HEALTH WATCH CENTRAL WEST LONDON Care Plan Report March 2014

1. Awareness of care plan

- CNWL needs to invest more in raising the awareness and importance of care planning with service users and as an organisation.
- This could be done in conjunction with community groups and voluntary sector such as SMART, MIND, the Advocacy project.

2. Service user involvement in creating care plans

- Care plans should be created jointly with service users at the point of entry into care and should be reviewed annually (at a minimum).
- Patient's views should be listened to and stated in their care plan.
- The care planning process should be clear and understood by all parties. This means allowing sufficient time when creating care plans and reviewing needs.
- To achieve this, we recommend that CNWL produce a care plan template which should be signed off by service users as well as a copy given to them.

3. Care plan reviews

- There should be frequent reviews of care plan with service users. Reviews should be annual at a minimum and more frequent as needs change and goals are achieved.
- Proportion of care plans that are reviewed regularly with service users should form part of trust performance monitoring

4. Family and advocate involvement in care planning

- Family and advocates should be involved in the care planning process and in line with the service user wishes.
- Proportion of patients who have their family and advocates involved with their care plans should be continually monitored, and should form part of the trust's Key Performance Indicators.

5. Care plans should be holistic

- Care plans should be holistic and address wider social needs including activities, housing and medication.
- In achieving this, there should be improved coordination with adult social care, primary care and community services particularly when a patient is being discharged from inpatient care into the community.
- This should also form part of trust performance monitoring process which should be done in conjunction with community groups such as User Focused Monitoring (UFM).

Better communication

- All staff should be trained on communicating with and developing constructive relationships with users. This should be measured as part of the performance management system.

- There should be an easy read version of care plans. All information leaflets and posters about care plans should also be done in an easy read version also taking into consideration suitable colour contrast for people with visual impairment.
- Report on the effectiveness of the care planning campaign in 2014, including the effectiveness of staff training, take up rates of care planning, sense of involvement and an audit of the quality of the care plans, should be done.

Rec No	Healthwatch Central West London Recommendations	Central & North West London NHS Foundation Trust Response / Actions Community Recovery Line and Acute Service Line
1	**Awareness of care plan**	
1.1	**Recommendation:** **CNWL needs to invest more in raising the awareness and importance of care planning with service users and as an organisation.**	Response: i. Care planning with service users was identified as a Quality Priority for 2013-2014. Quality priorities are developed in partnership with Healthwatch. ii. The trust target for this indicator is set at 65%. By the end of the final month in 2013/14 Kensington & Chelsea reached the target at 65% and Westminster exceeded the target and achieved 73%.The National Patient Survey has replaced questions about copies of care plans with questions about involvement in general for example, 'Have you been involved as much as you wanted to be in decisions about your care and treatment?', which achieved 92% in the May telephone survey. iii. The Community Recovery / Acute Service Line in KCW is engaged in ongoing work embedding a culture of co-production, the essence of which is partnership in the production of care plans and risk assessments. The principles of such are threaded throughout Trust policies on CPA and Risk Assessment. We need to continue our work in these areas to promote consistency across the system. iv. We are committed to attending the local Partnership meetings in order to develop work further and undertake a shared learning process. v. All teams in the Community Recovery Line and all inpatient wards complete a Team Recovery Implementation Plan (TRIP) which provides a benchmark on recovery focussed practice within the Team's. This approach is part of the Implementing Recovery through Organisation Change (IMROC) programme.

		vi. My Care and Support Plan CEO compliance - There appears to be discrepancy between what we record as being practice recorded as otherwise i.e. monthly survey results – perceptual staff need to be more explicit so that service users understand that this process is happening. vii. The Acute Service Line has commissioned quarterly Recovery Workshops, which are to be delivered by Rachel Perkins at both the Gordon hospital and St Charles Hospital in order to effectively raise the awareness and importance of care planning with service users. The Community Recovery Service Line have also set themselves a service user involvement key priorities for 2014-15 amongst which are the following three priorities:- 1. A Quality Priority for the Trust and for the Service Line is "***Community patients report that they were involved as much as they wanted to be in decisions about their care plan (definitely)*** Being measured on this priority on a quarterly basis identifies how we are performing in relation to direct face to face involvement and co production of care plans with service users. The current target set by the Trust is 65% and at the current time we are exceeding this, achieving 68%. The organisation wants to improve on performance still further and are raising the internal Service Line target to 75%. (+10%) **Measurement: Quarterly Dashboard** 2. We will develop robust service user involvement a) In the care quality meetings at a service line level, and b) In all frontline services. Teams are tasked to identify local methods to involve those who use services via the implementation of a Team Recovery Implementation plan (TRIP). All teams are required to develop such a plan, (as outlined above)

