GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

The Quality of Care and Treatment Planning

Assurance Review of
Adult Mental Health & Learning Disability Services

National Report

July 2018

1. Context

The Mental Health (Wales) Measure 2010 was commenced in 2012. Part 2 of the Measure places duties on the 'relevant mental health service provider' to appoint a Care Coordinator for an individual in receipt of secondary mental health services and to ensure that a Care and Treatment Plan (CTP) is developed for them. The Part 2 Regulations prescribe the form and content of the CTP.

The Code of Practice to Parts 2 and 3 of the Measure provides additional statutory guidance regarding the preparation, content, consultation and review of CTPs.

Part 2 of the Measure is applicable to all individuals in receipt of secondary mental health services, these people are described within the Measure as 'relevant patients'. 'Relevant patient' status also includes 'any individual who has a co-occurring learning disability and mental health problem and receives interventions and treatment from the learning disability service to address their mental health as well as their learning disability.'

Significant improvement has been made in ensuring that CTPs are in place for every individual. However, little external focus has been given to ensuring that CTPs are developed to an appropriate standard in line with the requirements of the Code of Practice to Parts 2 and 3 of the Measure and the recommendations of the Welsh Government's (WG) duty to review. The focus of the Delivery Unit (DU) review is to evaluate the quality of care and treatment planning processes in adult working age mental health and learning disability services.

2. Approach and Methodology

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 will 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 HBs. Field visits were undertaken to each HB 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 DU 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, measureable, 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.

The DU undertook field visits to the Health Boards on the following dates:

Hywel Dda University Health Board	**12th - 26th April 2017**
Cwm Taf university Health Board	**15th - 24th May 2017**
Powys Teaching Health Board	**30th June - 17th July 2017**
Aneurin Bevan University Health Board	**16th Oct -13th Nov 2017**
Betsi Cadwaladr University Health Board	**15th Nov -21st Dec 2017**
Cardiff and Vale University Health Board	**26th Feb- 23rd March 2018**
Abertawe Bro Morgannwg University Health Board	**9th - 30th April 2018**

In undertaking the visits, services were reviewed against the requirements of the Code. An audit tool based upon, but augmenting, the tool developed by Welsh Government and Part 2 leads was used. In learning disability services where patients did not have 'relevant patient'

status, a bespoke audit tool based upon the standards used by Healthcare Inspectorate Wales in their National Review of Learning Disability Services in 2016 was used to review these cases.

The assurance review included visits to at least one Community Mental Health Team (CMHT) and one Community Learning Disability Team (CLDT) in each of the 22 LAs and to at least one acute mental health inpatient unit (IPU) and one learning disability assessment and treatment unit (A&TU). A total of 30 CMHTs, 22 Community Learning Disability Teams CLDTs, 14 Mental Health IPUs and 6 A&TUs for people with a learning disability were visited. The CMHT number includes CAMHs and older adult mental health services in Powys which were visited at the request of the Heath Board.

During each visit a case note audit was undertaken. The team sought to analyse 30 randomly selected case notes in each CMHT and CLDT and 10 case notes in each mental health IPU and each learning disability A&TU. Due to problems with the accessibility of case notes at some sites, the target sample was not always reached. This was particularly the case in learning disability services where case files and electronic records were sometimes on different systems and on occasion in different offices. Nevertheless, some 1,436 case notes were audited during the assurance review, representing approximately 5.5% of 'relevant patients' in mental health services and 68% of 'relevant patients' in learning disability services.

Due to the fact that a significant proportion of people receiving learning disability services from CLDTs do not have 'relevant patient' status, a modified audit process was used to review a sample of case notes for people with a learning disability without 'relevant patient' status. 66 case notes of people without 'relevant patient' status were reviewed.

The details of all of the teams and in-patient settings visited are set out in the tables at appendix 1.

Prior to the commencement of the review, HBs agreed to release staff to act as peer reviewers working alongside the DU team participating in case note audit. This was initially suggested by one HB as a means to enhance their audit capability. It was subsequently agreed with all HBs and proved very successful and popular with the HB management and peer reviewers.

A Masters student with lived experience of a mental illness and research expertise into CTPs joined the DU for the majority of the review. She provided expert advice on a range of issues, participated in the focus groups and contributed to the production of local reports and this national report.

A Senior Nurse with expertise in learning disability services was seconded to the team from Aneurin Bevan University Health Board (ABUHB) to bring additional capability when reviewing CLDTs and A&TUs. When ABUHB was being reviewed a Senior Nurse from Abertawe Bro Morgannwg University Health Board joined the team to ensure impartiality.

At the conclusion of visits each HB was provided with an electronic copy of the audit tool used, together with the data collected during the case note audit. This methodology has meant that as a part of the review's legacy in addition to the DU's detailed report, each HB has a group of managers and practitioners skilled and practiced in undertaking case note audit, access to a Wales standardised audit tool and a baseline audit of a considerable sample of its patients with and without 'relevant patient' status.

Reporting

Following each visit to a CMHT and CLDT, Team Managers were provided with verbal feedback on the findings from the case note review, and discussions were held with the multidisciplinary team (MDT). Feedback focussed on the quality of care and treatment planning, the related assessment and review processes, issues pertinent to the delivery of Part 2 of the Measure and the relevant practice and recording issues highlighted during the review process.

At the conclusion of the visit to each Health Board the mental health and learning disability management team of the HB and its partner Local Authorities were provided with verbal feedback on the findings including any highlighted issues recommending immediate action. Subsequently, individual reports were prepared for each HB, providing more detailed analysis, findings and recommendations.

3. Overall Assurance

The review concluded that HBs and their partner LAs are 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 is generally poor. CTP outcomes are not routinely; specific, measurable, attainable, realistic and time-bound (SMART). As such CTPs outcomes are frequently not measurable.

Assessment and review processes are variable and frequently predate the commencement of the Measure.

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

Importantly the Measure is not being used as the central document to co-ordinate 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 is leading to frustration by staff and service users alike.

4. Key Messages

- Health Boards are largely compliant with the Measure Part 2 requirement to appoint a Care Coordinator and to complete a CTP for people with 'relevant patient' status. However, the quality of CTPs is, broadly speaking, not to the standards set out within the Measure Code of Practice (COP).
- Whilst the CTP is being completed to meet statutory compliance, the process is not at the centre of the delivery of care or the review of that care.
- The value staff placed on CTPs varied. Service users and carers reported that where CTPs were valued by staff and routinely used within their work, this had a positive impact on the degree to which the service user and carer valued the CTP process.
- CTPs tend to be process driven, lacking detail and full MDT input. The production of CTPs by some disciplines is weaker than others (notably, and generalising, those completed by psychiatrists frequently lack the detail of those produced by other disciplines). Occupational Therapists tended to produce some of the better CTPs seen.
- Risk assessments are being completed but are not being fully incorporated within the CTP in terms of "shaping" the plan and setting out crisis planning.
- In general service users are not adequately involved in the co-production of CTPs, the agreement of their content or their review.
- Service users' families, other informal carers and stakeholders, such as 3rd sector service providers, are not routinely involved in the CTP processes of assessment, planning and review. This is despite the fact that they frequently spend the greatest amount of time with service users.
- There is considerable inconsistency in the quality of CTPs. Greater quality tends to be driven by effective clinical leadership.
- Review processes are in place but consistency in the quality of review is not good.

- In LD services care coordination under the Measure, and therefore CTP production, tends to be a nursing task. Social Workers tend to focus more on the requirements of the SSWBA.
- A number of services are asking the question "How do we align the Measure with the Social Services and Wellbeing (Wales) Act 2014 (SSWBA)"? Whilst the legal requirements align, there appears an organisational schism in terms of their responses to the legislative requirements.
- Staff appear to have been trained in what they have to do in terms of legal compliance, but not how to formulate a SMART, outcome focussed plan.
- The Positive Behaviour Support (PBS) plan process in LD services lends itself to holistic care and treatment planning. This has led to some particularly good examples of CTPs in LD services. The culture of these services tends to be more patient inclusive.
- Where services co-locate NHS and Social services staff, this significantly enhances MDT working and service integration.
- The level of service integration in learning disability services is not as great as within mental health services. A consequence of this is less integrated planning and record keeping.
- Some concerns of the potential to lose integration in LD services as some LAs move to generic disability teams.
- The Welsh Community Care Information System (WCCIS) is being rolled out, but this is taking time and includes the necessity to "iron out a number of wrinkles".
- Examples of good and excellent CTPs were evident during the review and creative approaches were seen to be driving up standards. However, these positive examples were the exception within services.

