

Writing Good Care Plans



A good practice guide

Foreword

People who use health and social care services, should have services that they have been part of choosing, that meet their needs, and are based on the best research and standards.

Care plans are the way we plan and agree how someone's health and social needs can be met, and how good health and wellbeing can be supported.



They are the most important document that professionals, service users and their families share, and are the means of communicating an approach, a service, or a treatment between all those involved.

We believe that this process is so important that it needs proper support and training to help people develop skills and experience in working in partnership to agree a plan.

Carolyn Green

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Derbyshire Healthcare NHS Foundation Trust**

This guide has been put together by the Care Coordination Association and Derbyshire Healthcare NHS Foundation Trust in partnership (based on the Trust's award-winning booklet), and is intended to support good practice in care planning.

It includes a summary of current policy, standards, guidance and recommendations at the time of writing, together with guidelines and suggestions about how to write a good care plan. We also look at how someone can plan their own care, and manage their wellbeing.



It is the first of a series looking at best practice in the care process.

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Care Coordination Association

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Terminology: The terms 'service user' or 'person' are used throughout the document to indicate people who use health and social care services, in line with national policy and guidance.

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1. What is Care Planning?

This booklet is for anyone who wants to understand how to plan care, and would like to develop skills in care planning. This includes people who use health and social care services and their families and carers, those who work in health and social services, and those who work in partner organisations.

To help write better care plans, it's important first to understand what care plans are, and what is involved in making a care plan.

A care plan is...

A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review.

Care planning involves...

- **Gathering and sharing stories:** the views of all concerned, including the person's, family and carers, and professionals
- Establishing clear **mutual expectations** with service users and carers
- A **systematic review** of the needs of the person
- **Exploring and discussing choices:** to help work out what's most important, and the implications of different choices
- **Goal setting:** what do we want to achieve and by when?
- **Action planning:** what are we going to do, who is responsible, and when will it be reviewed?
- **Safety:** how do we make care as safe as possible?
- **Support:** for someone to manage their own health as much as possible



A care plan is...

- The written record of a plan of action negotiated with the person to meet their health and social needs
- Something which sets out who is doing what, when, and why (outlines aims, actions and responsibilities)
- A tool to support the safety of the service user and others
- A plan which can be used and understood in a crisis by service users, their families and carers and other agencies, as well as colleagues
- A plan which people feel they own
- Based on a thorough assessment of need
- Produced in partnership with all those concerned
- Coordinated by the most appropriate person, such as a Care Coordinator or lead professional
- Produced in the most appropriate forum
- Shared effectively with those who are part of it
- Part of a process that supports care planning under systems such as the Care Programme Approach, Care and Treatment Planning (Wales), Long Term Conditions Planning, Health Action Planning etc. and meets professional, local and national standards.



A care plan is not a...

- Bureaucratic exercise, **but is** an essential element in engaging service users and communicating what the service can and will do, and what responsibilities they, family and carers, and the person concerned will have
- Wish list, **but is** a plan of agreed elements of care
- Contract (although it may form part of a contract in some circumstances), **but is** a commitment to a course of action from all those involved.



What does a good care plan look like to me as the owner of the plan?

“The care plan is not just about problems, it’s a way of managing things you want or need to change in your life.” (service user)

“When I was in mental health care, I had a particularly good nurse. She was very good because she didn’t force herself on me, she was friendly, kept things light and helped me develop practical plans when I wasn’t so well.” (patient survey comments)



What does a good care plan look like to me as a family member?

“I have found that being included in the whole support package has made things work more smoothly. I can now contact the workers involved when early warning signs are being displayed, and with prompt intervention sometimes prevent hospital admission.” Please Remember Ben

How are we doing nationally?

“In response to every question asked in the survey about involvement only 50% to 60% were completely positive about being involved in their own care. This means that only:

- 56% of people responding were ‘definitely’ involved as much as they wanted to be in agreeing what care they received
- 61% ‘definitely’ felt that decisions were made together by them and the person they saw.”

CQC Community Mental Health Survey 2015

Why is personalised care so important and how is it demonstrated in care planning?

“As a Director of Nursing in an NHS Trust, I want to see that the clinical staff I employ are really starting to change their clinical practice, I would like to be able to open a person’s case record to get a real sense of the person in receipt of our services. What they want, how they feel, their treatment goals in the sense of symptom recovery, their health goals and their social recovery.

Until we have care plans that reflect the person, their goals and the clinical staff member’s role in enabling the person to meet their goals and achievements, however large and small, we are failing to provide the type of contemporary health service I want my family to receive.

We will achieve this, but we all need to embrace the shift in power, from the first contact, in enabling decisions to break the cycle of individuals and families being passive recipients of care.”

Carolyn Green

2. Care Planning Standards

Standards for care planning come from a number of sources, but the national CCA standard is:

“A Care Plan is a written record of the agreed care and treatment plan for an individual”

(Care Standards Handbook CCA 2014)

National Standards for care plans include:

- **The Care Quality Commission's (CQC) 'Essential Standards of Quality and Safety', Outcome 4: Care and welfare of people who use services:** People should get safe and appropriate care that meets their needs and supports their rights.
- **CQC Fundamental standards include:** care and treatment must be appropriate and reflect service users' needs and preferences.
- **NICE Quality Standard for service user experience in adult mental health** People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
- **Mental Health Act 1983 Code of Practice**
- **Department of Health (2007) Best Practice in Managing Risk**
- **Department of Health (2008) Refocusing the Care Programme Approach**
- **Professional standards**
- **National and Local Recording standards**

Your local or national care planning standard is....



