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ANNUAL OPERATING FRAMEWORK (AOF) – ADULT MENTAL HEALTH TARGETS FURTHER GUIDANCE 2009-10

This letter alerts you to the publication of a Data Set Change Notice DSCN(2009) 07(W) Crisis Resolution Home Treatment Services to monitor delivery of AOF target 13, and to further guidance on AOF target 12 relating to the Care Programme Approach (CPA).

The achievement of these targets is important to me, the Welsh Assembly Government and the people of Wales in our efforts to improve mental health services. I expect your organisation to achieve these, along with the other AOF targets by the end of the year, and compliance with these new monitoring arrangements will be a helpful stepping stone.

I will be kept appraised of progress and compliance by my officials.

The Care Programme Approach

Additional guidance to support implementation of 2009/10 AOF target 12

Policy guidance on the Care Programme Approach (CPA) was issued in 2003, setting out the underlying principles and expectations for providing a framework for care co-ordination in mental health care with the people who use the service at the centre of the process.

The framework of CPA required services to be:

- More accessible
- More responsive to provide help and support quickly
- Enabled to seek out those who are difficult to engage
- Capable of involving service users and carers in all aspects of planning
- Effective in using care processes

A CPA reporting template is attached at annex 1 to capture the information required to ensure the 09/10 AOF target is being met. Details of the minimum requirements for a completed care plan are also detailed attached at annex 2.

You will also wish to note that recent legislative changes in terms of the Children and Families Measure, with the consequent general legal duty to consider the needs of the family and whether a referral is required, for those who are at highest levels of need. From here on, CPA will be the process to record that this obligation to consider has been met.

Also attached at annex 3 is an extract from chapter 14 (care and treatment planning) of the Mental Health Act 1983 Code of Practice for Wales, which should be used as good practice for all enhanced care plans.

Service providers must ensure that from April 2009 all new service users who meet the criteria for standard or enhanced CPA have a care plan in accordance with AOF target 12. For existing clients, care plans should be quality checked at the next CPA review to ensure they are of sufficient quality to meet the requirements of AOF target 12.

A DSCN relating to CPA will follow shortly.

Crisis Resolution

Data set change to capture 2009/10 AOF target 13 data

In 2005, WHC (2005) 048, set out policy Implementation Guidance on the development of Crisis Resolution/Home Treatment Services (CRHT) in Wales. This guidance describes the functions and operational requirements of CRHT services to support the Adult Mental Health National Service Framework.

I issued an Annual Operating Framework target in 2009/10, relating to Crisis Resolution / Home Treatment Services.

This letter introduces the information requirements that have been developed to support the Annual Operating Framework 2009/10 Target. The DSCN along with data collection tool will be issued shortly by the data standards team. The information required will relate to all patients referred to Welsh Trusts, including non-Welsh residents, and from all sources. The data required only relates to adult patients over the age of 18 years.

Annex 1

CPA – Reporting Template

NHS Trust/ LHB Name: **CPA coordinators Name:**				
	Report period 01/04/09 to 30/06/09	**Report period 01/07/09 to 30/09/09**	**Report period 01/09/09 to 31/12/09**	**Report period 01/01/10 to 31/03/10**
1. Number of patients on Standard CPA				
2. Number of patients on Enhanced CPA				
3. Total Number of patients on CPA				
4. Number of patients with Standard Care Plan as defined in annex 2*				
5. Number of patients with Enhanced Care Plan as defined in annex 2*				
6. TOTAL number of patients with Care Plan as defined in annex 2*				

** See Ministerial Letter ML/EH/017/09.*

Guidance for completion

Row 1 – The total number of patients in NHS Trust/LHB area on standard CPA
Row 2 - The total number of patients in NHS Trust/LHB area on enhanced CPA
Row 3 – The total number of patients on CPA
Row 4 – The total number of patients on standard CPA who have a care plan which meets the new requirements of AOF target 12
Row 5 - The total number of patients on enhanced CPA who have a care plan which meets the new requirements of AOF target 12
Row 6 - The total number of patients on both standard and enhanced CPA who have a care plan which meets the new requirements of AOF target 12

Please note that to meet the requirements of AOF target 12, from April 1st 2009 service providers must ensure:

- all **new** service users who meet the criteria for standard or enhanced CPA that have an **agreed completed care plan** which meets the criteria set out in annex 2. (those patients **who do not have** an agreed completed care plan by the specified report date will be added to the next audit report)
- For **existing** clients, the agreed completed care plans should be quality checked **at the next CPA review** to ensure they are of sufficient quality to meet the new requirements of AOF target 12 **i.e. you do not have to check that existing care plans meet the criteria until their next review.**
- This audit will ensure that by 31/03/10, 100% of service users on enhanced CPA will have a care plan that meets the criteria set out in annex 2. and 90% of those on standard CPA will have a care plan that's meets the criteria set out in annex 2.