5. Recommendations

1. **Welsh Government in its response the Measure duty to review should reinvigorate the CTP process requiring regular audit and quality assurance of CTPs at a local level, aligning this work nationally with wider work on data gathering and measuring outcomes.**

2. **A 'train the trainer' programme focussed on the formulation of CTPs which are person centred, holistic and include recovery focused outcomes should be developed.**

3. **HBs, LAs and NHS Wales Informatics Service (NWIS) should review assessment and review processes ensuring that they align to the Measure and the requirements of the SSWBA as the Wales Community Care Information System (WCCIS) is rolled out across LAs.**

   These processes should support proportionate approaches to care and treatment planning and review, reduce bureaucratic burden and overlap, and empower service users and their families to contribute to the planning of their care.

6. Key Review Findings

Assessment Processes

The Measure introduced a statutory CTP pro forma but did not prescribe either an assessment or review pro forma. This was deliberate, allowing HBs and LAs to develop assessment processes tailored to local circumstances.

The review found that a range of assessment tools are being used across Wales. There is therefore no standardised approach to the assessment of the needs and strengths of individuals. In some HBs various tools are being used in different localities. NHS and Social Services' staff are in a number of locations using different assessment tools. This practice appears to have become more prevalent since the introduction of the SSWBA.

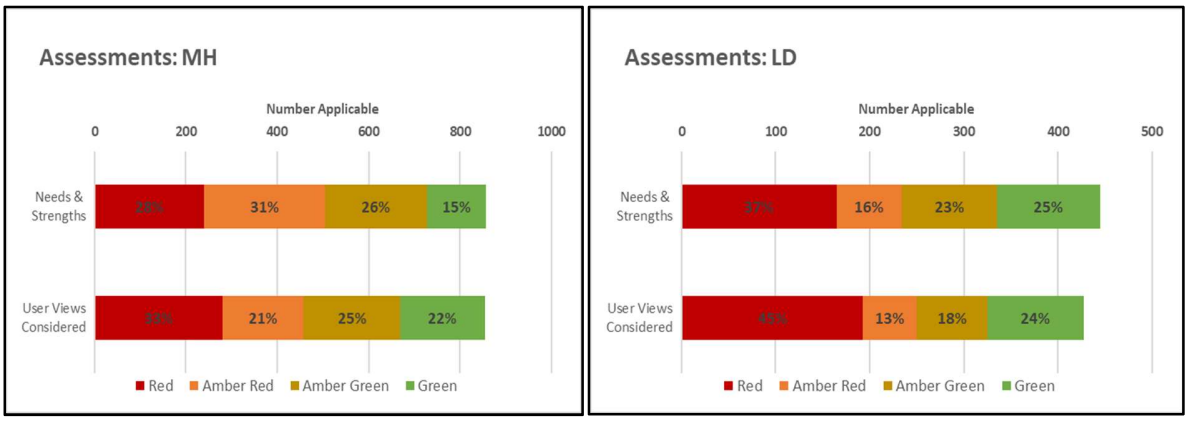
Some of the tools in use are more time consuming to complete than others, some lend themselves to more holistic planning and others to more strengths based approaches. There is potential for the roll out of WCCIS to assist in streamlining these processes and to minimise variation.

There is greater standardisation in the assessment of risk and in safety planning. All HBs are using the Wales Applied Risk Research Network (WARRN) formulation process. However, it is not the only process being used and the extent to which it is used varies across Wales. In all HBs, risk assessment tools other than WARRN are in use but WARRN was the tool used in 47% of case notes audited in within the review.

In Learning Disability services additional assessment tools were used for people with particular needs. These include the PBS process for people with 'behaviours that challenge' and 'epilepsy planning' processes. These tools appeared to add value to planning processes especially where the outcomes were appended to either CTPs, or for people without 'relevant patient' status their Care and Support Plans or other care plans.

The Assessment and Recording of Both Needs and Strengths within the Plan

Very few of the CTPs audited demonstrated a strengths based approach to assessment, nor did they routinely record the strengths of those people being assessed within their CTPs. A strengths based approach identifies the assets that an individual has or can draw on from family friends informal support systems. The outcomes recorded tended instead to be needs or deficits based. A number of cases were seen that used a strengths based approach to formulating outcomes. It was noted that some disciplines such as Occupational Therapists were more likely to use this approach. In learning disability services those people with a PBS plan were more likely to have a strengths based approach to their care. There was also evidence that training and paperwork from the SSWBA was promoting a strengths based approach from Social Workers.



The quality of assessment is shown as both a number and as a percentage of the colour rating applied during the audit

Findings:

The positive behaviour support planning process in LD services lends itself to holistic care and treatment planning which has led to some particularly good examples of CTPs in LD services. The culture of these services tends to be more patient inclusive.

Care and Treatment Planning

The vast majority of 'relevant patient' cases audited had a CTP on file, and in the vast majority of cases the CTP identified that a Care Coordinator was appointed. However, the quality of CTPs was variable. Some examples of excellent CTPs were identified during the audit and a small number of good CTPs were seen in all HBs but unfortunately the general quality of CTPs audited was poor.

It was evident from the audit that the CTP is frequently not the central document being used to coordinate care or to continuously review care and treatment. Instead other documentation or the running record in the case file tended to be predominant mechanism used to monitor and review care with the CTP being referenced only sporadically and most frequently at the point of its review.

It was also evident at review that CTPs are frequently produced from the perspective of the author and did not reflect the input of the multidisciplinary team. This was despite effective MDT working being described within MDT focus groups throughout the review.

Quality was considered against a number of criteria, these included:

- Whether the CTP was current, i.e. produced within the 12 months prior to the audit.
- Whether the plan recorded both the needs and strengths of the Service User.

- The quality of risk management and safety planning and the degree to which they were current.
- The degree to which the appropriate "areas of life" were addressed.
- Whether the plan was produced using SMART principles.
- The inclusion of relapse signatures and crisis planning.

The inclusion of Service User and carer involvement in the formulation of plans was also evaluated. This is reported in the section below on Service User and carer involvement.

Findings:

Health Boards are largely compliant with the Measure Part 2 requirement to appoint a Care Coordinator and to complete a CTP for people with 'relevant patient' status. The quality of CTPs is, broadly speaking, do not meet the standards set out within the Measure COP.

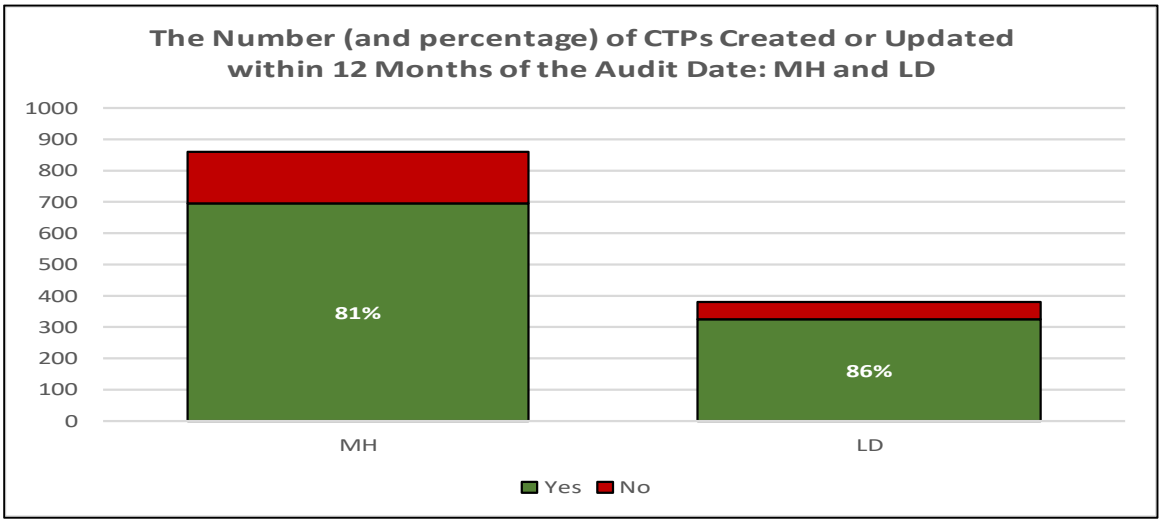
Whilst the CTP is being completed to meet statutory compliance, the process is not at the centre of the delivery of care or the review of that care. CTPs tend to be process driven, lacking in both detail and full MDT input.

The production of CTPs by some disciplines is weaker than others (notably, and generalising, those completed by psychiatrists frequently lack the detail of those produced by other disciplines). Occupational Therapists tended to produce some of the better CTPs seen.

Examples of good and excellent CTPs were evident during the review and creative approaches were seen to be driving up standards, but these positive examples are the exception within services.

How current were CTPs?

In the majority of cases CTPs had been produced within the 12 months prior to audit. However, in every HB, examples were found where CTPs were either over 12 months old or were not on file, suggesting that they had not been produced. This is contrary to the requirements of the Measure Code of Practice.