3. Person-centred planning

“Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services.”
Department of Health 2008 Refocusing the CPA



Person-centred planning should be at the heart of professional practice. Identifying needs and preferences and helping people to articulate these involve:

- Values including: respect; honesty; and dignity
- Listening and communication skills
- Assessment skills in a wide variety of areas
- Understanding issues of capacity and consent
- The right tools, resources or skills to support the person.

You might ask someone:

- What is important to you?
- What do you hope to do, and what prevents you?
- What works well, and who supports you?
- What do you want to change?
- How would you like your support to work?
- What would you like to do next?

The CCA standard for service user involvement and choice is:

“People who use services will be treated with respect as partners in planning care, and their recovery and wellbeing supported” (Care Standards Handbook CCA 2014)

The fundamental standards from the CQC include:

Person-centred care: Treatment that is tailored to the service user and meets their needs and preferences.

Guidance: Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

4. Managing your own care plan

There are many ways in which people can manage their own health, or parts of it, and this can be an important opportunity to help someone feel in control of what's happening, and to enhance their wellbeing.

Planning to improve your wellbeing could focus on the 5 Ways to Wellbeing:

Connect - Be active - Be mindful - Keep learning - Give to others

The idea of recovery and wellbeing supports this. Recovery approaches help people to manage their own health through tools such as WRAP (Wellness Recovery Action Planning), which help you to identify when you're not feeling well, and help you work out the best way to manage it.

Think of a health issue you would like to manage better, or use an example from someone you know:



My Plan

Health issue:

What makes it better?

What makes it worse?

Who or what can help:

What I plan to do:

5. Whose care plan is it anyway?

“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.” Department of Health Refocusing the CPA 2008

How a care plan is put together can have a major impact on how much the plan is owned by the person whose plan it is, and hence how effective the care plan is.

A care plan that is written by one person alone in an office may include all the key elements, but is not likely to be as effective in practice as one which is written in partnership with the person and others who are part of the plan.

A sense of ownership by all those concerned (and in particular the person themselves) is vital in making the plan translate into reality. This can be improved by:

- **Using people’s own words and phrases** (familiar and comfortable language, which avoids jargon and abbreviations)
- Using **goals, aims and outcomes** identified by the person
- Recognising that **care plans exist for the benefit of the service user**, and should be based around the needs of that person, not on the services available
- Understanding that people with long term conditions may be at **different stages on their journey**, which may affect how much control they are able to take
- **Ensuring the person feels that they own the plan**, through developing, agreeing and writing the care plan as much as possible, including the opportunity to review the plan to ensure it is understandable, and to have a copy as soon as possible
- Producing the plan in a **format and style that the person is comfortable with, and can use**
- **Being flexible** in the approach to the involvement of those who have a stake in the plan.

6. What's in a care plan?

Care plans should include (write in the missing words):

- **Why** are we doing this? (a_____)
- **What** are we planning to achieve? (o_____)
- **How** are we going to do it? (a_____)
- **Who** will do it? (r_____)
- **Where** will it be done? (l_____)
- **When** will it be done by? (t_____)

See suggested answers on p.38

The care plan should also:

- ✓ Focus on people's **strengths and wishes**
- ✓ Include the **person's role** in the plan
- ✓ Reflect the individuals **cultural and ethnic background** as well as their gender, sexuality, race, economic disadvantage, age, religion/spirituality, and disability
- ✓ Consider the role of any **family or carers** who are involved
- ✓ Include action and outcomes in **all relevant aspects** of an individual's life
- ✓ Consider any **safeguarding** issues for children or vulnerable adults
- ✓ Consider **safety** issues
- ✓ Include **crisis and contingency** arrangements
- ✓ Give the date of the **next planned review**
- ✓ Cover **transfer** details if appropriate
- ✓ Identify any **unmet needs**
- ✓ Acknowledge **areas of difference** or disagreement.



7. Safety planning

Safety planning and risk management are an essential part of care planning, and should be woven into the care plan. This should be based on a sound assessment of safety issues and risks to the person, their family and others. Safety plans should:



- Be formulated collaboratively with the service user and their carer(s)
- Avoid professional jargon and use language the service user understands; use their own words where possible
- Be clearly and effectively communicated to all concerned.

Person-centred safety planning

Person-centred safety planning is a fundamental process within a care plan. The Care Programme Approach process involves identifying specific actions based on an individual's needs, taking into account safety and risk issues. All the needs of the individual should be reflected in a care plan, including all those relating to risk.

“Best Practice in Managing Risk” (Department of Health, 2007) describes best practice in safety planning. The guidance identifies positive risk management, a collaborative approach building on strengths/resources and the roles of services and individuals as key to an effective safety management plan. Safety plans should incorporate actions which support the individual's needs and priorities alongside minimising risks to the individual or others.

The language used is important. For the person to retain ownership avoid the use of professional jargon. The term “risk management” can potentially create an obstacle to working together. Discussions about staying safe and how the organisation or individual can support with this can be more constructive and collaborative (Morgan, 2013).

Crisis and contingency plans

Crisis and contingency plans must be based on the individual circumstances of the person, however, where there are no risks identified, contact information may be sufficient. This should always include 24 hour a day 7 day a week contact details.

Crisis plans should set out the action to be taken if the service user becomes very ill, or their health is deteriorating rapidly. The plan should include:

- Who the **service user responds best to** and how to contact them
- **Previous strategies** that have been successful in similar situations
- **Early warning signs** and specific **relapse indicators**
- The **responsibilities of all members of the care team**. This should include the service user; the family (with their agreement) and the community.

