Fforwm Iechyd
Meddwl a Lles Cymru
Wales Mental Health
and Wellbeing Forum

Formerly National Mental Health Service User and Carer Forum

Report on Care and Treatment Plans from the National Service User and Carer Forum

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Background

Up to 2012 the Care Programme Approach (widely known as CPA) was the main way of assessing and identifying the care needs of people with a mental illness receiving secondary mental health services. Implementing CPA was a statutory requirement throughout the UK although the way it happened differed to some extent across Wales, Scotland and England. CPA continues to operate in England, but in June 2012 it was superseded in Wales by Part 2 of the Mental Health Measure (2010)

The main elements of the CPA were:

- an assessment of a person’s health and social care needs
- a written care plan agreed with all those involved in the delivery of a person’s care including the Community Mental Health Team, GP and carer
- nomination of a care coordinator to act as the main point of contact, coordinating the delivery of a person’s care
- monitoring and review of a person’s care plan, and health and social care needs

These main elements of CPA also feature in Part 2 of the Mental Health Measure and, where CPA was implemented well, there will be clear similarities.

The Mental Health (Wales) Measure 2010 was passed by the National Assembly for Wales in 2010 and received the royal assent at the end of that year. As such, it has the same legal status in Wales as other Mental Health Acts. However significant preparation was needed before it could be implemented, and Part 2 came into force in June 2012. It is therefore a relatively new law and it may be some time before its full impact will be felt.

Under part 2 of the Mental Health Measure (2010) all service users who receive secondary mental health care have the right to a Care and Treatment Plan. Local Health Boards and

Local Authorities have a joint duty to implement Part 2 of the measure and people who receive secondary Mental Health services have two important rights.

These are the right to have a care coordinator appointed to work with them to coordinate their care and treatment and the right to an individual and comprehensive care and treatment plan to assist their recovery.

The Measure is accompanied by a comprehensive code of practice which sets out what these rights should mean in practice. In brief summary it should mean

- holistic assessment to establish information from which care and treatment planning, and future work, can take place

- allocation of a care coordinator who will be a mental health professional with appropriate skills and qualifications (such as a social worker, mental health nurse, occupational therapist, psychologist or doctor) and who will be responsible for working with a person to agree a written Care and Treatment Plan.

The Care and Treatment Plan should consider at least eight areas of a person's life including

- Finance and money
- Accommodation
- Personal care and physical well-being
- Education and training
- Work and occupation
- Parenting or caring relationships
- Social, cultural or spiritual
- Medical and other forms of treatment including psychological interventions.

Introduction

During 2017 NHS Delivery Unit (DU) all Wales reviewed the quality of Care and Treatment Planning (CTP) in Mental Health and Learning Disabilities across all health boards in Wales and was completed in November 2017 with the final Powys Teaching Health Board report being received on 30 January 2018.

The All Wales report reflected the outcomes of the review across all health boards and provided individual health boards with recommendations of improvements that needed to be made. The Mental Health and Learning Disabilities Directorate were required to develop a wider improvement plan that incorporated the DU's recommendations along with those from other inspections, for example Health Inspectorate Wales (HI)W, internal quality reviews and local audits.

The aim of the DU assurance review was to work with Health Boards (HBs) to gain a clearer understanding of the progress made in the delivery of effective care and treatment planning since the commencement of the Measure.

When undertaking the review, specific consideration was given to the requirements of the Code of Practice to Parts 2 and 3 of the Measure. The review findings were to be used to support ongoing monitoring of the delivery of the Measure and the production of CTPs.

The methodology used for the DU's assurance review began with the development of terms of reference which were shared with each of the Health Boards. Field visits were undertaken to each Health Board and each of its partner Local Authorities (LAs). HBs were then asked to provide a range of information and to develop a programme for the Delivery Unit field visits incorporating all of the elements outlined in the terms of reference.

The two principle approaches used in the assurance review were a case note audit of CTPs and focus groups engaging multi-disciplinary teams, Service Users and carers and stakeholders. This information was then triangulated to draw conclusions and formulate recommendations and findings for the review.

The field visits focused upon the following areas relevant to ensuring the quality of the care and treatment planning processes:

- The formal assessment processes used to determine needs and risks.
- The quality of care and treatment planning and evidence that outcomes are recorded against all of the eight areas of life relevant to the Service User.
- Evidence of an approach to assessment and planning which recognises and records the strengths of the Service User together with the resources available from family, friends and the local community to meet their needs (a 'strengths based' approach).
- The degree to which Service Users and their families and other informal carers are involved in the co-production of plans and in the review of these plans.
- The extent to which plans are holistic and person centred with outcomes that are specific, measurable, realistic and time bound (SMART).
- The recording of relapse indicators and the quality of contingency and crisis planning.
- Evidence of both the Service User and the Care Coordinator having signed the statutory CTP wherever practicable or evidence for the reasons why this was not possible.