An issue on the timely and appropriate production of CTPs emerged during the focus groups. This concerned the timing of the production of a CTP following allocation of a Care Coordinator. In a number of HBs a blanket requirement has been set to produce a CTP within 6 weeks of the allocation of a case to the Care Coordinator, often described as “the 6 week rule”.

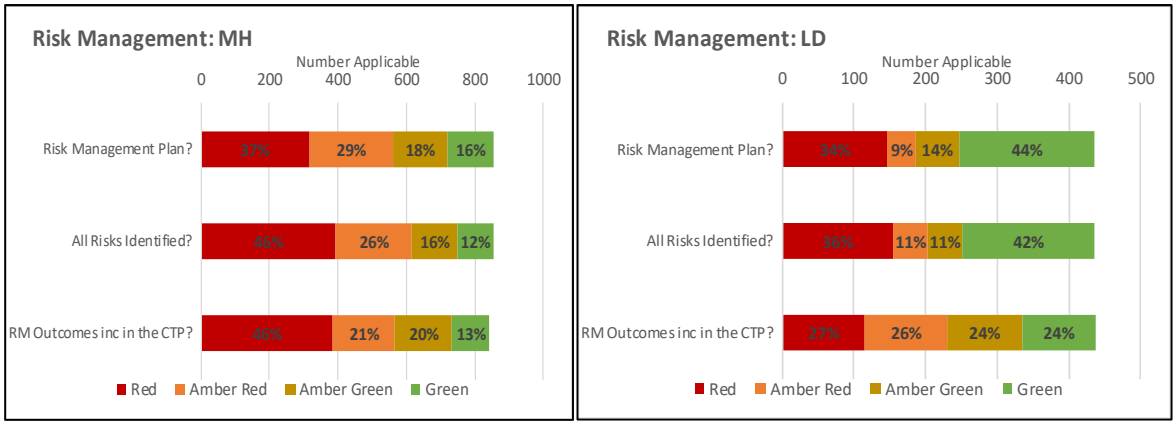
Whilst the production of a CTP as soon as is practicable following assessment should be the aim of the Care Coordinator, Service Users and staff identified that the requirement to produce a CTP within 6 weeks of allocation is not always beneficial and can be detrimental to the process.

Service Users stated that when they are very distressed, or otherwise very unwell, being asked to consider long term goals at this time can be challenging. Likewise staff stated that when clients are very unwell it can be difficult to elicit their views on the goals they seek to achieve in the coming months. Some staff added that a shortage of time to engage and plan can be exacerbated where the Service User does not or cannot attend appointments following allocation.

Whilst the Code requires the timely production of a CTP, it does not stipulate a maximum timescale for production. HBs and LAs should not apply blanket requirements for CTP production but should ensure, through their systems, processes and continuous audit, that CTPs have been produced and placed on file within the previous 12 months and as soon as is practicable once the assessment process has been completed.

The Quality of Risk Management and Safety Planning

Risk assessments were broadly current, with the majority of cases audited having a risk assessment completed within the year prior to the audit. However, whilst risk assessments were current and frequently of good quality, the incorporation of the risks identified within CTP outcomes was infrequent, and where they were incorporated this was often poorly executed. Service users are rarely involved in risk management planning nor do they receive a copy of risk management plans.



The quality of risk management planning is shown as both a number and as a percentage of the colour rating applied during the audit

Findings:

Risk assessments are being completed but are not being fully incorporated within the CTP in terms of "shaping" the plan and setting out crisis planning.

The Addressing of Appropriate 'Areas of Life' within CTPs

The degree to which relevant 'areas of life' were included within CTPs varied, as did the degree to which these related to the needs and risks identified at assessment.

A number of 'areas of life' were less frequently addressed than others. The least frequently included 'area of life' in mental health services was 'education and training', closely followed by 'work and occupation'.

Within focus groups Service Users described an inadequate priority being placed on education, training, occupation and employment. Their perception was that services do not adequately embrace a recovery approach.

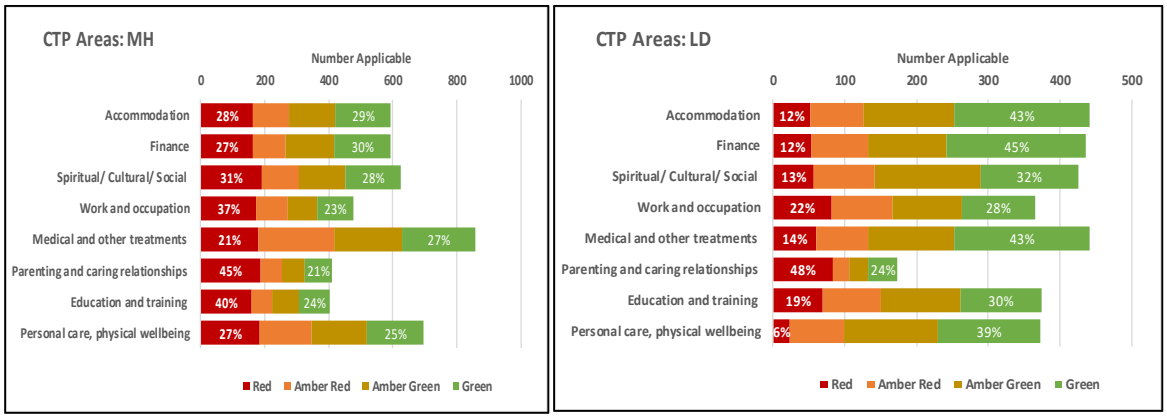
In learning disability services, the least frequently addressed 'area of life' was 'parenting and caring relationships'. The most frequently included 'area of life' in mental health services was 'medical and other forms of treatment', whilst in learning disability services 'accommodation' and 'medical and other forms of treatment' were the most frequently addressed 'areas of life' in equal proportion.

Commonly, the 'areas of life' included within a CTP related to those areas of need that the author of the plan would deliver themselves. Where other members of the MDT or another agency would be required to be involved in meeting a need or mitigating a risk, these were frequently not included or were included but with scant detail.

Whilst these shortcomings were identified within the audit, most CTPs did include a number of 'areas of life'.

The review team found that many assessors did not feel able to apply discretion in the interpretation of the areas of life. Instead, they used the wording on the CTP pro forma very literally and sometimes described an inability to capture some preferred outcomes under the headings contained within the CTP.

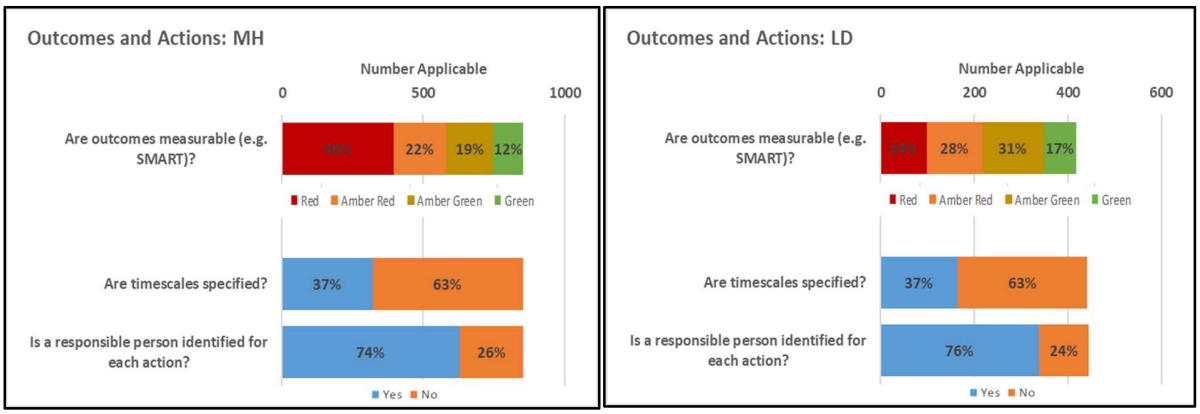
When explored with staff they frequently viewed a less literal interpretation as potentially enabling. Some staff said that they had been "taught" that the headings within the CTP must be treated literally as it is a statutory document.



The quality of the CTP 'areas of life' is shown as both a number and as a percentage of the colour rating applied during the audit

SMART Planning

The recording of SMART outcomes within CTPs is important, not least because SMART outcomes enable a meaningful appraisal at review of whether or not they have been realised. The audit of case files identified that most frequently the outcomes recorded within CTPs were not SMART and did not lend themselves to meaningful review.



Measuring of outcomes and their actions

Outcomes were often not specific nor measurable, they were instead vague statements of intent which it would be difficult to determine whether or not they have been realised by the treatment and care provided. Likewise many were not time bound, with a date by which the outcome or specified elements of the outcome aimed to be achieved.