Good practice example:

When Jay stops making eye contact and starts pacing, make sure that he has a quiet place to go where other people will not disturb him, ring his Mum on 243657 (who can usually reassure and calm him) and if further advice is needed contact his GP.

Contingency plans should help to prevent a crisis developing when, at short notice, the coordinator is not available, or part of the care plan cannot be provided. The person's health may be affected by the problem, but is not the cause of it. The plan must include:

- Information about **who to contact** if the coordinator is not available
- A **contingency** for any key elements of the care plan

Write a good practice example of a contingency plan for someone whose carer is frail and in poor health:

In practice it may be useful to think about:



- Can this plan help make the person feel that the stranger at the end of the phone knows about them, and understands what will help?
- Which elements of the care plan are essential, including those elements without which the person's wellbeing or safety would be seriously compromised?
- Making sure that those included in the plan understand and accept their role
- Crisis plans for people with more complex needs, such as those who need the CPA, or have complex long term conditions, should be more than just a list of telephone numbers
- Crisis plans will often be referred to when the person is experiencing distress, and events may be fast-moving, so plans need to be clear
- They should reflect the person's views and wishes
- Plans should be written with the person and their carer(s) wherever possible
- By being explicit and instructional the plan is more beneficial to the person, their carer(s) and other service staff
- People with mental health problems are at greater risk than the general population of developing physical health problems, with those diagnosed with a serious mental illness dying up to 20 years earlier than the general population from preventable diseases which affect the population, such as cardiovascular and respiratory disease.

Write a good practice example of a safety plan for Annie, an elderly woman with dementia who is regularly walking about outside at night.

Aim:

Person's view:

Actions:

8. Involving carers and families

Carers and families can play a vital part in keeping their relative or friend well.

In working with carers and families it is important to be clear about the views of the person being supported about their involvement, and what information can and should be shared.



Involvement in care planning can take many forms, and can be anything from getting copies of letters about appointments to full involvement in planning and reviewing care.

The Triangle of Care: Carers included (2010) has six key standards that outline the approach that mental health services should take:

- 1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- 2) Staff are 'carer aware' and trained in carer engagement strategies.
- 3) Policy and practice protocols re: confidentiality and sharing information, are in place.
- 4) Defined post(s) responsible for carers are in place.
- 5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
- 6) A range of carer support services is available.

The CCA standard for working with families and carers is:

“Families and Carers are partners in supporting the Service User, they should be involved in planning care, and have their own needs recognised.”

(Care Standards Handbook CCA 2014)

Carers Support Plans

All informal carers who provide regular support for someone are entitled to an assessment of their caring, physical and mental health needs, and a support plan to meet the needs identified.

This may include (depending on the needs identified):

- **Information**, including where and how to access services, both during office hours and in a crisis
- Action to meet defined **contingencies**
- What will be provided to meet the carers identified **mental and physical health** needs
- **Advice** on income, housing, educational and employment matters
- Arrangements for short term breaks and **respite**
- Arrangements for **social support**, including access to carers support groups
- Information about appeals or **complaints procedures**.



In practice it may be useful to think about:

- Other agencies may be commissioned to provide the assessment and support plan - find out who they are
- The carers support plan may (with everyone's agreement) be part of a joint one with the service user
- Where no needs are identified, or the carer refuses an assessment, contact information for the carer may meet the requirements of the support plan
- The carers support plan should be reviewed at least annually
- The Care Act 2014 affects carers rights and services. Find out the situation in your area.

Write an example of a support plan for a carer who needs to be able to take up a leisure activity:

Aim:

9. Writing good care plans

It is important to give some thought to the content and style of the care plan, as well as the process of putting it together.

We often use statements such as 'monitor health' or 'monitor medication' with no indication about what precise aspects of someone's health should be monitored, or how these should be monitored.

As a minimum, the care planning discussion should include:

- ✓ agreeing the person's own goals (e.g. I want to lose weight, stop smoking, get out more, get a job, manage the voices better)
- ✓ providing information that is timely, relevant, and accessible
- ✓ supporting individuals to take an active role in their own health
- ✓ agreeing any actions or treatments, and who is responsible for them
- ✓ agreeing a timely review date



In practice, it may be useful to write...

- The care plan as 'I need', to encourage the service user to own the care plan
- Clear outcomes that are person-centred
- Interventions that relate directly to the needs and goals
- Actions that include the person's own responsibilities
- Statements of action that are instructional and able to be followed in your absence
- Care plans in partnership with the person whose plan it is, in language they are comfortable with.



Remember: people should have a copy of their own care plan.

How could you write 'monitor mental health' better?

The **SMART** approach to care plans

SMART!

SMART is a well-known acronym for Specific, Measureable, Attainable/Achievable, Relevant/Realistic and Time-bound/Timely/Time-limited. It has been used to support systematic planning in many areas including health, business, and education. It can help you to develop plans that are clear, can be implemented, and can be evaluated.

S**pecific:** This stresses the need for a specific goal rather than a more general one. This means the goal is clear and unambiguous; without vagaries and platitudes.

M**easurable:** This stresses the need for concrete criteria for measuring progress. The thought behind this is that if a goal is not measurable it is not possible to know whether the service user and the team are making progress toward successful completion. Measuring progress is supposed to help us stay on track, and experience the positive experience of achievement.

