duties include:

- Undertaking appropriate review of the CPA Policy ensuring necessary consultation with partners.
- Ensuring the CPA process, standard and quality is effectively managed and maintained
- To promote and consider all matters risk related within CPA Risk

5.3 Care Co-ordinator

Duties include (see also Appendix 5):

- Establishing and sustaining a professional relationship with the service user and significant others, based on regular contact.
- Taking responsibility for ensuring that all aspects of the Service User's care needs that have been identified are met by the Staff or Agencies that are designated with specific tasks.
- Co-ordinating and monitoring the assessment, planning, delivery and review of care, including managing risk and ensuring that the CPA review takes place within 12 months of the previous review.
- Unless otherwise delegated, the Care Co-ordinator should also be the first point of contact for any enquiries or emergencies.

5.4 Lead Professional

Duties include:

- Take responsibility to ensure that all aspects of the Service User's mental health/learning disabilities care needs have been identified and that appropriate treatment strategies are in place, or have been advised, to address them.
- Unless otherwise delegated, the Lead Professional should also be the first point of contact for any mental health related enquiries.

5.5 **All Staff (Clinical & Medical and Administration staff involved in the process)**

Duties Include:

- Ensuring that they are familiar with the corporate Policy (SD21) and Procedure for the management of CPA.
- Ensuring that they access the most up to date version for use and application (on the Trust web site) and seek every opportunity to keep up to date with content.
- Adhering to the standards and requirements of the policy.
- Care Coordinators and responsible clinicians (Consultant Psychiatrists) need to be aware of their particular responsibilities as central to the overall clinical management of Service Users in their care.

6. **PROCESS**

6.1 **CPA / Non-CPA Criteria**

Following the core assessment, the multi-disciplinary team will decide the level of treatment and support the Service User requires to meet their individual needs. This may result in no support being offered by MCFT and the Service User being discharged to Primary Care. If further contact is to be offered then there is a requirement to place the Service User on either CPA, (if their needs are identified as being complex as defined below) or on Non-CPA where a Service User has more straightforward needs, lower risk, and contact with only one agency (or no problems with access to other agencies/support).

6.2 **Non-CPA**

- 6.2.1 Service Users receiving Non-CPA will have more straightforward needs and contact with fewer agencies or no problems with access to other agencies / support.
- 6.2.2 They will be allocated a Lead Professional who will support them.
- 6.2.3 The service user will require an assessment of their health and social care needs, including a risk assessment. An appropriate HoNOS, including HoNOS PbR should also be completed.
- 6.2.4 They will have a plan of care that is recovery focused and has been developed with the Service User and their Carer.
- 6.2.5 The care plan, including assessment of risk will be included in the statement of care. A full risk assessment could be completed if necessary.
- 6.2.6 All Non-CPA patients should have their needs and actions to address those needs in the statement of care with a review date.
- 6.2.7 The statement of care will be reviewed as and when required, up to a minimum of annually.
- 6.2.8 For service users who only have contact with a Consultant Psychiatrist their care plan and risk assessment will be contained in their out-patient letter.
- 6.2.9 The documentation of the plan of care may be a statement of care or a letter, good practice requires a copy to be given to the Service User and the GP, and should provide a clear understanding how care and treatment will be carried out and by whom.
- 6.2.10 For Service Users on Non-CPA there should be on-going consideration of need for CPA if risk / safety issues or circumstances change.

6.3 Characteristics to consider when deciding if CPA is required.

6.3.1 The list is not exhaustive and there is no minimum number of items that indicate the need for CPA:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity.
- Current or potential risk(s), including:
 - *Suicide, self harm, harm to others (including history of offending);*
 - *Relapse history requiring urgent response;*
 - *Self neglect/non concordance with treatment plan;*
- Safeguarding adult / child safeguarding e.g.:
 - Exploitation e.g. financial / sexual;
 - Financial difficulties related to mental illness;
 - Disinhibition;
 - Physical / emotional abuse;
 - Cognitive impairment / Learning disability;
 - Child safeguarding issues.
- Current or significant history of severe distress / instability or disengagement
- Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse,
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently / recently detained under Mental Health Act or referred to crisis / home treatment team.
- Subject to Community Treatment Order or Guardianship.
- Significant reliance on carer(s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of:
 - Parenting responsibilities;
 - Physical health problems / disability;
 - Unsettled accommodation / housing issues;
 - Employment issues when mentally ill;
 - Significant impairment of function due to mental illness;
 - Ethnicity (e.g. immigration status; race / cultural issues; language difficulties, religious practices).
- Sexuality or gender issues.

6.4 Assessment

6.4.1 The initial assessment of each Service User will be dependent on the circumstances of the individual's presentation. Regardless of this, the assessment will be carried out via an open, structured, discussion with the individual regarding their current situation. If possible the details and status of any Carers should be established at the start of the assessment and with the Services User's consent they should be involved in all aspects of the assessment. All people referred to service are entitled to a full assessment of their health and social care needs.

6.4.2 Staff should always be mindful of the difficulties faced by some Service Users in articulating their needs or being able to contribute to meetings in which they may be surrounded by Professionals. In order to do this, it may be necessary to involve Carers or Advocates who can help the user in these processes.