In a significant proportion of recorded outcomes the time frame recorded was "ongoing" - this appears to be a practice that has become embedded within the culture of care coordination.

The outcomes recorded were frequently not recovery focussed, with a tendency for outcomes to be focussed on a "maintenance model" of care with little expectation for improvement in a person's functioning or quality of life.

The Inclusion of Relapse Indicators and Crisis Planning

The recording of relapse indicators is important within the CTP. Their inclusion enables the Service User, members of their family or informal support network and members of the MDT to identify when a person's mental health is deteriorating. This enables early intervention and the prevention of a major relapse of a mental illness. To have the greatest impact, relapse indicators should be specific and personalised to the Service User.

The case note audit found that relapse indicators are frequently being recorded and are often personalised.

The quality of crisis planning within CTPs was poor and did not routinely flow from the assessment of risk and the relapse signature. Where crisis plans were produced, in the vast majority of cases they contained no contingency planning or any clarification of the response the Service User or their family might expect in a crisis.

Frequently crisis plans consisted of a list of telephone numbers or contact points for crisis or emergency services. They lacked descriptions of what crisis response services should do, based around anticipated crises, and did not contain contingency plans. They infrequently included the number for CALL Helpline, Samaritans or other listening lines and in many cases suggested attendance at the Emergency Department as the means to manage a mental health crisis.

Findings:

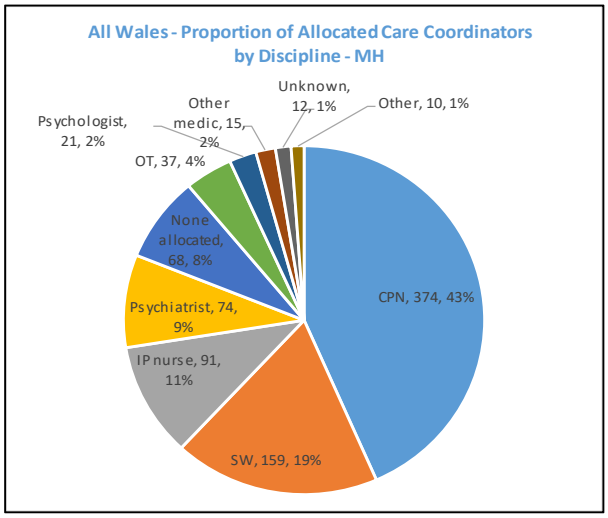
There was no evidence that the use of CTPs is enabling improved access to services in a crisis. In fact evidence was provided that this is not the case. As a result, the potential for proactive and protective responses directed by the CTP is not being realised.

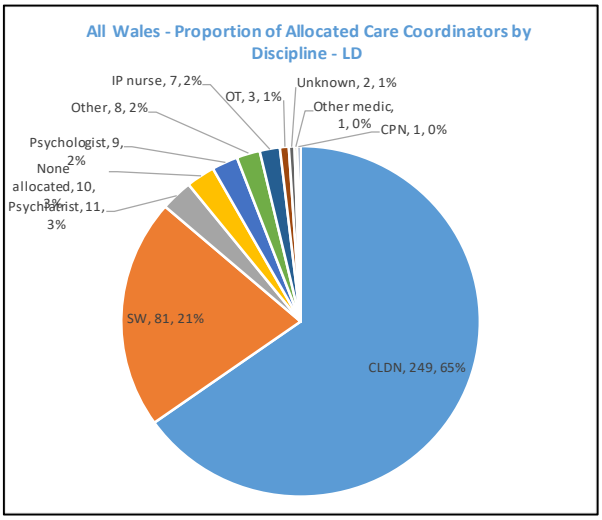
Care Coordination

High quality care coordination is the cornerstone of effective specialist care particularly in cases where care and treatment is complex and delivered by a number of different disciplines and agencies. The Code of Practice to Parts 2 and 3 of the Measure sets out the roles and responsibilities of the Care Coordinator and places a legal duty on Health Boards and their local authority partners to appoint a Care Coordinator for a person with 'relevant patient' status. Care Coordinators are being routinely appointed by services in line with these legal duties.

Most care coordination in mental health and learning disability services is being undertaken by nursing staff. Other disciplines are appointed as Care Coordinators, but this is less common. Where specialist teams such as perinatal or eating disorder services hold cases, the care coordination role is frequently retained within the CMHT. This practice was described as aiming to reduce the burden on highly specialist teams enabling them to focus on delivering specified therapeutic interventions. However, this practice is the cause of some disquiet among members of the CMHT as it was perceived to diminish the sense of specialism with CMHTs and to place duties and responsibilities on staff who are often not well sighted on the care being delivered to the person for whom they coordinate care.

Overall, 50% of all of the 'relevant patients' audited were care coordinated by a CPN or a CLDN.





Findings:

In LD services care co-ordination under the Measure, and therefore CTP production, tends to be a nursing task. Social Workers tend to focus more on the requirements of the SSWBA.

Service User Involvement in the Coproduction of CTPs and Reviews

A central tenet of the Measure is to enhance the degree to which Service Users are involved in the formulation of the outcomes to be achieved through the support of mental health or learning disability services, and to participate in reviewing whether or not these outcomes have been achieved.

Wherever possible, Service Users should co-produce their CTP with their Care Coordinator and where required, other members of the MDT. Whilst it is recognised that for some this level of participation may not be achievable, Service Users should be enabled to participate in the formulation and review of their CTP to the maximum degree possible.

The case note audit identified that the involvement of Service Users in the formulation of CTPs varied considerably. A small number of CTPs clearly demonstrated that Service Users had been fully involved in both their formulation and review. However, in the majority of cases involvement was limited and fell short of the level of involvement set out in the Measure. CTPs that did not demonstrate Service User involvement and had not been signed by Service Users were common.

In MDT focus groups staff cited a number of reasons for low levels of co-produced CTPs. These included a lack of interest from Service Users to be involved in formulating their plan, a lack of capacity to engage in the process and a lack of time to work in such a way that would allow co production.

Whilst in some cases there was some evidence to support the reasons given for infrequent co production, discussions with Service Users suggested that there was an appetite for greater involvement in the formulation of their CTPs. Many described having discussed their plan but when it was produced, the issues they had raised were absent from the plan. Some people expressed the view that they are allowed to have their say but are not heard. A number of Service Users stated that where staff valued CTP processes and used them in their routine work Service Users placed greater value on their CTP as an aid to recovery, the management of crises and thinking about their future.

Whilst staff frequently reported Service Users as not being interested in their care plans, many Service Users were very positive about receiving a copy of their plan. CTPs were described by some as a safety net and a means by which you can "call in the cavalry" at a time of crisis. More negatively some felt that if they did not agree with their care plan this could be held against them.

A Service User's lack of mental capacity was sometimes cited as a reason for not co-producing a plan. However, in some cases where this was the reason for not involving the person in the production of a plan, elsewhere in the file people were identified as having capacity. Examples were evident during the review that some staff go to great lengths to engage Service Users despite their limited capacity. In a number of cases creative approaches to assist people to participate in planning and review were seen and highlighted with HBs.

A number of staff interviewed were particularly resistant to sharing the outcome of risk assessments with Service Users and to involving them in the formulation of a crisis or safety plan. They suggested that this would not be an appropriate practice and a reason not to share the CTP with the Service User.

Both staff and Service Users said that formulating a plan at a time of crisis can be difficult because longer term goals may remain unclear until the person is able to think more clearly. Where a person is highly distressed this may place constraints on the degree to which people may be involved. However, staff should make every effort to involve Service Users whenever possible. If necessary, they may need to do so following the initial formulation of the CTP to ensure that their views have been included.

The culture within organisations should make it a requirement that Service Users are enabled to coproduce their plans and participate in their review wherever possible. Where Service User's views are not included, this should be an exception, with reasons for not doing so clearly recorded. CTPs, once produced should remain a live document routinely used in the planning, delivery and review of care and treatment.

It was evident to the review team that where a positive attitude to care and treatment planning and Service User engagement prevailed within an MDT, the quality of CTPs was better, as was the evidence of Service User participation in CTP production and review processes. Focus group participants suggested that a staff's response to CTP production could be person specific. They suggested that attitudes may be influenced by the degree to which the Service User could advocate for themselves, promoting meaningful involvement in these processes.

Findings:

Service users are not adequately involved in coproducing CTPs or agreeing to their content.

The Involvement of Families and Informal Carers in CTPs

Frequently CTPs did not reflect the involvement of the Service User's family or their informal care network within the formulation of the plan's outcomes. Whilst the constraints of confidentiality can, on occasions, place some limits on the amount of information that can be shared with family members, friends and other informal supports, this does not prevent these people from sharing their views with the Care Coordinator or other members of the MDT. These views can help to shape the CTP and inform the review processes.

