COLLABORATIVE CARE PLANNING

“Nothing about me without me”

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1. Introduction

Collaborative care planning is at the heart of the recovery process and must be developed in partnership with the person, and wherever possible, his or her carer/family. Recovery is about people’s whole lives, and the recovery journey must be led by the person who themselves defines what is meaningful and valuable to them. The personal recovery journey is supported by a range of resources, starting with the persons own experience, resilience and strengths. Partners in this process may include carers and other informal supports including friends, colleagues and neighbours, mental health services and community based services such as those providing education or housing. All of these supports can promote recovery when offered in a person-centred way.

The individual nature of recovery means there will be considerable variation between care plans. There is no single correct way to write one, but there are important common principles which underpin practice, regardless of the age of the person, their individual circumstances or the CPFT service which they are receiving.

This document sets out the responsibilities of CPFT staff and provides clarity about what collaboration means in practice and how to structure a care plan that reflects this. It puts the contribution of the support we offer as a Trust into the context of a person’s whole life. Or in other words, our ‘treatment plan’ is a small part of the wider recovery plan for a person… not the other way round.

This document has been co-created with our Trust’s Service User and Carer Representatives.

2. What is “collaborative care planning”?

In simple terms, collaboration means developing a care plan in partnership, sharing information, identifying goals together and writing the care plan using the language the person themselves would use and understand. It is about harnessing the active participation of the person in a shared understanding with those who are involved in supporting the person.

In some of our CPFT services, the role of both informal carers/family and paid carers is really important for the person. For example in Children’s, Older People’s and within our Learning Disability Services where maturity, cognitive impairment, capacity and communication issues may impact and pose challenges that need to be overcome in making collaboration meaningful.

Within all of our Trust’s services, the person should always be given the opportunity to drive the planning and delivery of care. It is through this collaboration that informed choices, shared decision making and meaningful goal setting can be achieved together.

3. Key principles of collaborative care planning

Collaborative care planning is essential if we are to work in a person-centred, recovery focused way. It has to be at the heart of what we do as workers in providing high quality care.

<table>
<thead>
<tr>
<th>Recovery principle</th>
<th>Application in practice</th>
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<tbody>
<tr>
<td>Recovery is possible for all.</td>
<td>Collaborative care planning is an important and essential process for all people receiving CPFT services, and will involve choices at all stages of their contact with our services.</td>
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</tbody>
</table>

1 In our services supporting children, older people and people with a learning disability the collaborative efforts would usually always involve the family, who would need to be a central source of information and support.
<table>
<thead>
<tr>
<th>Recovery is deeply personal and about all aspects of a person’s life.</th>
<th>The person is at the centre of the process – their story is central to where/how care is established. Collaborative care planning supports individualised solutions, reducing the reliance on mental health services wherever possible.</th>
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<tbody>
<tr>
<td>Recovery is owned by the person and supported by others.</td>
<td>Collaborative care planning locates responsibility for recovery with the person: they define what is important to them and what makes their life satisfying. The care plan reflects a whole person perspective and a multi-disciplinary approach: – a process of working together to make decisions and share responsibilities, ensuring the person has opportunity to tap in to a range of professional expertise. There is a mutual sharing of information, knowledge and experience. Evidence to support decision-making and plans moving forward are appraised from a range of perspectives. Duty of care goals are important and will follow as far as possible collaborative care planning principles (i.e. negotiated safety plans). Collaborative care planning is a continuing process – what people want may change. CPFT will have clear entry and exit points, whilst providing a service experienced as seamless.</td>
</tr>
<tr>
<td>Recovery capitalises on strengths.</td>
<td>Workers adopt a coaching style which promotes: partnership, self-management, shared decision making, personal responsibility, education and information sharing and is outward facing. Collaborative care planning values the contribution of others who have a positive impact on the person.</td>
</tr>
<tr>
<td>Recovery is supported by hope and goals.</td>
<td>Collaborative care planning is an important process in itself – it should enhance an individuals sense of hope. It requires a relationship between the person and the worker that is: believing, respectful, honest, transparent, power sharing, listening, caring and trustworthy.</td>
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4. **Who is the care plan for?**

Put simply, the care plan exists to help the person positively improve their health and wellbeing and turn their situation around. The care plan also affirms in writing that other people are there to help them, including those who know them best and in whom they trust. The care plan ensures that everyone involved knows what their contributions are and how they are actively supporting the person to work towards and/or achieve the goals that are important to them in their lives.

Trust workers with a legal duty of care to individuals and their families need to ensure that the care plan reflects a safe and holistic approach. The care plan should therefore include any legal considerations if necessary (for example restrictions on a person’s movement, capacity to consent in given situations). It should also include how the rights of the person will be protected and how they will be kept safe.