6.4.3 Recovery tools, such as the Recovery Star, are useful to identify a person's priority areas. If a person uses a Wellness Recovery Action Plan (WRAP), or has an advance

statement, this should be identified at this stage, and if the person is in agreement, feature within the care plan document. Cultural and any other barriers to communication should also be considered with steps to overcome them in a way most suited to the service user.

6.4.4 At initial assessment Staff should make every effort to enquire as to whether the Service User feels as though they have been subjected to any form of violence or abuse at any time in their lives. On first presentation, as this may be difficult, Staff should use their discretion in dealing with this issue. Discussing historical abuse may not seem appropriate on first presentation but it should be made clear that the Service User can approach staff involved in their care at anytime should they wish to raise any issues regarding abuse.

6.4.5 The assessments needed to be completed for all CPA assigned Service Users should include:-

- MCFT Risk Assessment
- Initial CPA Assessment 1 & 2 (or CPA Review part 1 & 2)
- An appropriate HoNOS and Mental Health Clustering Tool (MHCT)
(*These assessments should be carried out to inform the care plan and support package of the individual).

6.4.6 Currently Service Users receiving Non-CPA provision should receive:

- Initial CPA Assessment 1 & 2
- Mental Health Clustering Tool (MHCT) / HoNoS

Note - For further details on CPA assessments please consult CPA Pathway flowchart (Appendix 2)

For **HoNOS PbR (MHCT)** - please see Appendix 3 for further guidance.

6.5 Risk Assessment

*(Please refer to Risk Management Policy for more details)

6.5.1 All Service Users under CPA will have a risk assessment. Any risks or issues around safety identified will be incorporated into the care plan and reviewed, as appropriate, at least every 12 months. Clinical risk assessment is integral to the Care Programme Approach. Clinical risk assessments can range from being brief through to being extensive, depending on the type of assessment being conducted.

Risk assessments and management involves working with the person to help estimate and evaluate both possible beneficial and harmful outcomes and their likelihood. It is a dynamic and on-going process focusing on the safety of the individual, their family and carers, and the wider community.

“Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service users own experience and clinical judgement.”

Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services
Dept. of Health 2007

Keeping People Safe

- The core purpose is to develop a shared understanding of potential safety issues and agree strategies to reduce the severity and frequency of identified risks and adverse outcomes including to:
 - Consider long-term factors (static, not amenable to change)
 - Consider short-term risk (current) dynamic / unstable (those that interventions are most likely to change)
 - Consider hazards (triggers, non-clinical factors that increase risk)
 - Consider protective factors (strengths) that improve safety
 - Develop an estimation of potential risk
 - To enable the development of appropriate risk management plans which:
 - ❖ Have strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
 - ❖ Take into account that safety issues can be both general and specific and that good management can reduce and prevent harm.
 - ❖ Incorporate, as needed, knowledge and understanding of legislation on issues such as consent, capacity and mental health.
 - ❖ Include a summary of all safety issues identified, formulations of the situations in which identified risks may occur, and actions to be taken in response to crisis.
- 6.5.2 As a minimum, risk assessments must include the following:
- 6.5.3 **Risk to self**; including accidental self-harm, risks associated with alcohol, drug or substance misuse and the degree of dependence problems, deliberate self-harm and physical ill health. Risk of falls and impaired capacity must also be considered.
- 6.5.4 **Suicide**; including previous attempts, threats, opportunity, means.
- 6.5.5 **Violence to others**; including access to potential victims, specific threats made, history of violence to family, staff, other service users, the general public and degree of threat / actual harm including sexual assaults.
- 6.5.6 **Other types of risks/safety to others**; including risk to children under 18 years, arson, destruction of property, injury to animals, risk to others other than violence.
- 6.5.7 **Self neglect**; including inability to care for self, lack of carer support.
- 6.5.8 **Exploitation by others / vulnerability to abuse** such as financial, sexual (including inpatient / ward settings – for guidance cf. *'Sexual Safety on Mental Health Wards'*, Care Quality Commission, 2018), and physical and emotional.
- 6.5.9 For Inpatients - **Risk of Absconion** or **Physical risk** related to restraint.
- 6.5.10 **Risk Management** is defined as the actions taken, on the basis of a risk assessment that is designed to prevent or limit undesirable outcomes.
- 6.5.11 Key risk management activities are treatment, supervision, monitoring and if relevant, victim safety planning (e.g. helping a victim of domestic violence to make themselves safe in the future and know better what to do in the event of perceived threat).

6.5.12 Positive Risk Taking

Where a risk assessment is needed, a decision has to be taken about whether positive risk taking overall is necessary to achieve certain outcomes for the person concerned or any other people. This has to be determined in partnership with the person affected, and their family where appropriate. It is a professional judgment that should not be influenced by an overly cautious approach to risk. At the same time though, positive risk-taking is not negligent ignorance of the potential risks.