Carers frequently reported feelings of frustration, exclusion and powerlessness within the care of their family member. This frustration was most profoundly expressed in relation to the management of crises. Carers and other informal carers felt that they hold key information and take responsibility for supporting their family member at a time of crisis. Despite this, they often reported feeling left out of crisis management and crisis planning.

Whilst some participants in focus groups felt that they had been appropriately involved in planning and reviewing care, many felt that they could be better engaged and included in these processes.

Findings:

Carers are not routinely involved in the production and review of CTPs.

The Involvement of Stakeholders

In addition to Service Users, their families and other informal carers, stakeholders such as third sector organisations were also included in focus groups. Many of the third sector stakeholders believed that they could play a greater part in CTP processes. This included the potential for their services to be included more frequently within CTPs and the role that they could fulfil in contributing to reviews.

For example some stakeholders stated that in some people's care they see the client several times a week and for extended periods of time. As such they feel able to provide a valuable contribution to the review of whether and to what extent goals within the CTP have been met.

Whilst some stakeholders felt they were engaged to some extent in the formulation of CTPs and their review, they have the potential for greater involvement than currently occurs.

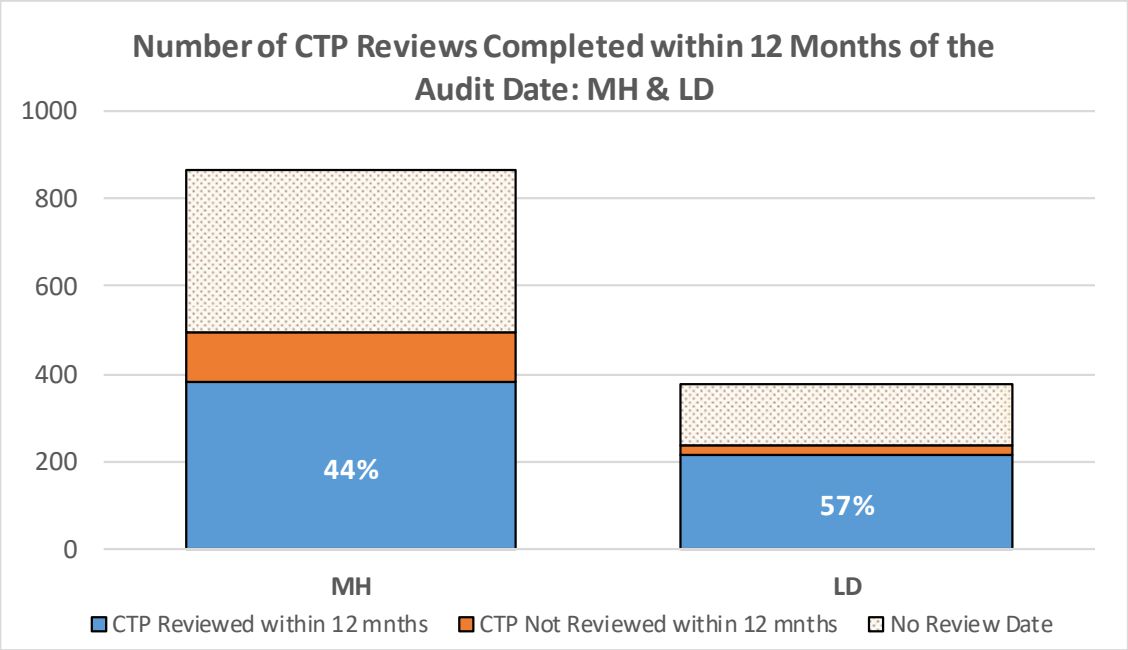
Findings:

Stakeholders are not routinely fully involved in CTP production.

Review Processes

The Code of Practice to Part 2 and 3 states 'In order to ensure that the care and treatment plan provision remains optimal to the 'relevant patients' recovery, regular monitoring of the plan and the delivery of services is required.' (6.3). Furthermore, the Measure places a duty on the local mental health partners to ensure that a 'relevant patient's' CTP is reviewed at least annually.

The review found that all HBs had established a formal CTP review process. However, these processes were not always adhered to, nor were they routinely completed in a timely manner. In learning disabilities services there was less consistency in the application of locally established review processes. In some instances there was variance in compliance with the review process within a single CLDT.



Reviews frequently did not include progress against all of the goals included within the CTP nor did they reflect the inclusion of the views of all of those involved in the delivery of care and treatment. This picture was consistent across all Health Board and Local Authority areas and in both mental health and learning disability services.

SMART outcomes within CTPs enable effective review, and effective review in turn enables more outcome focussed, recovery oriented service delivery. Reviews which involve those delivering services and held at appropriate intervals are critical to optimising care.

The review process should, wherever practicable, put the Service User at the centre of the review to ensure that their perception of the attainment of goals is identified and that they are central to the formulation of any revisions to the CTP emerging from the review.

Service Users reported uncertainty about what constitutes a review. A number described having discussed issues within regular meetings with their CPN whilst others reported MDT involvement in reviewing care. However, many had no recollection of having been involved in a formal review of their CTP.

Staff stated that review processes were frequently predicated on the availability of the psychiatrist a lack of which can be the cause of delay in CTP reviews being held.

Findings:

Leadership and Oversight

It was evident from the review that leadership and oversight of CTP processes including assessment and review are the single most influential factors in driving up standards of care. The provision of supervision, case load weighting and regular audit all serve to ensure the quality and currency of CTPs and effective care coordination. Where these were clearly applied, a more consistent standard of planning was evident, as was a culture of compliance to the requirements of the Measure and its Code of Practice. Where they were lacking, standards were poorer and quality was more dependent on the value individual practitioners placed on the importance of Service User involvement and planning processes.

Different managerial arrangements are in place within CMHTs and CLDTs in Wales. Most frequently teams are managed using "joint" management arrangements, with NHS staff being managed by a health service manager, and social care staff being managed by a Social Services' manager. These joint management arrangements whilst not offering fully integrated management were frequently observed to be effective in providing clear lines of accountability. Some examples of fully integrated management were also witnessed with a single manager managing all CMHT or CLDT staff.

Regardless of which model is used, it is imperative that these joint or integrated managerial arrangements ensure that systems are integrated across the whole system avoiding duplication and unnecessary bureaucracy. It will be essential that these principles are adhered to when addressing the statutory requirements of the Measure and the SSWBA and as WCCIS is rolled out.

Findings:

There is considerable inconsistency in the quality of CTPs. Greater quality tends to be driven by effective clinical leadership.

Work Pressures within CMHTs

The general workload of multidisciplinary teams was identified by the managers of some CMHTs and CLDTs as an impediment fully efficient care and treatment planning processes and the production of high quality CTPs.

Some of the pressures emanate from the requirement of these staff to participate in duty rotas, running depot and Clozaril clinics and the commitments of fulfilling the Approved Mental Health Professional Role. Additional pressures were also raised, these include Social Services

staff undertaking duties in addition to routine CMHT or CLDT work. These duties include undertaking safeguarding assessments and fulfilling the role of Best Interest Assessor under the Mental Capacity Act for people not necessarily on the caseload of the CMHT or CLDT.

These "additional" duties were cited as diminishing the ability for some disciplines to fully participate as a member of the multidisciplinary team. Despite these pressures the review found infrequent use of caseload management tools.

The assurance review identified that some Service Users had uncomplicated care and treatment needs which could potentially be met within primary care or by third sector services. However, they are being retained within CMHTs because their care includes components provided as statutory aftercare under S117 of the Mental Health Act 1983. This "117 status" brings them within the ambit of the Measure requiring care coordination by members of the specialist teams. This was viewed as disproportionate to need and counter to prudent healthcare principles.

Staff reported that changes to welfare benefit rules, such as the introduction of Personal Independence Payments (PIP), are also reducing the potential to discharge some Service Users from CMHT provision. Discharge from specialist care is perceived by many to jeopardise people's entitlement to these benefits because being under the care of a CMHT is adjudged to be an indication of a higher level of need. The impact of these factors reduces the potential for the use of recovery approaches within CMHTs.

Changes to welfare benefit arrangements have also increased the workload of CMHTs and CLDTs in terms of the work required to advocate on behalf of clients to secure welfare benefits. This work includes offering advice, completing forms, providing supporting evidence to claims and attending tribunals where entitlement is disputed. Staff were highly sympathetic to supporting clients in securing the benefits to which they are entitled but believe that some people, whilst requiring benefits could live independently of specialist team support but are fearful that to do so may lead to them losing benefit entitlement.

Staff believe that such losses impact adversely on people's mental health which can lead to relapse. For all of these reasons, Service Users are being retained within CMHTs and CLDTs which is leading to additional pressure on these services.

Findings:

Staff report that there are additional roles that they are required to undertake, which impact on their ability to Care Coordinate and complete CTPs to the standards required.