DEFINITION OF COMPLETED CARE PLAN

A completed care plan is defined as including the following;

- Identified interventions and anticipated outcomes.
- Recorded actions necessary to achieve agreed goals.
- In the event of disagreements, the reasons for these.
- A description of the intensity of planned interventions based on established categories i.e. 1= daily, 2= >3 contacts per week, etc. and give an estimated time-scale by which the outcomes or goals will be achieved or reviewed.
- An accurate identification of needs that have not been met.
- Assessment of risk and how this risk is being managed.
- Contingency and crisis plans where appropriate (all service users on the Enhanced Care Programme Approach will have these as a required element of their care plan)
- Details of the contributions of all the agencies involved.
- Name and contact details of the care coordinator.
- The patient holds a copy of the care plan.
- A record of the needs of the family and whether a referral is required (with regard to the recent legislative changes to the Children's and Families Measure) for those who are at highest levels of need.

For further information and guidance please refer to;

- ❖ Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users – A Unified and Fair System for Assessing and Managing Care
- ❖ Mental Health Act 1983 Code of Practice for Wales – Chapter 14: Care and Treatment Planning

Chapter 14

Care and treatment planning

14.1 This chapter aims to provide guidance on care and treatment planning for patients detained under the Act in hospital, discharged onto supervised community treatment (SCT) or received into guardianship.

14.2 The starting point for care and service delivery planning in Wales is the Unified Assessment Process (UAP). Guidance was issued by the Welsh Assembly Government in 2002 on this, and the guidance in this chapter is intended to complement this and Welsh Assembly Government guidance on the Care Programme Approach (CPA).

14.3 The chapter refers to after-care planning with patients to whom statutory after-care duties (under section 117 of the Act) apply. Further guidance on after-care is given in chapter 31 of this Code.

Terminology

14.4 Personal plans of care, service delivery plans, treatment plans, care programmes, person centred planning, programmes of care, and CPA plans are just some of the terms commonly used to describe a formalised arrangement for delivering care and treatment to a patient. For the purposes of this chapter the term 'care plan' is used and should be read as including 'treatment plans', the term adopted in this Code to describe the formalised arrangements for the delivery of medical treatment to patients under the Act.

Approach to care planning

14.5 Assessment, care and treatment should draw upon the patient's strengths, seeking their recovery and the re-establishment of their independence as soon as is safely practicable.

14.6 Patients should be involved in planning, developing and delivering their care and treatment plans. Professionals must ensure patients receive information in a timely manner and that they can clearly understand it. Independent advocacy has a significant role to play in empowering patients to be fully engaged in these processes, whether the individual is entitled to independent mental health advocacy (IMHA) as a qualifying patient under the Act, or can access other independent advocacy.

14.7 Care planning is concerned with identifying and recording outcomes from the care provided and the time scales within which it is hoped that the outcomes will be achieved. The key elements of successful care planning are:

- a holistic approach to providing care and treatment, in particular where this follows admission
- involving users and carers in creating and reviewing the care plan
- systematic planning, recording and reviewing the patient's care and support
- clear statements of the objectives of the care plan which set out the nature of services and facilities to meet the identified needs of the person
- appointing someone to take responsibility for coordinating and overseeing the delivery of the care plan (under CPA and UAP this will be the care coordinator)
- flexibility of service provision, responding to the person's changing needs.

14.8 These key elements apply to all patients receiving treatment and care from specialist mental health or learning disability services; for patients who have reached the age of 16 years these are embodied in both the CPA and UAP guidance.

14.9 While the after-care of detained patients should be included in the general arrangements for care-planning, because of the specific obligation under section 117 all patients who are entitled to statutory after-care must be identified and records kept. See chapter 31 of this Code for further guidance.