A**ttainable/Achievable:** This stresses the importance of goals that are realistic and also attainable. Whilst an attainable goal may stretch a team in order to achieve it, the goal is not extreme. That is, the goals are neither out of reach. When you identify goals that are most important to the service user you begin to work out ways you can make them come true. You develop the attitudes, abilities, skills and resources to reach them.

R**elevant/Realistic:** This stresses the importance of choosing goals that matter. A bank manager's goal to "Make 50 peanut butter sandwiches by 2pm" may be specific, measurable, attainable and time-bound but lacks relevance. Relevant goals support the service user to move forward. A goal that supports or is in alignment with other goals would be considered a relevant goal. A relevant goal can answer yes to these questions:

- Does this seem worthwhile? Does this match our other efforts/needs?
- Is this the right time?
- Is it being supported by the right person?

T**ime-bound:** This stresses the importance of grounding goals within a realistic time-frame. A commitment to a time-frame helps a team focus their efforts on completion of the goal on or before the due date. A time-bound goal will usually answer the question When?

- What can I do six months/six weeks from now? What can I do today?

Is the following care plan **SMART**? What areas are missing or unclear?

Care Plan date:	Comments
Aim: to improve John's current situation	
Actions:	
1. To help John get back to work OT	
2. Refer John to X for help with anger management CPN	
3. Monitor medication CPN	
4. Check benefits SW	
5. To review the plan in six months CPN	

Identifying needs:
Care plans should always identify needs (rather than services), so the following is an inadequate care plan:

Need	Action	Responsible
Home help	Every day	Home help

Instead of: Need = Home help or even Need = Have a fire lit and help with morning routines, the need should represent what the action is really intended to meet. No-one has a need for a Home Help, the need is for adequate warmth, or cleanliness, or personal care.

The action to meet the need might be:

- to have a home help who undertakes certain tasks, or
- support for the person to learn to do this, or
- to consider a change of heat source, depending on what the person feels would best support their independence.

Good practice example:

Need	Action	Responsible
Keep warm and get up in the morning	Home help every morning between 9 and 10 a.m. to light the fire and help with personal care	Jo Smith, Social Worker

Accuracy and completeness

The care plan should always be able to be picked up and used by colleagues if the person coordinating the care is not there, so must include enough information for someone else to implement the plan.

Need	Action	Responsible
Day Hospital	Every Thursday for Reminiscence	Manager

Write a better care plan:

Goal or outcome:

Need	Action	Responsible
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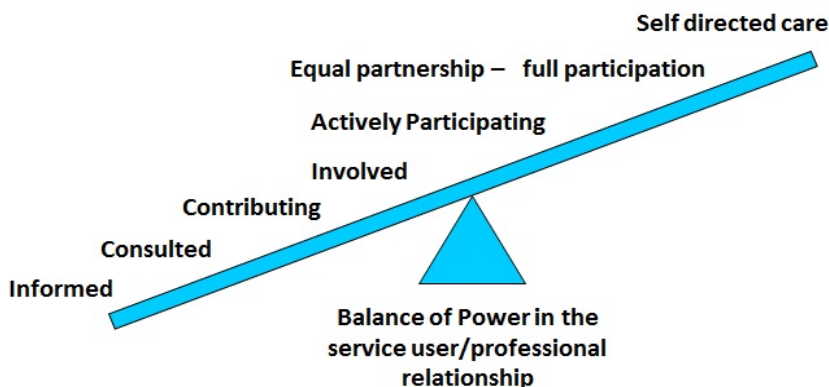
Unmet needs

"Named care coordinators should record any needs the person has that health and social care practitioners cannot meet. Discuss and agree a plan of action to address these needs with the person and their carer." NICE 2015 Older people with social care needs and multiple long-term conditions

It is important that any needs that are identified as part of assessment or review are included in the care plan. If they can't be met, this should be discussed, and the plan should include actions working towards meeting them.

10. Involvement

Involvement of the person in their own care is essential, but not always achieved. Many policy documents and good practice initiatives have the expectation that people are very actively involved in the decisions about their care and treatment. The diagram below aims to help us recognise and understand the different levels of involvement and in turn to recognise ways to promote and encourage that active involvement.



The model is portrayed as a seesaw, representing the balance of power within the service user/professional relationship. At the lower end, the level of participation and collaboration is quite low, with much of the 'power' appearing to reside with the professional. Even at this level there is an assumed level of participation relating to informing and consulting with the patient/service user. As you move up the spectrum, and they are involved more collaboratively in planning their care, the balance starts to shift more equally, then in the persons favour as they move more towards self-directed care. (Ann Munro)

What factors may make people fall to the bottom of the involvement balance?

Managing your own health

Involvement includes empowering, informing, supporting and encouraging someone to take control of their own health as much as possible. Patients with high levels of involvement and 'activation' understand their role in the care process and feel capable of fulfilling that role.

The Patient Activation Measure (PAM) measures an individual's knowledge, skill, and confidence for self-management, allowing the right kind of support to be offered for the level of activation (levels one to four). Research shows that appropriately designed interventions can increase peoples' levels of activation, with associated health benefits. The 13 question scale asks for one of four levels of agreement and covers:

- **Knowledge** (e.g. I understand the nature and causes of my health condition);
- **Beliefs** (e.g. When all is said and done, I am the person who is responsible for managing my health condition);
- **Confidence in interacting with healthcare professionals** (e.g. I am confident I can tell my health care provider concerns I have even when he or she does not ask); and
- **Self-efficacy** (e.g. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress).