		Measurement: a) Care quality minutes b) TRIPs 3. The nature of the service line workforce will continue to change over coming years due to embedding recovery orientated practice alongside significant economic pressures. This year, our plan is to employ at least 1 wte Peer Support Worker within each Recovery Team. Within Acute services we have successfully recruited a Peer Support Worker to all of our acute wards in KCW with the exception of Nile and Shannon Ward. The advert for these two vacancies is currently out to advert with interview dates set for the beginning of July 2014. **Measurement: Electronic Staff Record (Human resources system).**
1.2	**This could be done in conjunction with community groups and voluntary sector such as SMART, MIND, the Advocacy project.**	The Recovery Line would welcome the opportunity to work jointly with community groups. This will be carried forward by the Service Line. Effective links are well established with the User Involvement / Advocacy services within KCW inpatient services in raising the awareness and importance of care planning with service users. We would also welcome the opportunity to work with our other partners such as SMART / MIND. In addition the Recovery College of which both staff and residents in KCW can access offers / courses in relation to well being and effective care planning.
2	**Service user involvement in creating care plans**	
2.1	**Care plans should be created jointly with service users at the point of entry into care and should be reviewed annually (at a minimum).**	The Trust expectation is that at the point of entry into the service a core assessment is undertaken. The purpose of this assessment is to work with service users and any carers or other professionals/agencies involved to gather sufficient information about mental and physical health and personal/social circumstances to: • identify the service user's health and social circumstances, assess their implications and b able to monitor any changes • identify needs which can be met by health and/or social care services

		• review MH clusters within prescribed review periods and at appropriate transition points • assesses social care eligibility under Fair Access to Care Services (FACS) and then to support those eligible to develop personal budget arrangements • identify interventions to support recovery and promote safety and wellbeing • support the development of Care & Support Plans (for individuals on CPA) or care plans (for people receiving Lead Professional Care) Wherever practicable the contents of the Core Assessment should be developed in partnership with professionals, service users and carers My care and support plan
2.2	**Patient's views should be listened to and stated in their care plan**	The Operational Guidance explicitly states the following: - • Care Plans must be written from the service user's perspective and developed in partnership wherever possible • Care plans must record planned activity balancing service user wishes and professional duties of care, statutory responsibilities under the law and responsibilities for allocating resources • Wording such as 'I will' etc. should only be used if the service user explicitly agrees to this **Disagreement:** If there is disagreement between the service user and the professional team regarding the Care Plan, this must be outlined in the plan, along with action/plans to respond to it. Service users should be advised of their right to develop their own Health & Wellbeing Plan. The following is written into the Community Recovery Service Line Operational Guidance for CPA/LPC and should be followed by all care coordinators: - • Care Plans must be based on needs that are identified in assessments/Risk Assessments. • Care Plans must promote recovery by building on service users' strengths, interests