How

This must be systematic and informed by:

- Active participation of the person concerned including identifying what is likely to work. Active participation of informal carers and families
- Active participation of team members or others where appropriate
- Thorough review of any case notes
- Weighing up potential benefits and harms of choosing one action over another
- Positive risk management – improving the person's quality of life and plans for recovery whilst remaining aware of the safety needs of all concerned.
- Being willing to make a decision that involves an element of risk because the potential positive benefits outweigh the risks
- Using available resources and support to achieve a balance between a focus on achieving the desired outcome and minimising the potential harmful outcome

Good Practice Checklist

- The person has been involved in his or her own risk assessment and the views included in the written record of risk assessment, taking into account any self-management or recovery plans
- Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach
- The risk management plan is coherent, recognising the service users strengths alongside the possible problems that they might encounter
- The service user, carers and others who might be affected are fully informed of the decisions about risk, the reasons for them and the associated safety plans
- Use the 'Think Family' approach of: no wrong door, building on strengths, looking at the whole family, and tailoring support to need
- The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken including in response to crisis or safety concerns
- The risk management plan does not prevent positive risk-taking I should emphasise recovery and well-being
- Risk assessments for people with particular needs such as learning disabilities should reflect those needs
- Safety is clearly documented and reviewed regularly

- Use of processes such as MARAC, MAPPA, and safeguarding arrangements to help manage risk using a multi agency approach

6.6 Care planning

- 6.6.1 A care plan or statement of care is the Service User's own record of who is involved in supporting their care and recovery. It should promote continuity of care, treatment and support by using effective communication between all involved in the Service Users' care. It must be completed / updated at formal reviews, but it can be amended at other times as required.
- 6.6.2 **In line with best practice, it is important that only ONE, over-arching, care plan exists for each service user at any one time, irrespective of setting – this is the plan negotiated with and agreed by the Service User, where possible.** Should a professional member of staff need to amend an existing care plan they must inform the Service User and other people as appropriate.
- 6.6.3 For CPA, the appointment of a Care Co-coordinator is essential to enable close contact with the service user and this will facilitate monitoring and review of the care plan (Appendix 5 - care co-coordinators responsibilities).
- 6.6.4 The care plan should be written in collaboration with the Service User and, where appropriate, their carer(s). It should enable the Service User to maintain positive changes in their health and social care/circumstances. The care plan should focus on the person's strengths, assets and aspirations. Employment, accommodation and social relationships should be discussed with practical goals and strategies agreed. Where possible the care plan should be outcome focused, detailing how the plan will be actioned, who will be responsible and what the time frame will be. These choices should be less problematic or risk orientated and focused on the person's own life goals and aspirations. Any Advance Statements that the Service User has completed should also be taken into account when developing the care plan. If the Service User does not have an existing Advanced Statement they should be positively encouraged to develop one. Should they decline this should be recorded.
- 6.6.5 The care plan should have at a minimum the following life domains considered and documented. These are:
- Managing Mental Health
 - Self Care / Living Skills
 - Education / Training/Employment
 - Addictive Behavior
 - Identity, self esteem, trust and hope
 - Accommodation/Finances
 - Social Networks/Relationships
 - Physical Health
 - Caring Responsibilities
 - Carer Involvement.
- 6.6.6 All other collaboratively agreed goals should be added after these. In each of these domains the following format should be used; document any strengths, document any areas requiring support, how the person will be supported and by whom. As part of the care planning process service users should be enabled to make healthy lifestyle choices concerning exercise, diet etc. The care plan should also capture any medication that the Service User may be taking or allergies they have, especially for service users with

complex medication needs. Hence, the care plan should also outline any additional physical health needs. The care plan must also take into account any risk or safety issues that have been highlighted via the risk assessment. Where applicable, use of the Recovery Star can be a positive way forward.

- 6.6.7 The Care Co-coordinator should seek to confirm with the Service User that the care plan has addressed all domains requiring support and captured all aspirations. The plan should be updated on a regular basis and whenever circumstances change.
- 6.6.8 If a Service User wishes to explore the option of 'talking therapies' this must be clearly identified within the care plan detailing how 'talking therapies' will be provided.
- 6.6.9 The Service User is able to indicate, within the document, those whom they do not wish information to be shared with.
- 6.6.10 Along with mental health recovery plans the plan should always include a consideration of the person's physical health with specific strategies to address any issues identified.
- 6.6.11 A personal health budget can provide a service user with a significantly greater autonomy in managing their own recovery. Consideration of this option should be recorded.
- 6.6.12 A contingency plan with names and telephone numbers including out-of-hours service numbers should be clearly documented in the care plan.
- 6.6.13 **Service Users must be offered a copy of their care plan, where possible in a suitable format for the individual service user. If they decline a copy this should be documented as a clinical note or in their care plan with a reason given.**
- 6.6.14 **If there are cost implications to amending a care plan, these must be agreed by the relevant services / manager as per locally agreed policies. This must also be communicated to the Service User.**
- 6.6.15 In accordance with national guidance the Care Co-coordinator is responsible for ensuring the update of the Service User's over-arching care plan as and when required in collaboration with the Service User.

6.7 Review

- 6.7.1 A review of the care plan may be requested if there are significant changes in the Service Users' mental health / social circumstances or the Service User or another Professional involved in a Service User's care believes the current care plan does not meet the current requirements of the Service User. National guidance states that there will be a formal multi-disciplinary review annually, but that reviews are more likely to be needed more frequently.
- 6.7.2 The Trust requires that there must be a formal review held at least every year, but reviews should be held as and when required. However, it is important to review the implementation of a care plan **within one month of discharge from in-patient services**. It is also imperative that all Service Users are subject to a **7 day follow-up** after discharge from an inpatient admission. (This includes Service Users discharged on CPA, Non-CPA and those discharged directly back to Primary Care. Ward staff will refer to the relevant community team within Mersey Care who will arrange and carry out the follow-up visit within 7 days).