Think about how someone you know would answer these similar questions in relation to care planning. They may need to take it one step at a time, but they are indicators that the person is working towards being fully involved and managing their own health:

Knowledge

- ☐ I understand what my health condition is and how it can be managed
- ☐ I have choice in the treatments and support in my care plan

Beliefs

- ☐ I feel that I own my care plan, and that it accurately reflects my views, opinions and choices
- ☐ I am happy with the way that my family/carers are involved

Confidence in interacting with healthcare professionals

- ☐ I can talk to my health and social care professionals about my plan
- ☐ I know what to do if I have any side effects from medication

Self-efficacy

- ☐ I have my own plan to manage periods of stress and difficulty and am confident I can use it when I need to



How well is the plan working?

Think of ways in which you can truly involve someone in developing or reviewing their care plan. The method needs to fit the person's style or preferences. What works for one person may seem patronising to someone else, or too complex to another. Think about their learning and communication styles. Some people may like to discuss or write, some respond to a more pictorial style. Below is an example of something that might help to identify the views of the different people involved in the plan

	What's working? 	What's not working? 
I think 		
My family think 		
My health professional thinks 		

What other methods could you try, or have tried before?

11. Accessibility and communication

“If you have poor literacy skills, make sure the Care Plan is provided to you in a way that you can understand fully. Guidance says that technical language and jargon should be avoided in the planning process.” Care and Treatment Planning Hafal 2012

Until a care plan has been effectively communicated with the people who need to see it, it remains only a plan. A care plan found only in the record (whether paper or electronic) will not work very well. Think about the language of the care plan. Use of words such as ‘refrain’, ‘comply’ or ‘non-compliant’ can set a tone that doesn’t necessarily reflect the person’s experience of the needs that have been identified, and technical terminology can exclude people. However, simply sending out a written care plan in English on paper may not be enough, and some of the recipients may not be able to access this. Issues to consider include:

- The level of literacy
- The age of the person: children and young people may respond more to a visual approach
- The language the person is most comfortable speaking (e.g. Welsh)
- Sensory impairments and disabilities
- Cognitive impairment.



It is also essential that the care plan is legible, and typed or printed plans are to be preferred wherever possible. Consider the need to use:

- ✓ Manual or sign languages or communication methods such as British Sign Language (BSL), Makaton, Braille etc.
- ✓ Simplified language or larger size type
- ✓ Symbols or pictures
- ✓ CDs or DVDs
- ✓ Translation into languages other than English.

The care plan must be sent to everyone who plays a part in it, and made available to people who do not regularly play a part in it but may need access in a crisis, by making sure it is held in an accessible way. The Accessible Information Standard (NHS England) gives more information.

12. Choice and capacity

“The use of mechanisms such as advanced decisions to refuse treatment and the making of Lasting Powers of Attorney for health and welfare decisions under the Mental Capacity Act can be extremely useful in planning future care.” Welsh Assembly Government 2010 The Mental Health (Wales) Measure

Occasionally service users may not want to (or are unable to) be fully involved in their care plan. The reasons for this may be to do with their capacity, their level of insight, communication difficulties, or their personal choice.

General principles to support involvement would include:

- ✓ Use **innovative ways** of developing and explaining care plans, e.g. pictures, recordings
- ✓ **Revisit** their capacity and choice on a regular basis
- ✓ Involve their **carer or family**, with their agreement
- ✓ Remember that people may lack capacity in some areas but **may have capacity in other areas**
- ✓ **Do not assume** that they will not understand their care plan (or at least some parts of it)
- ✓ Write an **engagement plan**, detailing how you plan to engage them within the care planning process
- ✓ Try to engage them in **alternative environments** or activities
- ✓ Involve **other professionals** within your team, or partner agencies, who may have a different approach or different skills
- ✓ Follow your organization's '**Engagement**' or 'Did Not Attend (DNA)' policy
- ✓ If they don't wish to be involved in planning or review, **hold a review** in their absence and ensure there is a **robust and clear plan** that supports engagement as much as possible.

Capacity and care planning

The principles of the Mental Capacity Act should also inform our approach to care planning, starting with **the presumption of capacity**; that every adult has the right to make his or her own decisions and must be assumed

to have capacity to do so unless it is proved otherwise. **Individuals being supported to make their own decisions** and being given all practicable help to reach their own decisions, and that just because a person makes what might seem an unwise decision, they should not be treated as lacking in capacity to make that decision.

If there are concerns about the service user's capacity to participate in the care planning process the care team should consider:

- Has the individual (and their carers) had all the relevant information they need to make a particular decision?
- If they have a choice, have they been given information on all the alternatives?
- Have they made an Advance Decision or Advance Statement, or is there a Lasting Power of Attorney?
- Has the information been explained or presented in a way that is easy for the person to understand (for example, by using simple language or visual aids)?
- Have different methods of communication been explored if required, including nonverbal communication?
- Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
- Are there particular times of day when the person's understanding is better?
- Are there particular locations where they may feel more at ease?
- Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?
- Can anyone else help or support the person to make choices or express a view?

Give an example of how you have engaged someone in planning care, where either their capacity was limited, or they did not want to be involved.

13. Professional approach to care planning

The professionals involved in health and social care provision all undertake training pre- and post-qualification in the skills of assessment, planning and care provision. The aim is to use the particular skills and conceptual models (such as the Model of Human Occupation MOHO for Occupational Therapists) to provide an evidence-based service to the people who need it. All professions have standards and frameworks to help practitioners identify the treatment or support someone's needs, based on a system of ethics. The professions are registered and regulated.