As the care plan is the written ‘product’ of the collaboration that takes place to support the person using services, it will be meaningful and understandable to those involved. The care plan should be signed by the person and a copy given. Where this has not happened for whatever reason the worker will give the rationale. Divisions will need to consider the use of communication and decision-making aids to ensure that collaborative care planning is a reality in practice. For the person in receipt of services, the care plan will give a sense of control and hope, for carers a validation of their role and confidence that their loved one is receiving excellent services, and for CPFT staff and others involved, instil hope that their work is making a difference in actively supporting recovery, rather than merely ‘patching-up’ a situation that may reoccur. The care plan will be signed by the person and a copy given.

5. **What is a care plan goal?**

Goal setting is a critical part of collaborative care planning and should follow on from a whole person assessment. Each goal written within the care plan should be a statement that indicates the desired outcome and gives a greater understanding of what the person would like to achieve. For example, ‘medication’ is not a goal. However, ‘to identify a medication routine that means I can get up to take the children to school’ would be. Likewise ‘mental state’ is not a goal. However ‘to find ways of managing my voices so they do not distress me so much’ would be. Another example of a goal for someone who is under a section of the MH Act and may be angry or not accepting of this could be, ‘for Sarah to understand her rights whilst under Section 3’

Goals are very individual and sometimes setting goals can be difficult, particularly when people have received unhelpful messages about their value or potential in the past (resulting in ‘self stigma’ and low expectations), or sometimes when very distressed or very ill. This can mean that people struggle to identify aspirations and make choices. However, it is very important that staff ensure opportunities for the person to make choices and to discuss care plan goals at the very earliest opportunity. Hope inspiring, compassionate relationships and positive interactions with other people important to the person, are often essential for people as they make positive changes in their lives.

6. **What is a care plan intervention? How do these relate to recovery?**

Intervention(s) describe the range of ways staff can help the person to achieve their particular goals and in doing so support their recovery. There may be several interventions to support work towards a particular care plan goal and these may come from a range of staff. Interventions and who is involved in delivering these should be stated explicitly in order that the care plan guides everyone’s work together with the person.

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2 In our services supporting children, older people and people with a learning disability the collaborative efforts would usually always involve the family, who would need to be a central source of information and support.
Interventions from staff, including peer workers, may be one of many ways to support recovery and the care plan should therefore include what the person themselves, family members or other agencies will be doing to help achieve the stated goals.

Again, hope inspiring and positive relationships are at the heart of recovery orientated professional interventions.

7. What about collaborative care planning and risk?

The principles of collaboration apply to the assessment and management of risk issues too. Within CPFT services, people will be involved in discussions about their safety and specifically about past and current risk concerns, what has helped in the past when feeling unsafe and care preferences in keeping safe now. In other words workers will aim to co-create a negotiated safety plan (risk management plan) which has been the outcome of an honest and open dialogue and which will be implicit within the signed care plan.

Some people may have had disempowering experiences of risk assessment and risk management in the past. Therefore workers may need to pay particular attention to listening to people’s views and experiences in order to gain a good understanding and maximise the person’s input and ownership of the plan. As with other aspects of peoples lives, keeping safe is a very important area. At times of severe distress and illness, when people may wish to harm themselves or indeed others, the duty of care that workers have is highly important and as outlined above will be reflected in the care plan.

8. When does collaborative care planning take place?

In working collaboratively it is essential to establish what is important to the person at the earliest possible point. So, collaborative care planning starts as soon as the person enters our services. We may also know the person from a previous experience, and whilst this may provide a useful starting point (especially when we have a persons own expression of preferences of care in the form of an Advance Directive, Person Centred-Plan or similar) we must also seek to involve those who know about the person and what they may aspire to. It is also important to recognise that what is important to people can change over time.

Collaborative care planning will take place throughout the person’s contact with CPFT services and in the everyday interactions workers have, about how the person themselves feels they are progressing, and what could help them. There will be several key decision-making points, for example around commencing medication or psychological therapy. In all instances, information sharing about the benefits and potential side effects of any treatments is essential for people; to be meaningfully involved in shared decision-making and making the choices they think are best for them are key aspects of collaborative care planning.

The entry point to our services is very important because it is when workers have the opportunity to establish a person-centred relationship. The exit point is also very important. The recovery process does not stop there, nor should it be interrupted or negatively affected by discharge. There must be a seamless transition between those involved in supporting the recovery journey, who will collaborate with each other in ensuring continuity of support where needed.