The Use of CTPs and the Care Coordination Arrangements during Inpatient Admissions and at the Times of Care under "Specialist" Services

The use of CTPs and arrangements for care co-ordination during hospital stays varied across Wales. In some units an admission is treated as a significant change of circumstances triggering an assessment and revised CTP. Others retain the community CTP as the working document but develop a nursing plan to direct treatment during the admission, with the CTP used to prepare for discharge.

Broadly speaking care coordination responsibility is retained by CMHTs and CLTDs during admission and when care is being provided by a specialist team such as the eating disorder service.

Where a person is admitted to an acute inpatient setting, retaining care coordination within the community was viewed positively as it retains the link with the community team and assists discharge planning and post discharge follow up. However where admissions are planned as medium to long term, staff in CMHTs questioned whether care coordination should transfer to the inpatient unit, as they have responsibility for the day to day management of the patient and the CMHT may have little or no long term input other than at formal reviews.

Whilst relationships between CMHTs and CLDTs with their respective inpatient units is broadly good, the arrangements for care coordination between CMHT, CLTDs and inpatient settings was the area of the most profound confusion in terms of how the Measure should be applied. Where CTPs were developed within inpatient settings they tended to focus on medical interventions rather than more holistic planning.

When people are receiving care from a specialist team, frequently these teams do not care coordinate. Members of CMHTs and CLTDs understood that this can allow these teams to focus on the delivery of specialist interventions. However, they frequently expressed concern that they hold responsibility and accountability for care and treatment that they do not deliver, and are often not as well informed as they would wish to be, given the holding of the care coordination role. Some staff also stated that this arrangement did not recognise the specialist nature of CMHT work.

Workforce Development and Training

The Code of Practice to Part 2 and 3 of the Measure requires that HBs and LAs support Care Coordinators in the execution of their duties under the Measure. This support should include training and development.

Many staff in all HBs said that they had not had training since the commencement of the Measure. This means that people who have transferred into services from outside Wales or have transferred into mental health and learning disability services from other specialisms have had no training on the Measure.

Where training had been provided, the focus was frequently described as being on educating staff on the legal duties introduced by the Measure rather than on training staff to hone the skills required to effectively plan and review in a person centred holistic manner as required by the Measure's Code of Practice. Furthermore, in learning disability services staff reported that the training they had received had clearly been developed for use in mental health services and had not been adapted for learning disability staff through the inclusion of appropriate scenarios for example.

A number of student Nurses and student Social Workers were interviewed in the course of the assurance review. When asked what training they had received on the Measure during their undergraduate training, their answers varied. Some stated that the training provided by the university had focused on values based care and the centrality of the Measure to this approach, a significant number said that the training had focussed on legislative duties, not on skills or values.

Furthermore, students stated that universities expected skills to be developed during practice placements rather than through the "taught element" of training. Staff within MDTs frequently described an assumption that undergraduates are trained in the skills necessary to deliver the Measure at University.

It is the view of the review team that inadequacies in staff training is impacting upon their ability to formulate plans to the standard required by the Measure's Code of Practice. Training concerns include the lack of focus within some undergraduate training on the skills necessary to effectively formulate a person centred plan, and inadequate access to continuous professional development training on delivering the Measure since its commencement.

The review team also believe that the involvement of Service Users in the delivery of training on care and treatment planning will enhance the quality of this training. In particular Service User involvement would serve to inform staff on the value of involving Service Users in the co-production and review of CTPs.

Examples of positive practice and excellence in formulating high quality CTPs should be used to drive up standards within and between teams.

Findings:

Staff have been trained in what they have to do in terms of legal compliance but not how to formulate a SMART, outcome focussed plan.

Multi Agency and Multidisciplinary Integration and Integrated Record Keeping

For the Measure to be delivered effectively, it requires the various disciplines and agencies responsible for the delivery of care and treatment to work together in an integrated system. In order to optimise this approach, a single electronic case record, accessible to all members of the multidisciplinary team, should be available allowing them to use and contribute to its content. Access should include staff working in inpatient and primary care settings during regular working hours, at night and at weekends.

Unfortunately, this level of service and case note integration was not evident to the review team. In the vast majority of CMHTs, CLDTs and inpatient settings, NHS and Social Services have separate recording systems. These systems are frequently not electronic but rely on "hard copy" files.

Not all teams are co-located with all disciplines working from the same base. Where teams do share a base it is not uncommon for different disciplines to record separately using different electronic recording systems or paper based files. This was evident during the case note audit. The review team were frequently advised that some elements of the audit may not be possible due to the lack of a single record. On occasions, important information was held between two electronic systems or in case files held in different buildings.

The lack of integrated working and case recording was more prevalent in learning disability services than in mental health services. The fragmentation of case records in learning disability services led to an inability to review the intended sample due to the time taken to track down the necessary information to complete some of the audit fields.

Whilst all of the CMHTs had NHS and Social Services staff co-located, this was not always the case in learning disability services, with a number of teams visited having NHS and Social Services staff based in different locations. This led to reduced integrated working. Staff also described the potential for integrated working in learning disability services to be further reduced due to some Social Services departments moving toward a structure focusing on generic disability teams. Some staff described this initiative as reducing the degree of social work specialism in the CLDT MDT.

The use by some disciplines of "bespoke" assessment and planning processes is leading to higher than necessary levels of bureaucracy, duplication and fragmentation. WCCIS has the potential to ameliorate many of these problems but in order to do so it will need to address this fragmentation and will require agencies and disciplines to embrace the use of a single electronic record.

Findings:

WCCIS is being rolled out, but this is taking time and includes the necessity to "iron out a number of wrinkles".

The Interface of the Social Services and Wellbeing (Wales) Act 2015 and the Measure

The relationship of these two pieces of Wales' specific legislation is of critical importance in terms of the planning, delivery and review of care to adults with a mental health problem and/or a learning disability.

Both pieces of legislation place statutory duties on HBs and LAs to create statutory plans. The SSWBA requires the production of a Care and Support Plan (CSP) and the Measure requires a Care and Treatment Plan (CTP).

The Measure was commenced, and its Code of Practice published, prior to the commencement of the SSWBA. As such, neither the Measure nor its Code reference the SSWBA duties. However, the SSWBA and its Code demonstrate cognisance of the requirements of the Measure and cross reference the relevant legal duties. This has the effect of making the two pieces of legislation compatible, addressing broadly similar underpinning principles and intent.

Despite this compatibility of intent, the review team found in practice that the relationship between the two pieces of legislation is not always understood. In some instances this is leading to overlap and duplication and additional bureaucratic burden on staff. Whilst NHS staff were aware of the duties under the Measure, they were frequently less well sighted on the requirements of the SSWBA and its relationship to the Measure.

Whilst Social Services staff were more aware of the requirements of the SSWBA, they too were not always clear on its relationship to the Measure.

Some staff suggested that the thresholds within the SSWBA and local eligibility criteria for CMHTs are not aligned, leading to a cohort of vulnerable adults coming under the purview of Social Services staff but no other members of the CMHT multidisciplinary team.

WCCIS - a nationally procured information system has the potential to address the relationship of the SSWBA and the Measure as it is rolled out with assessment and planning processes developed to ensure compatibility.

Findings:

The level of service integration in learning disability services is not as great as within mental health services. A consequence of this is less integrated planning and record keeping. Where services collocate NHS and Social services staff this significantly enhances MDT working and service integration.

There are some concerns of the potential to lose integration in LD services as some LAs

Determining 'Relevant Patient' Status

In order to ensure that HBs and LA partners are compliant with their statutory duties, a process to determine and record each Service User's 'relevant patient' status is required. In order to ensure that the process is comprehensively applied, 'relevant patient' status should be considered at the time of initial assessment and reviewed when necessary.

In adult mental health services 'relevant patient' status is relatively straightforward with people accepted into secondary care services being afforded 'relevant patient' status.

In learning disability services 'relevant patient' status is not automatic but requires determination of whether or not the person's individual needs bring them within the scope of the Measure.

In all services some form of criteria have been applied. Most frequently services have used a tool developed by ABMUHB which sets out a number of criteria to be considered. However, in most HBs, whilst this tool has been used for the majority of clients, this was a one off exercise undertaken at the time of the commencement of the Measure.

Whilst it may be used when people move in to services it is not applied as part of the review process to re-evaluate whether 'relevant patient' status no longer applies or has become pertinent for a person whose circumstances have changed. One HB's learning disability service routinely uses a tool at review to reconsider 'relevant patient' status and retains a copy of the pro forma used at the front of the file.

Findings:

There is a higher proportion of 'relevant patients' (as defined by the Measure) in MH services than in LD services (this was to be expected and is generally appropriate).