Below is an example from the Royal College of Psychiatrists to explain what a professional care plan should contain:

"The different parts of your help or treatment are written down in the care plan. This should include:

- the problem (or problems)
- any risks involved
- your strengths
- what needs to be done to help you recover
- who should be doing what
- your views – you should have a copy."

Royal College of Psychiatrists - mental health services

Health and social care professions

Doctors include foundation doctors, specialty trainees, and senior medical staff such as specialist registrars and consultants. Medical staff have a key role in assessment, diagnosis, and care planning, and are an important member of the team working to support someone's health and wellbeing. They can take a leadership role or support another team member to take a lead in planning.

Occupational therapists deliver evidence-based interventions aiming to enable individuals to undertake the activities that are important to them in their daily lives. "Occupation" refers to practical and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day tasks such as self-care, work or leisure.

Occupational therapists work with adults and children of all ages with a wide range of conditions; most commonly those who have difficulties due to a mental health illness, physical or learning disabilities. (BAOT, 2015)

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. (ICN, 2002) Nurses may specialise in a wide range of areas, including acute and hospital-based nursing, district nursing, psychiatric nursing, midwifery, children's, or learning disability nursing.

Psychologists can be Forensic, Educational, Clinical or another specialism. Psychology is the scientific study of human mind and behaviour. Psychologists work in many different areas of society and are concerned with practical problems such as: helping people to overcome depression, stress, trauma or phobias; easing the effects of parental divorce on children; speeding up recovery from brain injury; helping to stop or prevent bullying at school or in the workplace. (BPS 2015)

Social Workers the social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (BASW Code of Ethics - International definition of social work 2000)

Many other professionals contribute to health and social care. The Health and Care Professions Council registers professionals including **arts therapists, chiropodists / podiatrists, clinical scientists, dieticians, physiotherapists, and speech and language therapists.**

Multiple care plans

Individual professional care plans describe the particular needs identified through the assessment process, and the support that the professional can offer. The challenge is always to make sure that care plans work together, and don't conflict with each other. A single overarching care plan can make sense of many disparate individual plans, and enable coordination. This is also essential to enable the person to make sense of what is happening.

14. Coordination of care plans

“Care coordination is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care.” Department of Health 2011 Care Co-ordination: Improving care for people with long term conditions

All care plans should have someone who takes responsibility for their oversight or coordination. A Coordinator is responsible for making sure that the care plan is:

- Produced with the involvement of the service user and carer
- Agreed and authorised
- Able to help clinical decisions in a crisis
- Coordinated by a named individual
- Circulated to everyone concerned
- Reviewed regularly

However, someone else may carry out these functions, as long as the Coordinator coordinates them.

In practice it would be useful to ask...

- ? What the person would like from services?
- ? What he/she would like to achieve?
- ? How they feel this could be achieved?
- ? How they feel they could contribute?
- ? Who the service user feels comfortable for you to talk with, and gain permission for this?
- ? How families and carers are involved and supported?



In practice it would be useful to think about

- The care plan being read by someone other than yourself
- Actions being specific, realistic and achievable
- The care plan being a useful communication tool in times of relapse or crisis
- What level of detail is needed in the plan to achieve the goals
- Would another worker be able to identify what to do?



15. Types of care plan

There are a number of different planning processes that may impact on people using health and social care services. The guidance provided in this booklet is appropriate for the majority of these. A brief summary of the main types is provided below.

Mental health care plan

A plan produced as the result of a mental health assessment of need.

- A written plan, which may be either produced on a care plan form/format, or as part of a letter which is identified as being a care plan
- Coordinated by a Care Coordinator or lead professional
- Determined by need but at least every year
- **More information available:** Care Coordination Association

Care and treatment planning (Wales)

Care planning for people with mental health problems in Wales is enshrined in legislation. The Mental Health (Wales) Measure 2010 introduced Care and Treatment Planning. The Code of Practice to Parts 2 and 3 includes:

“The Measure places a duty upon the care coordinator to collaborate with the relevant patient, and that relevant patient’s mental health service providers, with a view to:–

- a) agreeing the outcomes which the provision of mental health services are designed to achieve;
- b) agreeing the care and treatment plan; and,
- c) reviewing and, if necessary, revising the plan.”

Carers support plan

A plan produced as the result of an assessment of a carer’s mental and physical health needs, caring, leisure and employment needs.

- It will always be a written plan, but may be in the form of a separate plan, or a joint plan with the patient/service user
- May be coordinated by any agreed/commissioned service
- Reviewed at least annually
- **More information available:** Carers Trust: National Carers Strategy

Section 117 aftercare plan

A plan produced for someone with an entitlement to aftercare under s.117 of the Mental Health Act 1983 (who has been on a s.3, 37, 47, 48 etc).

Services provided under the plan generally cannot be charged for by health or social services (e.g. residential care).

- A written plan produced before the person is discharged from hospital, preferably at the s.117 pre-discharge meeting. This may be the CPA care plan, but services under Section 117 should be clearly identified
- After-care services must have the purpose of meeting a need arising from or related to the person's mental disorder and reducing the risk of deterioration and so reducing the risk of readmission. This can be articulated in the care plan's goals/outcomes
- Coordinated by a CPA Care Coordinator or lead professional
- Reviewed at least every year as part of the CPA review. Entitlement under s.117 must be discharged by both health and social services when the person no longer needs mental health aftercare
- **More information available:**
NHS Choices: Mental health aftercare
Mental Health Act Code of Practice 2015

Self-directed support/personal budget

Personalisation aims to promote independence and enable more choice and control in how services are provided for people who need support.