		and wishes. • Care Plans must specify interventions and intended outcomes, and described in ways that best meet service users' individual circumstances. Efforts should be made to agree wording wherever possible.
2.3	**The care planning process should be clear and understood by all parties. This means allowing sufficient time when creating care plans and reviewing needs**	Yes, perhaps we need to be more specific and explicit when engaging with carers and service users in the care planning process. This feedback will be given to individual Team Managers, who will be asked to ensure that staff are aware of and implement this recommendation. For example, providing written information to clients and family members on the process.
2.4	**To achieve this, we recommend that CNWL produce a care plan template which should be signed off by service users as well as a copy given to them.**	It is standard procedure for service users to be given an opportunity to sign their care plan. Care co-ordinators must indicate on the Care & Support Plan form whether the service user has or has not agreed and/or signed. Signed copies can be distributed if the circumstances of the case make this beneficial. Acute services have formulated an MDT (Multi Disciplinary Team) 'My Care Plan' template which has been successfully piloted on the inpatient wards in Brent and is due to be rolled out to KCW.
3	**Care plan reviews**	
3.1	**There should be frequent reviews of care plan with service users. Reviews should be annual at a minimum and more frequent as needs change and goals are achieved.**	Trust CPA data, shows that at least 95% of people on CPA have a review at least annually. This is a sustained improvement over the past 3 years, from performance that fluctuated on a monthly basis, with achievement less than 95%. Where it is indicated that clients are not having annual reviews, from the CNWL performance figures, this is examined in more detail with Team Managers, to understand the reasons and take remedial action. It is standard procedure - Community CPA review meetings must be held: • No later than 12 weeks after acceptance onto caseload for all new cases

		• At least once every 12 months • At least once in any period on CPA which is less than a year • If there is a significant change in the service user's circumstances • No later than 12 weeks after discharge from inpatient facilities • Before transfer to LPC • Before transfer of care to another mental health service or team • Before discharge from CPA or secondary mental health services • if it is necessary to bring the care team together for any other reason
3.2	Proportion of care plans that are reviewed regularly with service users should form part of Trust performance monitoring	This recommendation will be considered further by the Trust, specifically with regard to how this could be monitored.
4.	**Family and advocate involvement in care planning**	
4.1	Family and advocates should be involved in the care planning process and in line with the service user wishes.	Advocates can be involved in the care planning process, and information about these services is provided to service users. Advocates have also attended reviews and planning meetings. Where there is an indication that Advocacy could have a role, this is discussed with individual clients, and information is provided. Advocacy services respond then to client requests for participation. *The service recognises the key role that is played by families in supporting service users. There are a range of strategies in place in the service to:* 1. Identify family members and to provide support in completing formal Carers Assessments, with actions coming out of those assessments responded to. 2. Where family members are involved in the service user's care, they are generally included in invitations to meetings. The Trust recognises that carers have raised concerns about not being invited, or being given short notice of meetings, and where

		this is identified, remedial action is taken, for example, care co-ordinators are expected to liaise directly with the family. This is a Trust quality priority for 2014-15. There is a newly established Carer /CNWL interface meeting, which will meet bi-monthly. This involves carers, Trust managers and third sector and other agencies, and has the intention of improving carer experience. Teams are monitored regularly on their performance in identifying carers and ensuring assessments are offered / carried out. The Trust recognises that the experience of carers needs to improve, and is taking action, as outlined above to do this.
4.2	**Proportion of patients who have their family and advocates involved with their care plans should be continually monitored, and should form part of the Trust's Key Performance Indicators.**	The Trust view is that this is monitored, including by identifying who family members and carers are, and where they are involved in care, this is maintained by the staff working with the clients. However, the Trust also recognises that there is improvement required, as outlined above, and remedial action is being taken.
5.	**Care plans should be holistic**	
5.1	**Care plans should be holistic and address wider social needs including activities, housing and medication.**	Care plan documentation already includes; • the date the care plan applies from • the date of the next planned review • care team members and contact details • emergency contact details • whether the service user has a Health and Wellbeing Plan they wish to share • whether the service user has an advance decision and where it is located • recovery goals, including activity, training and/or employment plans • any differences of opinion and plans to address them • the type and frequency of contact planned