- 6.7.3 It is good practice for the Care Co-ordinator to meet with the Service User prior to the formal review to discuss how the care plan is working and what changes, if any, need to be made. It is imperative that the Care Co-ordinator attends the review.
- 6.7.4 The purpose of a review is to consider:-
- The views of the Service User, Carer/s and Professionals.
 - Any progress the Service User has made.
 - How the Service User has responded to the services being provided.
 - Prevention and early detection of ill health, including relapse, by reviewing any risk factors.
 - Any Suicide Prevention measures indicated.
 - Ways in which their needs or circumstances may have changed and as a result the extent to which their care plan requires amending.
 - Ways in which any previously identified risk or safety issues may have changed and as a result the extent to which their care plan requires amending.
 - The need for services to be amended to meet the needs of the Service User.
- 6.7.5 The format of the review depends upon the needs of the Service User. Staff are reminded of the disempowering nature of large meetings and to ensure reviews are held to meet the needs of the Service User and not the service or bureaucracy. The previous care plan must set the agenda for the review.
- 6.7.6 **The following features should be present during each review:**
- The review must be planned in advance, the time and venue negotiated and agreed with the Service User. This then allows the Service User and their Carers' time to prepare for the review.
 - The review should be based around the Service Users' previous care plan.
 - The review will take account of the views of the Service User, Carer/s, Peer Mentor, and other Professionals.
 - The review must be recorded effectively on the appropriate care plan document.
 - Staff invited to a review but who cannot attend must liaise with the Care Co-ordinator and submit a verbal or written summary of their input and professional views of current and future care.
 - Changes to the care plan, risk assessment should be agreed and recorded.
 - Discussion regarding advance statements / directives / decisions must be recorded.
 - Any identified goals or care requirements that cannot be met must be recorded.
 - Amendments to ICD-10 diagnosis must be discussed and recorded.
 - Any alerts present on the Service User's record should also be reviewed.
 - The date and venue of the next review negotiated, agreed, recorded and a new care review document commenced.
- 6.7.7 A Service User may choose not to attend a review meeting, choosing instead to be represented either by a Carer/Friend or advocate. The Service User may wish for his/her views to be discussed beforehand and represented by the Care Co-ordinator, advocate, peer mentor, carer. If this is the case then the service user's wishes must be considered and documented at the review held in their absence. In some cases, the review may comprise of a series of conversations, perhaps some by telephone co-ordinated by the Care Co-ordinator. In these cases, the decisions finally agreed will be recorded in the care plan.
- 6.7.8 **An amended care plan should be disseminated, particularly to the Service User, Carers, Peer Mentor (if appropriate), Advocate and GP, as soon as possible but within a maximum of two weeks from the review.**
- 6.7.9 **CPA – Inpatients**

- 6.7.10 All inpatients will be subject to CPA. Clinical systems enable in-patient staff access to contemporaneous information – particularly risk assessment, care plans and any alert documents currently open. The systems equally enable in-patient staff the opportunity to contribute to such records and create and edit documents as appropriate, including care plans.
- 6.7.11 There are occasions when a Service User's first contact with services is via an admission to an acute in-patient unit. In-patient Staff should capture information about medication especially noting if the Service User is prescribed other medication such as methadone, anti-depressants etc. The CPA process should begin directly following admission, whether the admission is informal or formal and continued through to discharge. Inpatient staff should create an acute care plan on admission to include reference to any intervention plans that will be in place during the admission. Liaison with the Care Co-ordinator should be maintained throughout any admission and a copy of the acute care plan must be given to the Service User, Carers (where appropriate) and the GP.
- 6.7.12 Throughout a Service User's stay in hospital it is the responsibility of inpatient Staff and the Care Co-ordinator to maintain a dialogue with each other and with the Service User and Carer(s). All inpatients are allocated a named nurse. For patients without an existing Care Co-ordinator the ward will also make referral to the appropriate community team for them to appoint a Care Co-ordinator if required.
- 6.7.13 Service Users should leave hospital with a copy of their care plan which has been developed in partnership with all involved, agreed by them and signed by them where possible.

7. CARER INVOLVEMENT

- 7.1 Carers form a vital part of the support required to aid a Service User's recovery and should be effectively involved in the care planning process. Carers should receive as much information as possible regarding the assessment, care plan and review of the service user. Their views should be taken into account and documented.
- 7.2 The consent of the service user should be sought to involve their carers/relatives in their care plan. Should the service user not give consent for carer involvement then practitioners should provide information in relation to their own support needs and refer them to an appropriate agency for on-going support. A carer's assessment should be considered and these actions should be recorded.
- 7.3 Should a patient refuse consent for a carer's involvement then the carer's view should still be listened to and considered even though specific details of the care cannot be divulged to them. (For further information see Carers' Policy SD39)
- 7.4 The Trust is fully committed to the Triangle of Care and all staff should encourage and actively promote Carer involvement at each step of the care planning process.
- 7.5 All Care Co-coordinators, lead professionals and key workers should be aware of who the main Carer/s is, what their relationship is with the Service User and how to contact them. It is essential to maintain good communication with Carers. Carers and Relatives can always feedback information with or without patient consent, and staff should work towards including Carers as much as possible. However, they need to be mindful that sometimes this may not be appropriate.