- A written plan produced, monitored, and reviewed by a social care worker (in conjunction with any Care Coordinator)
- Reviewed 72 hours after a residential placement, then after 3 weeks, then every 6 months
- **More information available:** NHS Choices: Direct Payments and Personal Budgets

Direct payments plan

A plan produced to describe services provided as a Direct Payment, which can be given to enable someone to purchase their own services. This can be for the person who needs care and support services, or their carers.

- A written plan following an assessment by Social Care, which outlines how the person is to be supported both in their use of Direct Payments, and through other services
- Reviewed at least once a year
- **More information available:** NHS Choices Direct Payments and Personal Budgets

Wellness Recovery Action Plan (WRAP)

WRAP© is designed and managed by the service user, ideally involving the key people who support them, and is designed to:

- Decrease and prevent intrusive or troubling feelings and behaviours
- Increase personal empowerment
- Improve quality of life
- Assist you in achieving your own life goals and dreams

All WRAP plans will be unique to, and managed by the individual, but with the service user's agreement incorporating WRAP within CPA/care coordination can have a significant impact in ensuring that care plans are truly collaborative in all aspects.

- Wellness tools/daily maintenance parts of the WRAP plan can be incorporated into care planning to address identified needs with the outcomes desired being the care plan goals
- A WRAP plan could either in total or in part contribute to the development of a service users relapse/crisis/contingency plan
- The triggers and/or early warning signs of distress sections of the WRAP plan can be incorporated into the Crisis/Risk management plan
- **More information available:** Mary Ellen Copeland

Health action plan

A plan produced with people with learning disabilities to describe the health services being provided to support them.

- A written plan based on a full health check, which includes their health needs, the professionals who support these, and any appointments they have
- Coordinated by a health facilitator, who may be anyone supporting the person
- Reviewed regularly
- **More information available:** Foundation for people with learning disabilities

Person-centred plan

A plan produced as a result of Person-Centred Planning (PCP) with someone with a learning disability. This helps someone plan all aspects of their life, making sure that they are central to the process.

- A written/pictorial plan which takes into account how the person communicates

- The process involves looking at the people who are important in their lives (circles of support), what strengths people have, their dreams, and what support they will need to achieve them
- Revisited and reviewed regularly
- **More information available:** Foundation for people with learning disabilities

Long term conditions care plan

Everyone with a long term condition can have a care plan if they want one, which is an agreement between the person and their health or social care professional about managing health day to day.

- The care plan is designed to help the person, rather than the GP and other healthcare workers. It will cover areas including: the goals you want to work towards, the support services you want, who is in charge of providing these services, what the support services have agreed to do, and when they will do it, emergency numbers, medicines, an eating plan, an exercise plan
- Reviewed annually
- **More information available:** NHS Choices: What is a care plan?

Young person's care passport

This is an initiative to enable children and young people with specialist or complex needs to have a 'passport' of key facts and information that follows them around, which they were part of, and which highlights their needs and wishes.

- The decision about which plan to use will depend on the needs of the child and family, but the lead professional or Care Coordinator's role is to coordinate support and services from across agencies to meet the needs, for example, of children and young people in contact with the youth justice system, whose care may otherwise fall between several different agencies. For young people with more severe mental health difficulties or those transitioning to adult mental health services, the Care Programme Approach may be the most appropriate approach
- Reviewed regularly
- **More information available:** NHS England (2015) Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing

Advance decisions and advance statements

Planning in advance is a way for someone to say how they would like to be treated in the future if they lose the capacity to make decisions themselves. The Mental Capacity Act gives a statutory framework to some aspects of this.

- An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision someone can make now to refuse a specific type of treatment at some time in the future. The treatments must all be named in the advance decision. This has legal force and is binding on the decision maker, except where the person has been detained under a section of the Mental Health Act 1983
- A statement of wishes and feelings (or an advance statement) sets out wishes and feelings of the person about any issue. It is not legally binding, but the decision maker does have to take it into account.
- A Lasting Power of Attorney may be for personal care or financial affairs. It appoints someone to take charge of your affairs if you don't have the capacity to make decisions
- It is good practice to have reference to any advance decision or statement in any health or social care plans
- **More information available:**
 - o NHS Choices: Advance decision to refuse treatment
 - o NHS Choices: Advance decision (living will)
 - o Rethink: Advance statements – planning for the future
 - o EMAHSC: Advance planning for people with bipolar disorder

Prisoners release plans

Where a person now in prison was previously cared for by mental health services, the care plan should (with the prisoner's consent) be formulated with the full involvement of their Care Coordinator before release.

A written plan coordinated by the Prison Healthcare service working with the (CPA) Care Coordinator

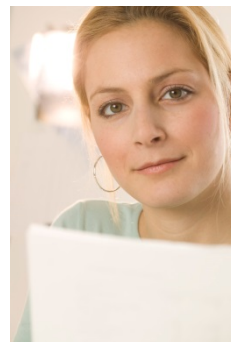
- Reviewed at least every six months, including police, probation and housing colleagues where relevant
- **More information available:** Mind factsheet



16. References, legislation, policies

Care Quality Commission

The CQC Fundamental Standards (2015) Regulations – service providers and managers include:



- **Person-centred care** – Treatment that is tailored to the service user and meets their needs and preferences.
- **Dignity and respect** – Making sure that service users have privacy when needed and wanted, are treated as equals, are given any support needed to help them remain independent and involved in the local community.
- **Consent** – The service user (or anybody legally acting on their behalf) must give their consent before any care or treatment is given.
- **Safety** – Service users must not receive unsafe care or treatment or be put at risk of any harm that could otherwise be avoided. Risks must be evaluated during any care or treatment pathway, making sure your staff have the qualifications, competence, skills and experience to keep clients safe.
- **Safeguarding from abuse** – Service users are entitled to receive care without suffering any form of abuse or improper treatment. This includes neglect, degrading treatment, unnecessary or disproportionate restraint or inappropriate limits on freedom.