Risk assessments and managing risk

14.10 In line with the Code's guiding principles, patient well-being and safety should be at the heart of decision-making and where relevant this includes ensuring the well-being and safety of others. Patients and their carers and other interested parties should be actively engaged in assessing the risks to the patient's health and safety and that of others. Managing risks should maximise the patient's strengths and should wherever possible focus on recovery.

14.11 There should be a full assessment of any potential risk(s) to the patient or other people, and professionals must ensure that any tools used for risk assessment have some research-based validity. Subsequent care plans should identify the services and support available to manage any risks.

14.12 Risk assessment and risk management are central to developing a care plan to meet a patient's needs and should be viewed positively as a way of maximising a patient's autonomy within the limits imposed by the Act.

14.13 In the cases of patients under Part 3 of the Act, the circumstances of any victim and their families should be considered in the risk management plan.

14.14 Decisions around risk management should be made in an open and transparent way, subject to the need to manage information where disclosure could cause harm to the patient or others.

Preparing the care plan

Involvement in preparing the care plan

14.15 Those who should be involved in preparing the care plan to meet the patient's needs include:

- the patient, if he or she wishes and/or a nominated representative (including, if appropriate, an IMHA or donee of lasting power of attorney (LPA) if the patient lacks capacity and the LPA covers welfare decisions)
- the patient's responsible clinician
- the patient's care coordinator
- the patient's carer (where they will be providing care that is identified in the care plan and subject to the normal procedures for respecting a patient's right to confidentiality)
- members of the inpatient care team (if the patient is in hospital).

14.16 Those who could also be involved in preparing the care plan to meet the patient's needs include:

- a social worker/care manager specialising in mental health work
- the general practitioner (GP) and primary care team
- a community psychiatric/mental health nurse
- an occupational therapist
- a representative of relevant voluntary organisations
- in the case of a restricted patient, the probation service
- subject to the patient's wishes, his or her nearest relative
- a representative of housing authorities, if accommodation is an issue
- a donee of a relevant LPA, if appropriate
- an independent mental capacity advocate (IMCA), if appropriate.

14.17 Those involved in making decisions, particularly about after-care planning, must be empowered to make commitments on behalf of their agency's involvement. If approval for plans needs to be obtained from more senior officials (for example, for funding) it is important that this does not delay implementing an after-care plan.

14.18 If a different responsible clinician is to take over responsibility for a patient being discharged onto SCT, it will be essential to liaise with that clinician, and the community team, at an early stage.

14.19 For patients placed in services away from their home area, services from their home area should remain involved in their care through attending formal care planning meetings, and regular involvement in other discussions.

Considerations for care planning

14.20 When the care plan is being prepared, account should be taken of:

- the patient's own wishes, needs and aspirations, and those of any dependents
- the views of any relevant relative, friend or supporter (including an IMHA) of the patient
- the need for agreement with all other authorities and agencies in the area where the patient is to live
- in the case of mentally disordered offenders, the circumstances of any victim and their families should be taken into account when deciding where the patient should live
- the patient's carer(s)
- the involvement of other agencies, such as probation or voluntary organisations.

Elements of the care plan

14.21 The development of a fully-agreed care plan should be based on a thorough assessment and clearly identified needs. It should cover the time when the patient is detained in hospital and also preparing for and covering the time after discharge, and should set out the timescales for delivering the different aspects of the care plan.

14.22 The professionals concerned should establish an agreed outline of the patient's needs, taking into account their social and cultural background. All professionals with specific responsibilities should be properly identified. Once plans are agreed, any changes should be discussed with all others involved with the patient before being implemented. The plan should be recorded in writing, signed by the patient and a copy given to the patient. If the patient does not agree with the content of the care plan, or the treatment proposed, this should be recorded on the care plan. The intention is not to impose the signing of care plans by patients but to offer the opportunity to express their views.

14.23 The care plan should indicate the objectives of the care proposed and anticipated outcomes for the patient. In line with the guiding principles set out in chapter 1 of this Code, the retention of independence, wherever practicable, and promotion of the recovery of the patient should be central to all interventions under the Act. The care plan should reflect this.