- 7.6 Any information that the Carer may have concerning the Service User's care will be welcomed. However, the Service User's agreement will be necessary for any information regarding their care to be shared with their Carer or Relative. This agreement can be overridden in the event that Staff have concerns about risks to others.
- 7.7 All Carers should be advised that they are entitled to a Carer's assessment of their caring, physical and mental health needs and should be offered this. Following a Carer's assessment the Carer may require a Carer's support plan, which should be reviewed annually.
- 7.8 Carers should always be aware of how they can contact the Care Co-coordinator or lead professional and everyone else involved in the Service User's care both within normal working hours, and how to contact someone out of hours for help and advice. Carers should be encouraged to be involved in the care planning process and in the development of any crisis plans.
- 7.9 Young Carers are those under 18 who provide substantial personal or emotional care to another family member. Assistance to Young Carers should not reinforce the role of the child or young person as a Carer. Interventions to help support the family as a whole and promote the parenting role of parents are more likely to be helpful and ensure that a Child's welfare or development is not impaired.

8. SAFEGUARDING ADULTS AND CHILDREN, INCLUDING CHILDREN OF SERVICE USERS

- 8.1 All statutory caring agencies have a prime responsibility to Safeguard Adults & Children. Any decision-making processes regarding Service Users who have Children should have full regard for the interests and safety of those Children. Trust staff should record the details of dependent Children and also record details of Children being 'looked after' in the homes of Service Users, e.g. in child minding situations or fostering situations. They must also record who to contact if the service user becomes unwell and the Children require looking after.
- 8.2 Where Trust staff suspect Children may be at risk, the MCFT's Safeguarding and Protection of Children policy (**SD13**), **MUST** be applied and in the case of Adults, (**SD17**) Safeguarding Adults from Abuse policy.

9. CPA & THE CRIMINAL JUSTICE SYSTEM

- 9.1 The Care Programme Approach (CPA) is the framework for mental health care regardless of the setting, and, hence, includes prisons and secure hospital environments. The national guidance states that the following points should be taken into account:-
- There is a high prevalence of mental health issues, learning disabilities and substance misuse amongst those detained within custodial settings.
 - Many convicted and remand Prisoners may be receiving mental health care and support prior to sentence and this care should continue during sentence.
 - For some Prisoners, the first contact with mental health services will be through the criminal justice system.
 - People entering prison often lose touch with mental health services.
 - Prisoners are often released without any plans for their ongoing mental health needs;
 - Prisoners should receive health care of an equivalent standard to that of the general population (Ref. *The Future Organisation of Prison Health Care*: Joint Prison Service and National Health Service Executive Working Group, March 1999).

- The Clinical Commissioning Groups, Local Authorities and Mental Health Providers have a role in maintaining contact with Prisoners during their sentence and in arranging plans for the time of release from prison (National Service Framework).
- Information sharing is crucial for a thorough assessment of need and assessment of risk to be completed (ref. Homicide Enquiries).
- From 2004, no Prisoner with a serious mental illness will leave prison without a care plan and a Care Co-ordinator. (NHS Plan 2000).
- A Prisoner may indicate a desire not to return to his / her original area of residence. The multi-disciplinary team from the original area will have the responsibility of ensuring that plans are developed for relocation to another area, that the receiving district are informed and are willing to accept responsibility and that issues of **RISK** are communicated.
- If a Prisoner who is due to be released presents with known or perceived high risk behaviour, then consideration will be given for the need to comply with the appropriate Multi-Agency Public Protection Arrangements (MAPPA) in respect of sharing information and the management of such risk.

9.2 If a Service User, receiving care from Specialist Mental Health Services, is placed on remand then care co-ordination continues until there is an outcome of the legal process. The Care Co-ordinator should endeavour to link with the prison in-reach service, if one exists, to ensure continuity of care whilst the Service User is in prison.

9.2 Should the Service User be sentenced and detained in prison then a review of care must be arranged to explore practicalities of transferring the care to the in-reach team from which appropriate care and support can be provided.

9.3 The trust will ensure that effective systems are in place for receiving information about prisoners from external agencies and that it is shared by the care co-ordinator in a timely manner with the receiving prison healthcare service and entered into the health care record. The aim should be to ensure that information from other agencies, while subject to the required protection, is made available quickly to the prison healthcare staff that need it.

10. CONSULTATION

10.1 The provision of CPA for Service Users in receipt of an MCFT service is a collective responsibility. Where possible, input and consensus has been sought from all involved to reassure that the highest possible standards are maintained at all times.

10.2 MCFT aspires to be an open and welcoming organisation, and hence, through extensive consultation, it has designed a system of CPA provision which aims to support Service Users as efficiently and safely as possible.

10.3 This policy was reviewed in conjunction with the Executive Director of Nursing and Operations, the Director of Patient Safety and senior clinical staff.

11. TRAINING AND SUPPORT

11.1 The Executive Director of Nursing and Operations will ensure the Learning and Development Team continues to make available appropriate training to staff who require it (as per mandatory requirements) which supports the CPA described within this policy based on the Trust's current training needs analysis and CPA mandatory training programme for 2019.

12. MONITORING

- 12.1 Implementation of the policy will be monitored through collection of data in relation to the timeliness standard for updating clinical information systems to show that CPA reviews and other assessments have been completed. Reviews associated with both CPA and non-CPA service users have taken place within three working days (section 3.3 of IT06 – Health Records Policy and Procedures; section 5 item 18 IT11 – Corporate Data Quality Policy).
- 12.2 A number of National and Local KPIs related to CPA and non-CPA agreed annually are reported upon via the CCG Quality Schedules.