Care Quality Commission Mental Health Service Users Survey 2015

Standards for health services in Wales

Standard 8 Care Planning and provision says that: organisations and services should ensure that all patients within their care receive individualised care plans that recognise their differing needs. The organisation may have to work with a range of partners to meet these needs. Organisations and services recognise and address the needs of patients, service users and their carers by:

- a. Providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care

at the end of life, in a timely way consistent with any national timescales, pathways and best practice;

- b. Providing support to develop competence in self-care and promote rehabilitation and re-enablement; and
- c. Working in partnership with other services and organisations, including social services and the third sector.
- d. Hafal (2012) Guide to Care and Treatment Planning outlines the standards for people using services

Mental Health (Wales) Measure 2010

This introduced Care and Treatment Planning for people with mental health problems in Wales. The Measure has four main Parts:

- Part 1 of the Measure ensures more mental health services are available within primary care
- Part 2 makes sure all patients in secondary services have a Care and Treatment Plan
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted

NICE

- **Quality Standard for Service User experience in adult mental health (QS14) December 2011** Quality Statement 8: People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
- **Older people with social care needs and multiple long-term conditions (NG22) November 2015** This guideline covers planning and delivering social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services.
- **Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27) December 2015** This guideline aims to improve people's experience

of admission to, and discharge from, hospital by better coordination of health and social care services.

Care Programme Approach (England)

The Care Programme Approach describes the approach used to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex mental health characteristics.

- Department of Health (2008) Refocusing the Care Programme Approach: Policy and Positive Practice Guidance
- Mental Health Foundation/National Service User Network (2012) Service users experiences of recovery under the Care Programme Approach.

Care Act 2014

The Care Act 2014 says that needs assessments or carers assessments must be carried out where it appears to a local authority that they are necessary. The assessment should be appropriate, proportionate, person-centred and ensure a focus on the duty to promote wellbeing. Once an assessment has been made local authorities have a duty to produce care and support plans, to offer a personal budget, and to review care and support plans to ensure that they continue to meet the needs of the person.

Person-centred care and involvement

- Kings Fund (2014) Supporting people to manage their health: An introduction to Patient Activation
- Carers Trust (2010) The Triangle of Care: Carers included
- Department of Health (2011) Personalised Care Planning
- CAFCASS (2015) My Needs wishes and feelings

Safety and risk

- Department of Health (2007) Best practice in managing risk. London: Department of Health
- Morgan, S. (2013) Risk decision making: working with risk and implementing positive risk-taking. Hove: Pavilion

- Refocusing the Care Programme Approach: A learning resource for care coordinators. Trainer's Manual (2009) University of Lincoln, CCAWI, MH Foundation, Linking Voices, CPAA, NMH DU
- Risk Safety and Recovery, IMROC Briefing 2014

Consent and capacity

- NHS Choices (2014) Consent to treatment
- Department of Health (2009) Reference guide to consent to treatment
- Office of the Public Guardian (2014) Mental Capacity Act: Making Decisions
- NHS Choices (2015) What is the Mental Capacity Act?

Wellbeing and recovery

- Department of Health (2014) Wellbeing: why it matters to health policy
- NEF 5 ways to wellbeing
- Mary Ellen Copeland, Wellness Recovery Action Planning
- National Alliance of Voluntary Sector Mental Health Providers The Recovery Star

Accessible information

- NHS England (2015) Accessible Information Standard: Making health and social care information accessible

Answers to quiz section 6

Aims, outcomes, actions, responsibilities, location, time.

Links to the documents listed in this guide can be found on the Care Coordination Association website on: www.cpaa.org.uk

The Care Coordination Association

‘See People, See Potential’

The Care Coordination Association (previously known as the Care Programme Approach Association or CPAA) supports people involved in implementing care processes (such as the CPA in England and Care and Treatment Planning in Wales) particularly those working directly with service users such as coordinators, and managers.

In recent years the Associations work has no longer been just about the CPA, and Refocusing the CPA (2008) removed that term for many service users. There is now much national work in relation to long term or complex conditions that is underpinned by the same principles. Policy, understanding and good practice in care planning continues to evolve and develop.

The Association in collaboration with Derbyshire Healthcare NHS Foundation Trust has published 'Writing Good Care Plans' - its first care planning handbook. This handbook is built around a person-centred approach to care planning, recognising the needs of staff and their organisations, and aims to support good practice in health and social care in the critical art of care planning and the elements that make it effective.

The handbook will help organisations to provide better care to the people they serve, as well as supporting their compliance with national standards such as the Care Quality Commission Essential Standards of Quality and Safety; and evidencing Care and Treatment Planning under the Mental Health Measure (Wales).

The handbook is designed to support organisations with staff development and training in relation to care planning. New staff, including those who will be leading on care, such as care coordinators, will find it a useful resource to support their induction and training.

This is part of a series expanding on aspects of care standards in 'The Care Standards Handbook' also published by the CCA. To order this or other resources, please visit www.cpaa.org.uk or contact the CCA on 01246 515975. For the blog see: <https://carecoordinating.wordpress.com>