9. Why are hope inspiring, respectful, trusting and accepting relationships so important in collaborative care planning?

When a person(s) using services has lost all hope of their situation ever improving, those supporting them need to be ready to offer and carry hope…. and to believe in the person. Hope is essential if people are to identify their aspirations for the future and this will form the basis for goal focused discussions. Some people who use services may be reluctant, untrusting or traumatised and will therefore need to have opportunities to build safe, respectful relationships as a first step. Others may be cognitively impaired
and/or have communication challenges and will therefore primarily need individualised help to support their understanding. Others will be well equipped with information, keen to explore the range of options available and ready to make informed choices about what will help them in their lives. Traditionally people have been referred to as “not engaging” – in working collaboratively we would say that “we haven’t yet found a way to fully harness the partnership potential”.

Wherever the person is at, they will be given the choices and opportunities to drive the development of their own care plan and exercise their right to self-determination.

10. **Where does collaborative care planning take place?**

Discussions about care planning need to be taking place frequently with the person and those supporting them\(^3\). The outcomes of care planning discussions should reflect the language and world as the person themselves view it. The important guiding principle is that decision-making will take place in the presence of the person and those supporting them rather than workers making decisions as ‘experts’ that are then delivered to the person. Collaborative care planning is impacted and influenced in a range of settings/situations. For example:

- In everyday interactions – the worker will seek to value the person, be respectful and honest, carrying a belief that the person and their situation will improve and taking opportunities to be outwardly encouraging and hopeful.
- In 1:1 care review sessions – the worker will seek to understand the perspective of the person and be checking back their understanding of what they have heard.
- Where decisions are made about medication or therapy - the worker will share information about what is entailed and the range of options, how the treatment(s) may benefit the person and sharing information about possible side effects before reaching a shared decision.
- In handovers – where the worker will feed back to the team what has happened and the plans they have agreed with the person.
- In care review meetings – these will be conducted in a way that the person and those supporting them find helpful and useful. (For example, a traditional 'ward round' where the person enters with a large number of experts in a room, some unknown to the person, can drive a culture and process which does not promote collaboration).
- During clinical supervision - attention will be placed on a constant reflection on whether hearing the person’s story has occurred, rather than assumptions being made by the worker about what is best for the person.
- In team meetings or away days. Teams across all Divisions will continue to develop care processes that enable collaboration with people and their families. For example, rather than processes where workers draw ‘expert’ conclusions which are then presented to the person, ways will be found where care and treatment options are arrived at through processes of mutual information giving and shared decision making.

11. **Collaborative care planning tools and approaches**

Tools can be helpful when the worker or the person need a structure to guide holistic conversation and decision making. Some people have clear ideas about what is important to them and what role mental health services may play in achieving their goals so tools may be less helpful in such instances.

There are various tools which may help with the collaborative care planning process and people should be able to choose what is most helpful for them. Such tools may be most useful when the person needs assistance to sift and sort through what is really important to them.

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3 In our services supporting children, older people and people with a learning disability the collaborative efforts would usually always involve the family, who would need to be a central source of information and support.
New tools/approaches are being developed all of the time and a range already exist including:

- Recovery star
- Health Passports and Person-Centred Planning
- Life Story Books
- INSPIRE
- Choice and Partnership (CAPA)
- Wellness Recovery Action Plan (WRAP)
- Whole Life Plan

The best tools for promoting recovery, through hopeful conversations, are those that focus on the person and their goals rather than diagnoses, see the person in the wider societal context and:

- Are meaningful and relevant to the person
- Are holistic
- Are experienced by the person themselves as helpful for their recovery
- The process of using them is validating of the person
- Promote self-management

12. Did you work in collaboration – some questions for reflection?

In our practice it is helpful to take time to reflect on our day to day interactions with people. In respect of collaborative care planning the following are some key statements which you might find helpful to reflect on in terms of appraising your practice –

Did you:

- Demonstrate belief in the person’s existing resilience, strengths and resources and validate these?
- Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership?
- Take the opportunity to say something affirming, hopeful or encouraging?
- Identify non-mental health resources relevant to the achievement of their goals and which encourage self-management?

And finally in addressing the burning question -

13. “Surely collaborative care planning process will just take far too long”?

Collaborative care planning can actually save time in the long run. This is because we get to the heart of what’s important to the person and those supporting them as quickly as possible. From then on we can be confident we are spending our time on work which improves the persons experience and which is meaningful and relevant to them, thereby promoting recovery.

It also provides for a very efficient and confidence building way of working together, for all. People only get what they really need from mental health services and draw on their own internal resources and external ‘normal’ supports as far as possible. Carers, families and others important to the person know that their role is valued and workers can be satisfied that they have taken the opportunity to work in a truly person-centred way in giving care that they can be proud of.
Adult Acute Care Setting – Care Plan Example

Sarah is twenty five and has been admitted to acute recovery services. She has a partner, Paul, and is currently studying for a degree and hopes to be a teacher. They do not have children yet. Sarah is feeling extremely low and when this happens she feels like hurting herself. Currently, she sees little hope for the future, whilst at other times Sarah has been able to express her love of life and appreciates the need to keep herself safe. She already has an ‘advance directive’ in place. She is in good general health. However, she is concerned about hers and Paul’s rising debt and their unstable housing situation.