13. SUPPORTING DOCUMENTS

- a) The Care Programme Approach for People with a Mental Illness - HC(90)23/LASSL (90) 11
- b) Effective Care Co-ordination in Mental Health (NHSE/SSI, October 1999)
- c) Refocusing the Care Programme Approach (March 2008) DH
- d) Mental Health Act 1983, Code of Practice (2008) DH
- e) The CPA and Care Standards Handbook (CPAA 2008)
- f) NHS and Community Care Act 1990
- g) Department of Health Fair Access to Care Services (FACS) Policy Guidance was introduced in 2003 and updated 2010
- h) Triangle of Care
- i) Clinical Negligence Scheme for Trusts (CNST) Standard 8
- j) Payment By Results guidance
- k) CQC Care planning Standards 2010
- l) 'The Care Standards – supporting quality care standards' (The Care Co-ordination Association 2018)

14. GLOSSARY OF TERMS

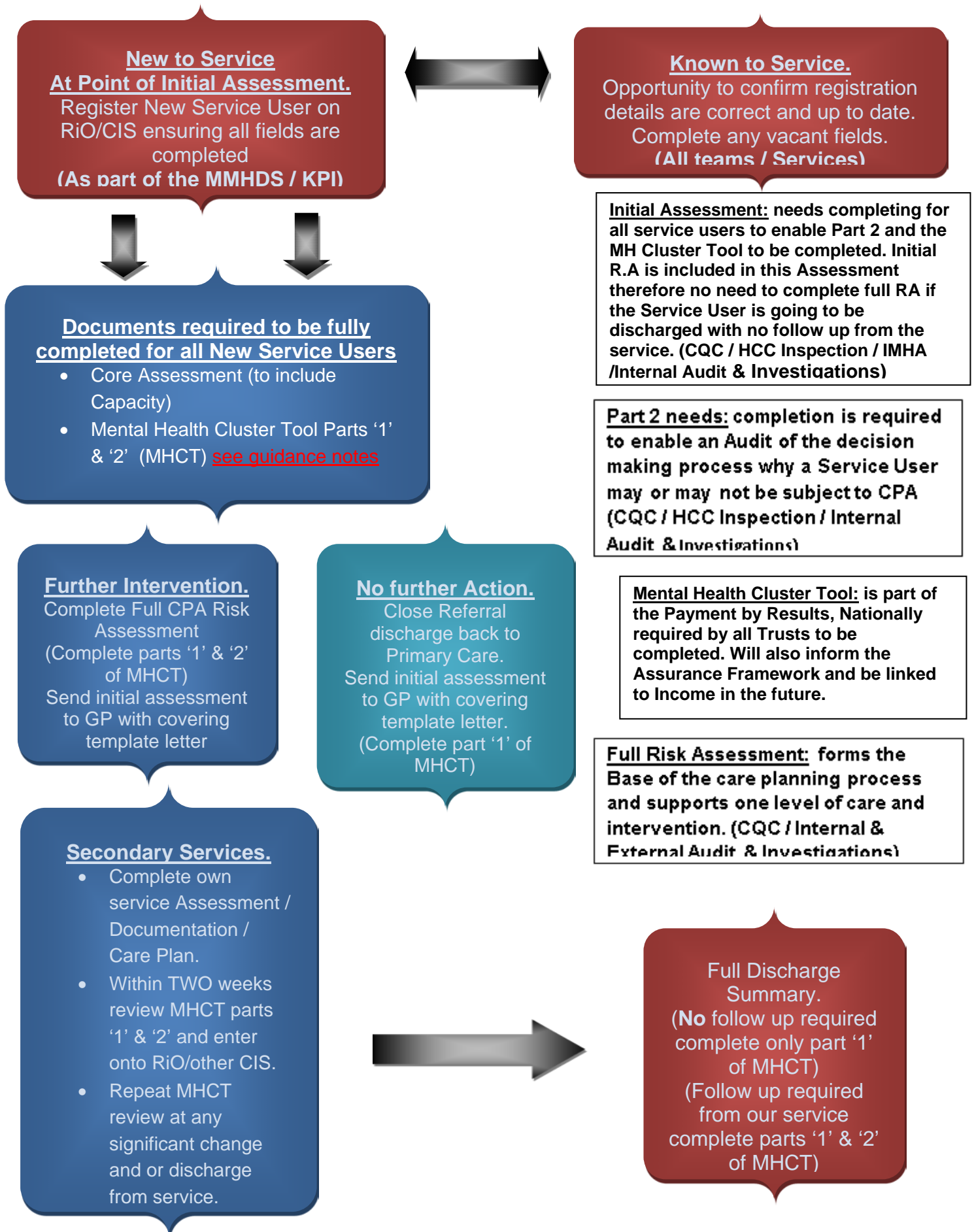
CAMHS	Child and Adolescent Mental Health Services
CIS	Clinical Information System
CPA	Care Programme Approach
GP	General Practitioner
HoNoS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Services
ICD-10	Classification of Mental and Behavioural Disorders
MCFT	Mersey Care NHS Foundation Trust
MHCT	Mental Health Cluster Tool
MHMDS	Mental Health Minimum Data Set
PbR	Payment by Results
RC	Responsible Clinician (MHA 1983 – 2007 Amendment Act)
RIO	Clinical Information System (Local Division) for recording CPA
WRAP	Wellness Recovery Action Planning (Principles for Recovery)

15. APPENDICES

Appendix 1 Statement of Values and Principles

- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.
- Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.
- Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care.
- The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Appendix 2 – Clinical Pathway



Appendix 3 Guidelines for Clustering in Mersey Care NHS Foundation Trust

Payment by Results is a national initiative that will determine the way that MCFT services are commissioned. It is expected that when carrying out an initial assessment, staff will attribute the most appropriate care packages to service users based upon their clinical assessment by 'clustering'. Please see the attached flow chart for details. There are 21 clusters which describe groups of Service Users with similar needs of care. The cluster will define the package of care a patient will receive while under care of services. A tariff will be developed, in line with these clusters, of costs the Trust should be charging for the services it provides.