14.24 Care plans should cover all of the applicable areas identified within the unified assessment process guidance. For patients receiving treatment and care from specialist mental health or learning disability services the areas to be addressed in the written care plan should include:

Areas for inclusion in the care plan	Care and treatment plan for a patient detained in hospital	Care and treatment plan for patients on SCT, guardianship or after-care
Medical treatment (medication etc)	• information for and discussion with the patient about any proposed treatment	• continuing review of the patient's treatment plan on and after discharge, in partnership with the GP where appropriate
Other forms of treatment, including psychological interventions	• access to appropriate psychological and other treatments in hospital	• continuing access to psychological and other treatments in the community
Personal care and physical well-being	• review of all aspects of the patient's general health including medical issues, dentistry, optician and lifestyle issues and how these will be covered in hospital	• encouraging appropriate contact with GP and continuing consideration of all aspects of a patient's physical well-being and personal care
Accommodation, including housing	• consideration of appropriate accommodation issues inside hospital • consideration of the security/ maintenance of the patient's home in their absence	• preparation of the patient's home for discharge • registration of homelessness/ referral for supported housing where necessary
Work and occupation	• occupational therapy and other structured opportunities in hospital • support to maintain contact with an existing employer or to seek vocational guidance	• support to maintain existing employment, or • support to contact employment agencies, access specialist mental health employment services, seek new job opportunities or to volunteer
Training and education	• opportunities for learning in hospital or access to opportunities from hospital	• opportunities to take up training or educational courses in the community
Finance and money	• support to access benefits or other income, and deal with financial problems or anxieties when in hospital	• support with maximising benefits, budgeting and responding to financial anxieties on discharge and at home

Areas for inclusion in the care plan	Care and treatment plan for a patient detained in hospital	Care and treatment plan for patients on SCT, guardianship or after-care
Social, cultural and spiritual	• access to social activities within hospital • support to maintain or build relationship with family, friends and community networks when in hospital	• support to maintain or build a social network and leisure activities in the community
Parenting or caring relationships	• support to maintain links with children • support/consideration of meeting needs of those cared for by the patient	• support to maintain parenting and caring roles within the community

14.25 Any unmet needs should be clearly identified and recorded.

14.26 For all patients their care plan should include contingency and crisis plans, but this is particularly important for patients in the community on leave of absence, or on SCT, or received into guardianship.

14.27 The contingency plan is aimed at preventing circumstances escalating into a crisis by detailing the arrangements to be used at short notice, whereas the crisis plan specifies the actions to be taken in a crisis. By anticipating the nature of a potential crisis, appropriate action can be taken, and this should be the least restrictive possible. For example, for a patient on SCT, the plan could set out the behaviours or circumstances that could indicate a worsening of the patient's mental health. It could suggest the early involvement of additional support that could be provided in the patient's home, such as the input of a crisis resolution home treatment service which could avoid the recall of the patient into hospital.

Relationship with after-care (under section 117 of the Act)

14.28 Before any decision is made to grant leave, discharge absolutely or onto SCT, the responsible clinician must ensure (in consultation with other professionals involved), that the patient's needs have been fully identified, assessed and that the after-care plan addresses them in a way that manages risks positively. If a patient is being granted leave for only a short period, a less comprehensive review may be sufficient, but arrangements for the patient's care should still be properly recorded (see also chapter 31).

Delivering and monitoring the care plan

14.29 Care plans should be delivered by practitioners from the appropriate range of statutory and non-statutory agencies working in partnership to meet the needs of the patients and those of their carers. This is particularly important where patients have co-occurring problems such as physical ill-health, or learning disability, or substance misuse together with a mental health problem.

14.30 If parts of the care programme are being delivered by carers, mental health professionals should ensure they work in partnership with those carers.

14.31 The care plan should be regularly reviewed in accordance with UAP and CPA guidance, to ensure it continues to meet the patient's assessed needs and to check that the outcomes of the interventions are being achieved. Reviews should continue until it is agreed that the patient can be discharged from secondary care services, when the patient's GP should be advised on ongoing management and support in primary care.

14.32 The frequency of these reviews will also depend on the patient's circumstances, including whether they are subject to the Act in hospital, discharged from hospital but still under the Act (for example on SCT) or no longer subject to provisions of the Act. These reviews can be at set points and times (for example, at a weekly ward round or a monthly outpatient appointment) but should also take place when a change in the patient's circumstances prompts a review.