See page 9 for a care plan example using collaborative care planning principles. You will see that this care plan is person centred, goal orientated and reflects a multi-disciplinary approach. Importantly, the person themselves is taking responsibility for addressing their care plan goals.
<table>
<thead>
<tr>
<th>Aim</th>
<th>Action</th>
<th>Who responsible</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah wants to improve her mood and ‘feel like myself again’</td>
<td>Sarah to ascertain whether medication and a medication schedule will be helpful through discussion/information sharing with her Psychiatrist</td>
<td>Sarah/ Psychiatrist</td>
<td>Within 24 hours of admission</td>
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<tr>
<td></td>
<td>Sarah to be supported to feel hopeful about herself and her situation through twice weekly 1:1 time</td>
<td>Sarah/Primary Nurse</td>
<td>Ongoing (Mon/Thur)</td>
</tr>
<tr>
<td></td>
<td>Sarah to keep going to her regular water aerobics class at the university (Saturday mornings)</td>
<td>Sarah/ HCA staff if required</td>
<td>Ongoing (every Saturday am)</td>
</tr>
<tr>
<td><strong>Sarah to improve her understanding of her own mental health history</strong></td>
<td>Sarah to complete Wellness Recovery Action Plan (WRAP) to explore and plan her personal recovery journey</td>
<td>Sarah/Primary Nurse</td>
<td>Within 7 days of admission</td>
</tr>
<tr>
<td></td>
<td>Sarah and her partner to learn about WRAP for use as an ongoing tool to support recovery</td>
<td>Sarah and Paul/Primary Nurse</td>
<td>Ongoing (at two weekly meetings with primary nurse)</td>
</tr>
<tr>
<td>Sarah can experience the urge to cut her wrists and has stated (via an Advance Directive) that she wants staff to support her to abstain from self-harm through distraction and emotional support and to stay with her in times of crisis</td>
<td>Sarah to notify her key nurse (or any other member of staff she wishes to) if she feels like she may want to start cutting her wrists</td>
<td>Sarah</td>
<td>Within 7 days of admission</td>
</tr>
<tr>
<td></td>
<td>Sarah to create visual support (poster) of meaningful things in her life (family photos, postcards) for staff to use as prompts to inspire hope in Sarah when in crisis</td>
<td>Sarah/Primary Nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If Sarah is unable to control her urge to harm herself staff to provide Sarah with 1:1 time and emotional support, including Intensive Supervision when required</td>
<td>Sarah/Nursing Staff</td>
<td>Review as necessary – minimum daily with Sarah/handover/MDT meeting.</td>
</tr>
<tr>
<td></td>
<td>Sarah to explore alternative</td>
<td>Sarah/Psychological</td>
<td></td>
</tr>
<tr>
<td>Coping Strategies via Psychological Therapy</td>
<td>Therapist</td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
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</tr>
<tr>
<td>Sarah is currently studying for a degree. She needs to maintain links with her personal tutor, retain her role identity as a student and maintain her study skills, to support a return to her studies next term.</td>
<td>Sarah to be supported to access the internet to have email contact with her tutor each week</td>
<td>Sarah/ward staff /University tutor</td>
<td>Weekly (Friday am)</td>
</tr>
<tr>
<td></td>
<td>Sarah to retain her role identify as a student through full use of student portal via internet</td>
<td>Sarah/ward staff/University library IT</td>
<td>Weekly (Monday/ Wednesday pm)</td>
</tr>
<tr>
<td></td>
<td>Sarah to be supported to identify time within her personal schedule to read about her degree subject and reflect on its personal meaning</td>
<td>Sarah/OT</td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Sarah to discuss any side effects from her medication which may negatively impact on her ability to study</td>
<td>Sarah/ Psychiatrist</td>
<td>Reviewed weekly at MDT meeting</td>
</tr>
<tr>
<td></td>
<td>Sarah and Paul to continue to attend student quiz night on Friday nights</td>
<td>Sarah/ Paul / HCA staff if required</td>
<td>Weekly (Friday pm)</td>
</tr>
<tr>
<td></td>
<td>Sarah to explore career 'next steps' regarding post-graduate teacher training and how she can manage her health to support full time work</td>
<td>Sarah/OT</td>
<td>Weekly</td>
</tr>
<tr>
<td>Sarah and her partner Paul are in debt and worried about their tenancy. Sarah wants to explore ways to improve their situation whilst she is a student</td>
<td>Sarah to work with social worker to establish current status of their finances and identify areas which can be improved (e.g. explore student loan) and also discuss housing concerns</td>
<td>Sarah/Paul/Social Worker</td>
<td>Meeting within two weeks then agree further work</td>
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