Please note that this guidance is likely to change in future.

Cluster allocated to a specific Patient is likely to change during the course of journey depending on the needs which are likely to change. Hence, all clients with an open episode of care to MCFT should be re-clustered. Kindly refer to the attached flow chart for guidance.

It's the responsibility of individual Staff Members to ensure that Patients they are involved in for assessment / treatment are appropriately clustered. In case of any clarification, Supervisors / Line Managers should be consulted in first instance.

Which documents do I need to complete and in which order for Mental Health Clustering?



NB. It is the responsibility of all 'Disciplines' both None Medical & Medical to complete the core assessment and complete the following documentation. This cannot be delegated to other people).

New Patients referred to our service: - Seen within A&E, Out Patient, Police Custody, Court, or Domiciliary Visit, with either no known previous history or known history to our services. Following assessment, the patient is discharged straight back to Primary Care with **NO FOLLOW** up from our service.

This group of patients will receive:

- Full core assessment including assessment of Capacity.
- **Part 1 of the Mental Health Cluster Tool**, which will be entered onto RiO via the Clinical Pathway.
- Discharge back to Primary Care.
- Send the core assessment to GP with covering template letter.

New Patients referred to our service: - Seen within A&E, Out Patient, Police Custody, Court or Domiciliary Visit, with either no known previous history or known history to our services. Following assessment, the patient is **ACCEPTED INTO** our service for treatment and support via the Community services or In Patient areas.

This group of patients will receive:

- Full core assessment including assessment of Capacity.
- **Part 1 and 2 of the Mental Health Cluster Tool**, which will be entered onto ePEX via the Clinical Pathway.
- Send the core assessment to GP with covering template letter.
- The service completing the initial assessment **must ensure** they have completed all these documents prior to transfer to other services or admission into the In Patient areas.

(NB. Non-completion of these documents must not prevent admission or transfer of any patient to other services. Documents must be completed as soon as possible by the original assessor and handed over)

Once the person has been transferred to the appropriate services the following documents and process must be followed:

Secondary Services (accepted by Inpatient Services, Crisis Resolution Home Treatment or Known to Community Services)

Complete own service assessment and care plan.

Review **MHCT both parts 1 and 2** within 2 week period.

MHCT reviews must be linked into the CPA review process.

Repeat **MHCT parts 1 and 2** at any significant change.

Update Risk Assessment and Care Plan.

If discharged back to Primary Care without any follow up from our services: complete only **part 1 of the MHCT**.

If discharged and follow up services are required i.e. Out Patients, CMHT, etc. then parts **1 and 2 of the MHCT** are completed.

Community secondary services referring on to Acute Care Services

Update CPA care assessment/ care plans and risk assessment

Complete **MHCT part 1 and 2**

Appendix 4 – Re-clustering Matrix

Re-clustering is linked to scheduled reviews. This table sets out for each of the clusters the expected review interval. They vary considerably from cluster to cluster as some clusters relate to short episode of mental illness, others to mental health as a long-term condition. The maximum review interval is annually; in line with the Care Programme Approach (CPA) guidance that reviews should take place at least once a year.

Care Transition Protocol

Cluster	Cluster Description	Indicative Minimum Episode of care (wks)	Indicative Maximum Episode of care (wks)	Cluster Review (wks)
0	Variance			52
1	Common mental health problems (low severity)	8	12	12
2	Common mental health problems	12	15	15
3	Non-Psychotic (Moderate Severity)	16	24	26
4	Non-Psychotic (Severe)	26	52	26
5	Non-Psychotic (Very Severe)	52	156	26
6	Non-Psychotic Disorders of over valued ideas	0	156 +	26
7	Enduring Non-Psychotic Disorders (High Disability)	0	156 +	52
8	Non-Psychotic Chaotic and Challenging Disorders	0	156 +	52
9	Blank Cluster	n/a	n/a	n/a
10	First Episode in Psychosis	0	156	52
11	Ongoing Recurrent Psychosis (Low Symptoms)	0	104 +	52
12	Ongoing or Recurrent Psychosis (High Disability)	0	156 +	52
13	Ongoing or Recurrent Psychosis (High Symptoms and Disability)	0	156 +	52
14	Psychotic Crisis	8	12	4
15	Severe Psychotic Depression	8	12	4
16	Dual Diagnosis	0	156 +	26
17	Psychosis and Affective Disorder Difficult to Engage	0	156 +	26
18	Cognitive Impairment (Low need)	0	156 +	52
19	Cognitive Impairment or Dementia Complicated (Moderate need)	0	156 +	52
20	Cognitive Impairment or Dementia Complicated (High need)	0	156 +	52
21	Cognitive Impairment or Dementia (High Physical or engagement needs)	0	156 +	52
Additional Review Periods (Weeks)				
	Not Yet Seen			8
	Seen: Not Yet Assessed			4
	Assessed not yet Clustered			2

