Care Planning Policy
Version: 3

Summary: This policy describes the system of care and how care planning is delivered by all Divisions within Southern Health NHS Foundation Trust. This includes all those subject to areas of mental health and learning disability practice that use the Refocused (new) Care Programme Approach and how care planning is managed for all others in contact with a secondary mental health service.

Keywords (minimum of 5): Care Plan, Care Programme Approach (CPA), Care System, Care Coordinator, Lead Professional, Keyworker, Review, Review system, Assessment Process, CPA Audit, and CPA Training.

Target Audience: All staff involved in Care Planning & CPA

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Approved and Ratified by: Records and Care Planning Quality Programme

Date of meeting: 1/10/15

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## Version Control

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1. Introduction

“In its most simple form a care plan is what different people agree to do in response to a person’s assessed needs. It then provides a document for discussing progress against those needs. The aim should be to create care/support plans that are working documents that reflect personal priorities and can be more easily owned by people who use our services.”

Steve Morgan

1.1 Care planning is a fundamental part of the care that we provide in Southern Health Foundation Trust (SHFT). Effective care plans have the potential to enhance and benefit patient experience and also help achieve the vision of the organisation, to shift service provision from inpatient and 24 hour care to community based services that concentrate more on the empowerment of the people who use services to take control of their care in a structured and clear way.

1.2 Nationally since the Francis report the spotlight has been on ensuring that care planning is robust, involves the person receiving the care and consistently at a high standard. Transforming Participation in Health and Care developed by NHS England September 2013 [http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf) outlines how this can be achieve through taking a whole systems approach and engaging, empowering and hearing patients and their carer’s. One of the core principles describes the need to;

“Ensure that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.”

1.3 Care Quality Commission (CQC) detail in a similar way the need to evidence that care plans are meaningful. They assess quality of care plans against the following criteria;

- be up to date
- reflect the person’s own assessment of their situation and priorities
1.4 To date there are excellent examples of care planning within the Trust however there is a lack of consistency and the feedback from some of the people who use our services and carers is that they do not always know what their care plan is or have a copy. This policy therefore aims to outline clear standards and responsibilities that are expected to be achieved in order to improve the quality of our care plans and the experience of people who use our services and care for them.

Our values

Person & Patient Centred

The people who use our services are at the centre of our every thought and every action. By working innovatively yet meticulously we deliver care which is tailored around the unique requirements of individuals and constantly evolving around their changing expectations.

Context

1.5 Care planning is a core part of the process of care delivery which is generally as follows

1. Assessment – including risk assessment and management
2. Lead professional/Care Co-ordinator identified
3. Drawing up a care plan – including specific outcomes
4. Review

There are a number of important elements to each of these sections as part 6 of this policy details and some people using our services will need this process to be delivered, or particular parts of it, in a more comprehensive way.

1.6 Within some divisions of SHFT the Care Programme Approach (CPA) is the national model of care delivery that is implemented. It is the framework that guides the process of care for many individuals using services. CPA was introduced into UK mental health services in April 1991, and has been reinforced (Department of Health, 1995), modernised (Department of Health, 1999) and refocused (Department of Health, 2008a) at a national level. CPA core principles (Appendix 1) should be used when considering the application of Care Planning. The CPA framework helpfully reflects the different levels of complexity people who use our service may have, guiding the degree of engagement needed. The CPA framework can be used to develop Care Planning approaches and support the Standard Operating Procedures (Ref 2.1).

1.7 Evidence to date illustrates that the process of care has the risk of being delivered in a way that is systems driven and risk focused as opposed to being truly person centred.
1.8 The challenge is to find a solution that ensures that our standard of care planning is improved to be responsive to the people who use and work within our services, complies with record keeping and encompasses national policy, which includes:

- Personalisation/self-directed support and recovery in mental health services (Department of Health, 2010)
- Person-centred planning in learning disability services (Department of Health, 2009)
- Healthy Child program in children’s services which includes strengthening support for all families during the formative years of children’s lives (HCP, DOH 2009)

2. Related Policies/Documents

2.1 The following documents informed the development of this policy:

- Clinical Risk Assessment and Management of patients/people who use our services
- Safeguarding Adults and Children Procedures
- Records Keeping Policy
- Effective Care Co-ordination; Modernising the Care Programme Approach DH 1999
- Refocusing the Care Programme Approach, DH March 2008
- Transforming Participation in Health and Care, NHS England September 2013
- Guidelines for Good Practice in Care Planning, Steve Morgan August 2013

Each Division will have its own Care planning Standard Operating Procedures which describes how to document the care provided to people who use our service.

3. Purpose

This policy describes the principles that should be applied when care planning is provided in each of the Service Directorates of SHFT.

4. Scope

4.1 This policy applies to staff across SHFT who provide services directly or who arrange for services to be provided by another provider where contact with the person using our service is maintained.

4.2 This policy identifies duties, responsibilities, the mandatory training requirements of staff and the Directorate responsibilities in relation to its implementation and operation.

5. Duties and Responsibilities

5.1 The identified member of the Trust Board is the Director of Mental Health and Learning Disability who is responsible for the strategic leadership, implementation and meeting the standards of the CPA and Care Planning frameworks across the Trust.

5.3 Each Division has an identified lead for Care Planning development and implementation.

5.4 An identified CPA Lead (Clinical Lead – Recovery Focused Care) has responsibility for the delivery of Care Planning within mental health.