Findings of the DU review

The review concluded that Health Boards and their partner LAs were meeting their statutory duties, ensuring that those people with 'relevant patient' status are, in the majority of cases, being provided with a Care Co-ordinator and that a CTP is being produced for that 'relevant patient'.

However, the review found that the quality of CTPs was generally poor. CTP outcomes were not routinely; specific, measurable, attainable, realistic and time-bound (SMART). As such CTPs outcomes were frequently not measurable.

Assessment and review processes were variable and frequently predated the commencement of the Measure.

The consequences were that they were not always tailored to the formulation of the CTP, can lead to duplication and did not always allow for a proportionate approach to delivery of the Measure.

Importantly the Measure was not being used as the central document to coordinate and review treatment and care, nor are service users or carers being routinely engaged in the formulation of their CTP as the Measure intended. This led to frustration by staff and service users alike

Workshop at National Service User and Carer Forum on 31st July 2019

Following engagement events held in Powys on CTP's where a number of issues were raised, it was felt it was important that a workshop be held to gather the views of the Forum on the plans, especially what works well, what doesn't work well and what changes could be made to them. The feedback would form a report to be taken to the NPB to help inform the discussion around what is a very important aspect of an individual's care. During the workshop the questions were divided into three separate points and people were asked in groups to comment on each one.

Below is a brief summary of the feedback from the questions.

What works well?

- When the CTP is updated regularly
- When everyone involved in completing it knows what needs updating
- When the person is involved in CTP and agrees with it.
- Meaningful conversation to address person's needs
- Gives CPN'S guidelines as to what should be done.
- Needs to be a living document
- Only works if plan is implemented
- Long term goals and steps
- Recognise achievements
- Relapse triggers
- Personalised, signatures
- Focus on 6 areas of life
- Encourages interaction and assessment between service user and care co-ordinator.
- Involving other services
- Can/ should be holistic

What does not work well?

- Fitting everything on to one page and not flexible enough

- Format ‘hamstrings’ professionals
- When CTP not implemented
- When changes in staffing
- When promises e.g. appointment times are not kept and no information given
- When client is late … “not engaging”
- When people don’t know they have CTP
- Awareness of rights under the Mental Health Measure
- When care co-ordinator writes plan alone
- Name is wrong should be recovery plan
- Needs not always met
- Service users not aware of the plan
- Lack of quality/ lack of understanding
- Emphasis on meeting targets rather than quality
- Crisis plans can be poor
- Unrealistic recommendations/ advice
- Not really prioritised/ importance
- Lack of support to attend activities and other services
- Not everyone has a computer or can afford one
- Living document with fuller information
- Electronic
- Staff fully trained and understand the importance.

What changes would you like to see to the Care and Treatment Plan?

- Better crisis plans
- Better relapse signatures
- Clarity of purpose and process
- Keep people involved
- Better access to review when needed
- Referral (direct) to social groups that are appropriate
- ‘What matters to me’ conversation
- Mandatory ’social prescribing’
- Consistency in sending/ giving CTP to service user and explanation
- When CTP is updated regularly
- Induction to CTP
- Agreed outcomes
- Regular review
- Safe place/ people
- Crisis plan
- Carer CTP
- Make sure it is implemented
- Need what to do in crisis
- Agreement to plan at beginning of document and not at end
- Involvement of carers if service user agrees and/ or person’s network

- Knowing the triggers – carer allows person to engage or not
- Engagement of carers can undermine their relationship with the service user
- If doctor involved and carer/ patient may not understand at the time and may need to come back with questions or comments on CTP later
- Needs to be more on-going interaction with care plans
- Building a relationship first essential
- Might not physically have papers in front of you
- Service users and carers should be involved in quality assuring CTP’s
- CTP should ensure person knows what available/ the options
- Holding people to account

The workshop highlighted that whilst CTP works well in some areas, the problems that people experience far outweighs the positive experiences that people encounter when receiving CTP. The workshop highlighted a number of changes that the Forum felt the Welsh Government and Health Boards should look at implementing to enable people to have a better experience when they become unwell and require help.

The problems that people faced could be solved by having a better audit, feedback and improvement cycle and better training for care co-ordinators.

Questions for the National Partnership Board?

How are the LPB’s currently involving service users and carers in the co -design and delivery of audit feedback and improvement cycles?

If they have not already robustly involved service users and carers, what plans do the boards have for improving or implementing this in the future?

How are the LPB’s currently involving service users and carers in the co -design and delivery of care co-ordinator training?

If they have not already robustly involved service users and carers, what plans do the boards have for improving or implementing this in the future?