		• family/friends/carers involvement • any treatment or medication, including physical health treatment; medicines and supplements; how and when medication will be reviewed; any issues about taking medication and plans for managing them • any concerns about service users' capacity to make decisions for themselves and action to help with this • personal budget items, how a budget will be managed and details of any financial contributions • relapse indicators/things which may suggest the service user is becoming unwell, plans to help service users and others stay safe • any back up/contingency plans needed in case planned actions cannot be organised • support for carer/s agreed following a carers assessment (if appropriate) • actions necessary to respond to diverse needs arising from cultural and ethnic background, gender, transgender status, sexuality, any physical disability or health problem • whether the service user is eligible for Aftercare under Section 117 MHA, any aftercare/support provided under s.117 and any changes since previous care plan/s • who will take lead responsibility for each action and who else is involved • any unmet needs • the date the care plan was given or sent to the service user, the GP, and other members of the care team (which must be within 14 days of a review meeting)The core assessment and my care and support plan is holistic and includes wider social needs including occupational functioning, vocational assessment, spirituality, personal budget assessments • The Inpatient MDT Care Plan 'My Care Plan' is a holistic document and address wider social needs including activities, housing and medication.
5.2	**In achieving this, there should be improved coordination with adult social care, primary care and community services particularly when a patient is being**	The Trust CPA policy requires this approach, including the requirement for discharge planning meetings before discharge from hospital. These meetings involve key community and acute staff, the service user and carer, where known, as well as other key personnel from community organisations. Where it is not possible to arrange a meeting, for example if someone has a very short admission, then a review meeting will be arranged shortly after

	discharged from inpatient care into the community.	discharge, with key people invited. A discharge notification is sent to GPs within 24 hours of one of their patients leaving hospital, including key information. All patients leaving hospital are followed up by staff within 7 days of discharge. This applies to both CPA and LPC clients. Investment has been identified in order to provide posts within inpatient services i.e. Social workers based on the Triage wards, Peer Support Workers on every ward and acute outreach OT posts based within the Inpatient Therapy Teams that enable effective discharge planning and positive link working to community resources from an inpatient setting back to the service user's local community.
5.3	**This should also form part of Trust performance monitoring process which should be done in conjunction with community groups such as User Focused Monitoring (UFM).**	The Trust welcomes the involvement of UFM in quality improvement. This is currently in place. CNWL has effective working relations with KCW UFM and representatives for example the borough Lead OT's Service Managers, Social Work Leads attend a bi monthly meeting at the UFM premises where issues are discussed and action plans implemented and reviewed.
6	**Better communication**	
6.1	**All staff should be trained on communicating with and developing constructive relationships with users. This should be measured as part of the performance management system.**	The Trust has an expectation that all staff who have undertaken professional training, e.g. Nurses, Doctors etc, have been trained in communication. Where particular issues are raised, these are investigated under the Trust Complaints and/or PALs procedures, and addressed as required. The Trust also runs customer care training, which is available to all staff, and where particular communication issues have been identified, staff are expected to undertake this training. The 'No Force First' initiative is being delivered within the Trust Adult Acute services. It enables the service to foster a compassionate and respectful environment whilst decreasing the use of physical intervention and the use of seclusion within CNWL Adult Acute services.

		How staff effectively communicates and enable constructive therapeutic relationships shall be closely monitored via data reporting via the initiative. In addition the ongoing review of the ward TRIPS shall positively meet this recommendation.
6.2	**There should be an easy read version of care plans. All information leaflets and posters about care plans should also be done in an easy read version also taking into consideration suitable colour contrast for people with visual impairment.**	Where a particular need is identified in an individual's care for specific adjustments to formats of Care Plans, or letters or documents, these can be made; for example translating into other languages, Braille documents or others. These are individually addressed. Trust leaflets are available in a range of languages and if identified, as above, these can be translated into other languages as well. Easy read Care Plans, posters and leaflets are routinely utilised in Learning Disabilities services within the Trust, and have been co-produced. As explained above, where a need is identified, then teams respond to these on a case by case basis. In addition there is a representative from both Community (Lesa Bartlett) and Acute (Westminster SM /K&C Matron) that attend a monthly 'Improving access to Healthcare' which closely monitors Care Plan documentation and accessibility.
6.3	**Report on the effectiveness of the care planning campaign in 2014, including the effectiveness of staff training, take up rates of care planning, sense of involvement and an audit of the quality of the care plans, should be done.**	Staff training is regularly delivered on care planning both locally and on a Trust level. Effectiveness of training is monitored via regular audits and reporting in handovers, staff supervision sessions and SU feedback via UI meetings.