However, the determination of 'relevant patient' status can be variable in LD services and in some instances in mental health services.

A number of services are asking the question "How do we align the Measure with the SSWBA"? Whilst the legal requirements align, there appears an organisational schism in terms of their responses to the legislative requirements.

The Assurance Review team was made up of the following membership:

Phill Chick	Assistant Director Mental Health and Learning Disability - NHS Delivery Unit
Dave Semmens	Performance Improvement Manager Mental Health and Learning Disability - NHS Delivery Unit
Kate Burton	Performance Improvement Manager - NHS Delivery Unit
Deb Popperwell	Advanced Information Analyst - NHS Delivery Unit
Hannah Garbett	Information Analyst - NHS Delivery Unit
Richeldis Yhap	Masters Student and person with lived experience (excluding visits to Cardiff and the Vale of Glamorgan University Health Board)
Heather Oram	Community Service Manager - Aneurin Bevan University Health Board (excluding visits to Aneurin Bevan University Health Board)
Maria Anderton	Head of Mental Health and Learning Disability Nursing - Swansea Locality - Abertawe Bro Morgannwg University Health Board (visit to Aneurin Bevan University Health Board only)

In addition to the DU review team an invaluable contribution was made to the assurance review by peer reviewers drawn from the HB and LA workforce.

Without the contribution from the peer reviewers the scale and quality of the assurance review would have been significantly diminished.

Acknowledgements

The NHS Delivery Unit would like to acknowledge the support received from the staff and management of Health Boards and Local Authorities in the preparation for and the carrying out of this assurance review.

The work of staff in these and third sector organisations added significantly to the quality of the review.

Particular gratitude is owed to the Service Users and their family members who gave of their time to participate in focus groups and to colleagues in the third sector who assisted in the organising, facilitation and participation in these focus groups.

Appendix 1: Schedule of Assurance Review Events

Hywel Dda University Health Board : 12/4/2017 – 26/4/2017		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	12/4/2017	-
Wellfield Road CMHT, Carmarthen	20/4/2017	30
Stakeholder, Service User and Carer Focus Groups (Mental Health)	20/4/2017	-
Morlais Ward, Glangwili Hosp.	20/4/2017	10
Aberaeron CLDT	21/4/2017	15
Stakeholder, Service User and Care Focus Groups (Learning Disability)	21/4/2017	-
Awel Deg CMHT, Llandysul	25/4/2017	30
Stakeholder, Service User and Carer Focus Groups (Mental Health)	25/4/2017	-
Llanelli CLDT	25/4/2017	15
Stakeholder, Service User and Carer Focus Groups (Learning Disability)	25/4/2017	-
Bro Cerwyn CMHT, Haverfordwest	26/4/2017	30
Stakeholder, Service User and Carer Focus Groups (Mental Health)		-
Tudor House, Assessment and Treatment Unit	26/4/2017	4
Senior Management Team Feedback	26/4/2017	-

Cwm Taf University Health Board : 15/5/2017 – 24/5/2017		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	15/5/2017	-
Merthyr Tydfil CMHT	17/5/2017	31
Merthyr Tydfil CLDT	17/5/2017	29
Acute assessment ward, Royal Glamorgan Hospital	18/5/2017	6
Hafod Y Wennol Assessment and Treatment Unit	18/5/2017	4
Service User and Carer Focus Groups (Mental Health and Learning Disabilities)	22/5/2017	-
Ty Draw CMHT, Pontypridd	23/5/2017	32
Service User and Carer Focus Groups (Mental Health)	23/5/2107	-
Rhondda Cynon Taf West CLDT	24/5/2017	24
Service User and Carer Focus Groups (Learning Disability)	24/5/2017	-
Senior Management Team feedback	24/5/2017	-

Powys Teaching Health Board : 30/6/2017 – 17/7/2017		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	30/6/2017	-
The Hazels Centre, Llandrindod Wells	03/7/2017	57
Ystradgynlais CMHT	04/7/2017	58
South Powys CAMHS	05/7/2017	21
South Powys CLDT	05/7/2017	14
Stakeholder, Service User and Carer Focus Groups (South Powys)	10/7/2017	-
Bro Hafren CMHT, Newtown	11/7/2017	60
North Powys CAMHS	12/7/2017	19
North Powys CLDT	05/7/2017	13
Redwoods Unit, Shropshire	13/7/2017	-
Acute IPU, Bronllys Hospital	13/7/2017	6
Stakeholder, Service User and Carer Focus Groups (North Powys)	14/7/2017	-
Senior Management Team Feedback	17/7/2017	-

Aneurin Bevan University Health Board : 16/10/2017- 13/11/2017		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	16/10/2017	-
Torfaen CMHT	17/10/2017	30
Talygarn Ward	17/10/2017	10
Ebbw Fach CMHT	18/10/2017	30
Carn Y Cefn Ward	18/10/2017	5
South Monmouthshire CMHT	19/10/2017	30
Stakeholder, Service User and Carer Focus Groups (Learning Disability)	24/10/2017	-
North Caerphilly CMHT	26/10/2017	31
Ty Cyfannol Ward, Ysbyty Ystrad Fawr Hospital	26/10/2017	10
Newport CLDT	27/10/2017	25
Assessment and Treatment Unit, Llanfrechfa Grange	27/10/2017	6
Goldtops CMHT, Newport	06/11/2017	30
Adferiad Ward, St Cadoc's Hospital	06/11/2017	10
Blaenau Gwent CLDT	07/11/2017	25
Caerphilly CLDT	07/11/2017	24
Stakeholder, Service User and Carer Focus Groups (Learning Disability	08/11/2017	-
Torfaen CLDT	09/11/2017	21
Monmouth CLDT	09/11/2017	20
Senior Management Team Feedback	13/11/2017	-

Betsi Cadwaladr University Health Board : 15/11/2017 – 21/12/2017		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	15/11/2017	-
Stakeholder, Service user and Carer Focus Groups, East (Mental Health)	20/11/2017	-
Wrexham CMHT	21/11/2017	30
Tryweryn Ward, Heddfan Unit, Wrexham Maelor Hospital	21/11/2017	8
Wrexham CLDT	21/11/2017	16
Pwll Glas CMHT	22/11/2017	30
Mold CLDT	22/11/2017	16
Assessment and Treatment Unit, Bryn y Neuadd Hospital	29/11/2017	7
Stakeholder, Service User and Carer Focus Groups, Central (Mental Health)	29/11/2017	-
Rhyl CMHT	30/11/2017	25
Acute Assessment ward, Ablett Unit, Ysbyty Glan Clwyd	30/11/2017	10
Rhyl CLDT	30/11/2017	15
Conwy CMHT	01/12/2017	30
Conwy CLDT	01/12/2017	15
Stakeholder, Service User and Carer Focus Groups, West (Mental Health)	05/12/2017	-
Ynys Mon CMHT	06/12/2017	30
Acute Assessment Ward, Hergest Unit, Ysbyty Gwynedd	06/12/2017	10
Ynys Mon CLDT	06/12/2017	16
Gwynedd CLDT	07/12/2017	16
Tremadog CMHT	07/12/2017	22
Senior Management Team Feedback	21/12/2017	-

Cardiff and Vale University Health Board : 26/2/2018 - 19/3/2018		
Team	**Date of Visit**	**No. of Records Reviewed**
Senior Management Team Interview	26/2/2018	-
Pentwyn CMHT	27/2/2018	30
Amy Evans CMHT	28/2/2018	29
Cardiff CLDT	05/3/2018	23
Rowan House, Assessment and Treatment Unit	07/3/2018	3
Vale of Glamorgan CLDT	09/3/2018	15
Gabalfa CMHT	14/3/2018	30
Stakeholder focus Group (Mental Health)	19/3/2018	-
Locality Wards, Hafan Y Coed Unit, Llandough Hospital	19/3/2018	10
Carer Focus Group (Mental Health)	21/3/2018	-
Service User Focus Group, Cardiff (Mental Health)	22/3/2018	-
Senior Management Team Feedback, Mental Health	23/3/2018	-
Service User Focus Group, Vale (Mental Health)	27/3/2018	-
Service User Focus Group (Learning Disabilities)	05/4/2018	-
Service User Focus Group (Learning Disabilities)	06/4/2018	-
Senior Management Team Feedback, Learning Disabilities	09/4/2018	-