5.5 Each allocated clinician e.g. Care Coordinator, Lead Professional, Named Worker or Keyworker, Health Visitor, School Nurse and Children in Care Nurse is responsible for working collaboratively with people who use our services to deliver the principles of care
planning. The allocated clinician will facilitate care planning and will encourage ownership and involvement by the people who use our service.

6. **Principles of Care planning**

6.1 Care planning is a fundamental requirement.

6.2 Care planning is a process of assessing, agreeing, collaborating and supporting an individual across the spectrum of care.

6.3 Care planning is not delivered in one uniform way—there are a number of care planning frameworks in operation within SHFT some of which are implemented in partnership with Hampshire County Council, Southampton City Council and other partners and which reflect more specific national guidance.

6.4 Broadly speaking there should be a common process for CPA and Care Planning, including an assessment of need, a SMART (Specific, Measurable, Achievable, Realistic, Timely) care plan, a timely review and ongoing assessment of need.

6.5 This Policy provides the guiding principles for the delivery of care for all people who use SHFT services where we are the lead agency or support other agencies in models of care delivery for example:

- The Care Programme Approach (CPA),
- Person Centred Planning (PCP),
- Care/ Case Management
- Health Action Planning
- Common Assessment Framework

6.6 Care planning will be delivered in a way that is collaborative using language that is easy to understand, empowering, meaningful and hopeful to the person using the service.

6.7 There will be evidence in the records that care plans are:

- up to date
- reflect the person’s own assessment of their situation and priorities
- be written in simple personally meaningful language
- be created in partnership with the person using the service and when appropriate their carer
- have clearly identified SMART goals and actions (including a review date)
- copied for the person who uses the services to keep

6.7.1 People who use our services will be encouraged and supported to exercise choice through personalisation when making decisions regarding their own care regardless of how unwell they may be.

6.8 The delivery of care by staff in SHFT will pay attention to the potential for inequalities in outcomes of individual care planning. These inequalities can be in terms of age, religion or belief and sexual orientation of people who use our service or carers.

6.9 All documentation that is used must be accessible (e.g. appropriate language, format etc.) and copies provided to the person using our service and others, where agreed subject to consent to share information principles.
6.10 Information regarding the care planning process, treatment and care should be provided to the people who use our service and others who are involved in their care (this will be detailed in each Divisional Care Planning SOP).

6.11 Training will be provided to staff to ensure that they are competent and confident to work collaboratively with the people who use our services.

6.12 Carers will be involved in care planning and if appropriate, offered carers assessment.

7. Core Elements of Care Planning Frameworks

7.1 Assessment: The purpose of assessment is to identify the health and social needs of people who use our services in order that they may be met. Assessment will be systematic, thorough and have due regard to confidentiality. It will be focused on people who use our service’s strengths with the aim of promoting recovery and ownership of their care.

7.2 Positive Risk Assessment & Management: Risk Assessment is an essential part of good quality care planning and should be balanced with the variety of strengths/needs that an individual may present with. The risk assessment should be carried out in line with SHFT’s Clinical Risk Assessment Policy and Safeguarding Procedures.

7.3 Drawing up the Care Plan: The Care Plan is a record of needs, strengths, actions and responsibilities written in an accessible and jargon-free way. It summarises identified needs and how they are met and is a formal record of what is going to be done, why, when and by whom. Details of how to access support in the event of a crisis must be included in the Care Plan.

7.4 Review: Review of the people who use our service’s care plan should continue at a frequency which is determined by need. For those under CPA this review should be at least every 12 months. The Review is a process, not always a specific meeting. The people who use our services should always be involved in any review unless there are clinical reasons why this should not occur, in which case these should be recorded in the Clinical records. Every formal review should consider whether the support provided is still required and whether the people who use our service should remain on their current care planning framework.

7.5 Outcomes: Clear outcomes will be agreed with the people who use our service, or their representative, when the Care Plan is drawn up and these will be part of the regular reviews. It is essential that these outcomes are meaningful for the people who use our service or their representative and are achievable. Other outcome measures which are required for contractual or other reporting purposes may also be used; however these will always be in addition to those agreed with the people who use our service.

7.6 Allocated Worker: All people who have a care plan will have an allocated Health Care Professional responsible for facilitating the delivery of care. This could be for simple or more complex needs, multi-agency input or higher risk, and/or may also require some element of health and/or social care funding.

8. Documentation

8.1 Each care planning framework will have specific documentation which will be agreed by each Division and should include the consideration of modern technology, and any additional literacy needs someone who uses the service may present with. This would normally be an agreed simple standard template. Management of care planning
documents will be consistent with health records standards, relevant Electronic Patient Records and the Standard Operational Procedures.

9. Training

9.1 The level of training will be determined by the roles that staff would be expected to undertake within the specific care planning framework used in their division. This training will be identified by staff as part of their supervision and appraisal. The training will be mapped to training needs analysis and reflect organisational learning.

10. Process for monitoring compliance with the requirements of this policy

10.1 Compliance of this policy will be monitored through the following structures;

Quality Improvement and Development meeting

Trust Record Keeping and Care Planning work stream

Divisional Records/Care Planning meeting

10.2 In addition to this policy each Division will have a Care Planning Standard Operating Procedures (SOP’s) which will sit alongside Electronic System SOP’s. This will need to be regularly updated as the design and infrastructure of care planning evolves and as integration across services and agencies is realised.
Appendix 1

Refocusing CPA 208 - Statement of Values and Principles Table 1

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/people who use our service second.

Care assessment and planning views a person ‘in the round’ seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care. Carers form a vital part of the support required to aid a person’s recovery. Their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between people who use our service and the care co-ordinator is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.