Appendix 5 - Care Co-ordinators Responsibilities

- To ensure that a full, systematic health and social care assessment including the identification of Service User's strengths is undertaken, including referral for other specialist assessments.
- Carry out an assessment of risk, document and communicate to the Multi-disciplinary Team and Senior Managers any identified serious and significant risk.
- To be responsible for formulating, with the active involvement of the Service User, a clear and jargon free care plan that is recovery based and includes crisis and contingency plans. This care plan should be acknowledged and agreed by the Service User and the multi-disciplinary team. Any disagreements should be explored and where possible resolved. Unresolved disagreements should be recorded within the care plan and in a clinical note.
- The care plan should take into account any Advanced Statement from the Service User.
- If the Service User does not have an Advanced Statement the Care Co-ordinator should actively encourage them to consider completing one.
- To ensure a copy of the care plan is offered to the Service User and to fully explain that the document is a plan of their care. The outcome of this offer and explanation must be recorded in the service users' notes.
- To be responsible for contributing to or making a diagnosis (ICD-10 coding) and communicating such with the Service User offering support, education / information and signposting them to seek further information.
- To be a specific point of contact for Service Users, Carers, GP's and others involved in the delivery of the care plan.
- To explain to the Service User and their Carers about Non-CPA and CPA, and what to expect from the process.
- To co-ordinate the agreed care package for CPA.
- To provide appropriate information leaflets as and when required.
- To ensure that regular contact is maintained with the Service User directly or via named people on the care plan.
- To arrange regular reviews of the care plan.
- To report any service deficiency (unmet need) and inform Senior Managers to ensure that these issues are reported through the clinical governance agenda.
- To maintain good communications with members of the wider care team.
- To ensure that all documentation is maintained and shared with other parties (inc. GP).
- Arrange for someone to deputise if absent, and pass on the Care Co-ordinator role to someone else if no longer able to fulfill it.
- To ensure that all Carers, including Young Carers, of Service Users are offered an assessment of their own health and social needs and that any subsequent care plan is reviewed.
- Where a young child appears to be a child in need, an assessment will be requested from Social Services' Children's Team. Appropriate liaison is also to be maintained with the relevant corporate services.
- To maintain contact with Service Users who enter the prison system to ensure continuity of care.

Good Practice Checklist

- The Care Co-ordinator has the appropriate skills and experience to undertake the role with the client group they are working with.
- The Care Co-ordinator is committed to working in partnership with the service user and (where appropriate) their family/carers.
- The Care Co-ordinator ensures that a recovery/wellbeing approach underpins the way in which they work with individuals.

Equality and Human Rights Analysis

Title: Corporate Policy and Procedure for the Care Programme Approach

Area covered: Trust wide

What are the intended outcomes of this work?

The objective of this policy is to describe the framework for assessment, care, support, planning and review of people referred to secondary care mental health services provided by the Trust.

It highlights the CPA has been extended to Older Adults, CAMHS, Learning Disabilities and Substance Misuse Services under the Refocusing Guidance. It describes:-

- The duties of all parties within Mersey Care NHS Foundation Trust
- Non-CPA
- CPA process
- The process for monitoring compliance with the standards of the policy

Who will be affected? Staff (excluding IAPT service), service users and carers.

Evidence

What evidence have you considered?

The Policy

Disability (including learning disability)

The policy extends to Learning Disability services within the trust.

Sex

No issues identified.

Race

No issues identified.

Age

P6 section 3.2 extends CPA to all age groups.

Gender reassignment (including transgender) No issues identified.
Sexual orientation No issues identified.
Religion or belief No issues identified.
Pregnancy and maternity No issues identified.
Carers No issues identified.
Other identified P5 section 5.2 extends CPA policy to all services within the trust.
Cross Cutting No issues identified.

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	The Policy is supportive of the protection of life through risk assessment and care planning.
Right of freedom from inhuman and degrading treatment (Article 3)	Use supportive of a HRBA if applicable.
Right to liberty (Article 5)	Not engaged
Right to a fair trial (Article 6)	Not engaged
Right to private and family life (Article 8)	The policy details the right of involvement with consent of carers Advance statements are referred to in the policy.
Right of freedom of religion or belief (Article 9)	Not engaged

<p>Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)</p>	<p>Not engaged</p>
<p>Right freedom from discrimination (Article 14)</p>	<p>Not engaged</p>

Engagement and Involvement

Review of the policy was in consultation with senior clinical staff representing the local services.

Summary of Analysis

Eliminate discrimination, harassment and victimisation

The policy provides a statement of values at Appendix 1 Page 20.

Advance equality of opportunity

The policy promotes a person centred approach and has been extended across services.

Promote good relations between groups

The policy promotes involvement and communication with all parties involved with consent of services users.

What is the overall impact?

No negative impact has been identified.

Addressing the impact on equalities

No impact noted.

Action planning for improvement

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For the record

Name of persons who carried out this assessment:

Denis Cullen – Policy Author

Alex Henderson – Clinical Services Manager, Local Division.

Date assessment completed:

15th January 2019

Name of responsible Director:

Trish Bennet, Executive Director of Nursing & Operations

Date assessment was signed:

26th February 2019