Abertawe Bro Morgannwg University Health Board : 9/4/2018 – 26/4/2018		
Team	**Date of Visit**	**No. Of Records Reviewed**
Senior Management Team Interview	09/4/2018	-
Ty Einon CMHT	10/4/2018	30
Fendrod Ward, Cefn Coed Hospital	10/4/2018	10
Stakeholder and Service User Focus Groups, Swansea (Mental Health)	11/4/2018	-
The Forge CMHT	12/4/2018	30
Ward F, Neath Port Talbot Hospital	12/4/2018	10
Maesteg CMHT	13/4/2018	30
Ward 14, Princess of Wales Hospital	13/4/2018	10
Stakeholder, Service User and Carer Focus Groups, Neath Port Talbot (Mental Health)	16/4/2018	-
Stakeholder, Service User and Carer Focus Groups, Bridgend (Mental Health)	17/4/2018	-
Swansea CLDT	18/4/2018	20
Llwneryr Assessment and Treatment Unit	18/4/2018	4
Neath and Port Talbot CLDT	19/4/2018	28
Stakeholder, Service User and Carer Focus Group, Neath (Learning Disability)	19/4/2018	-
Bridgend CLDT	20/4/2018	13
Senior Management Team Feedback	30/4/2018	-

Total Number of Records Reviewed	**1436**

Appendix 2: Examples of innovative practice

Mental Health Services:

Example	Location
Crisis planning built around five senses	ABUHB
Service users and Transcend developed and produced training DVD	ABMUHB: Swansea Locality
CTPs well developed in context of acute inpatient care	ABUHB: Carn Y Cefn Ward, Ebbw Vale Hospital ABMUHB: Ward 14, Princess of Wales
Co-location of third sector within CMHT premises	Betsi Cadwaladr University Health Board (BCUHB)
Linkage with Nottingham University Recovery College	BCUHB: Rhyl CMHT
'One Stop Shop' aligned to GP Cluster	BCUHB: Wrexham CMHT
Third sector organisations supporting people to engage with CTP and discharge	Cardiff and Vale of Glamorgan University Health Board (C&VUHB): Sefyll, 4Winds, Mind in the Vale, Amy Evans CMHT
CTP review format aligned to areas of life	Cwm Taf University Health Board (CTUHB)
Multi agency CTP partnership group	CTUHB
Use of the traffic light caseload weighting "Matrix Tool" that informed supervision	Hywel Dda University Health Board (HDUHB)
Crisis plan providing detail of what support person can expect from services contacted during a crisis	Powys Teaching Health Board (PtHB)

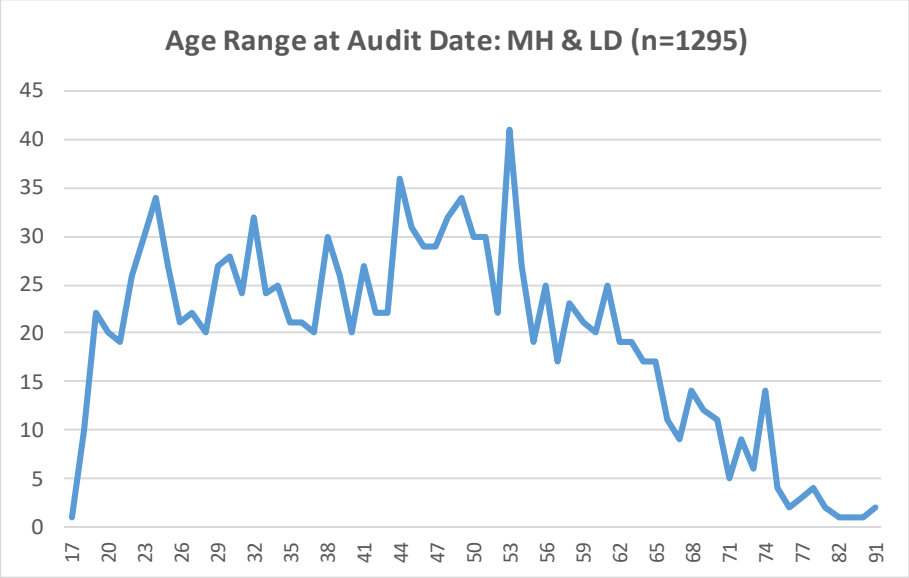
Learning Disabilities Services:	
Example	**Location**
Development of easy read tool for preparation of CTP	Aneurin Bevan University Health Board (ABUHB): Assessment and Treatment Unit
Team Network days to review CTP and case formulation	ABUHB
Fishbowl methodology to enable focussed MDT analysis of care planning	ABUHB: Blaenau Gwent CLDT
Regular use of LD relevant patient screening tool	ABUHB
Easy read toolkit developed by Speech and Language Therapist to encourage Service User engagement	ABMUHB: Neath and Port Talbot CLDT
Person Centred Planning and involvement in CTP	ABMUHB: Llyneryr Assessment and Treatment Unit
Good example of case manager linking CTP and CSP processes	ABMUHB: Bridgend CLDT
Training by Glyndwr University supporting SSWBA has positive impact in SMART care planning	BCUHB
Acorn team learning sessions aimed at quality improvement	BCUHB: Ynys Mon CLDT
Monthly CTP meetings chaired by the Care coordinator	BCUHB: Assessment and Treatment Unit
Active seeking of Service User feedback following discharge	C&VUHB: Assessment and Treatment Unit
Third sector support engaging and empowering Service Users	Advocacy Matters Wales, Sbectrwm / Vision 21
Caseload weighting tool	CTUHB: Merthyr Tydfil CLDT
Easy read CTP review to prepare Service Users to participate	HDUHB: Llanelli CLDT

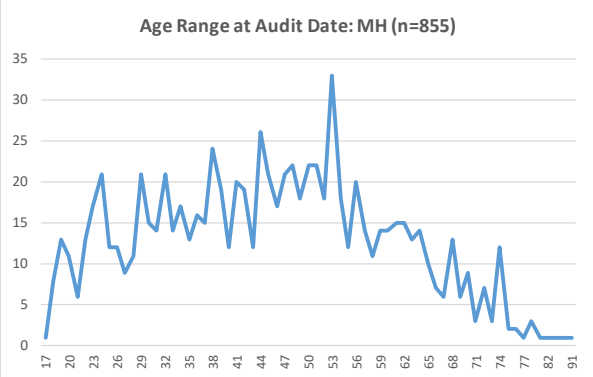
Appendix 3: Demographic information on audited sample

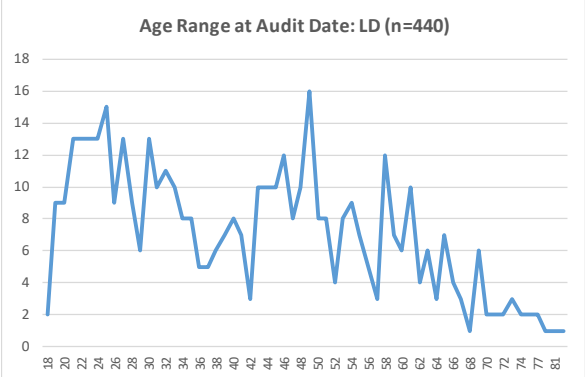
Age Range:

(There were 14 records where the DOB could not be found (8*CMHT; 6*CDLT)

Distribution of ages

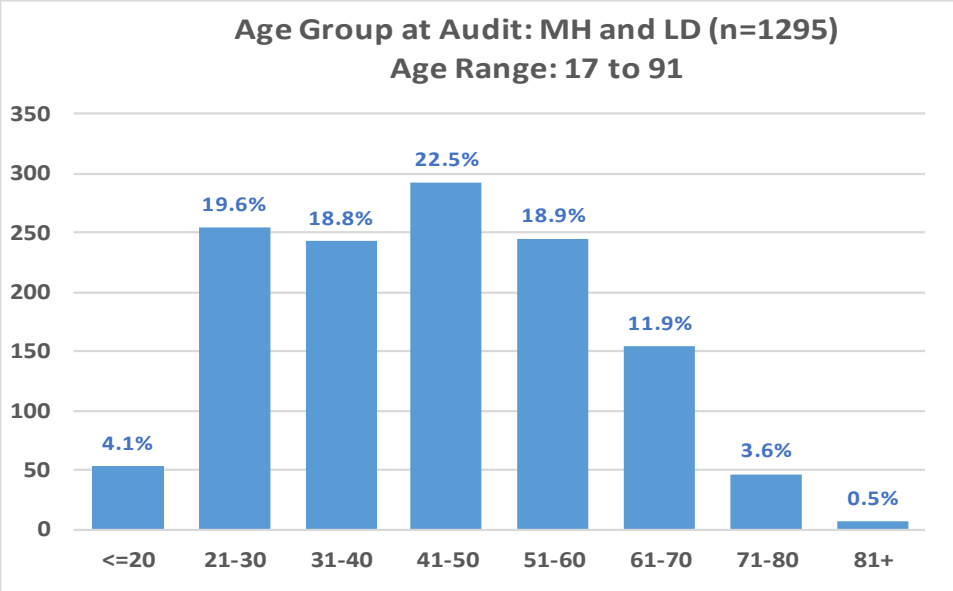




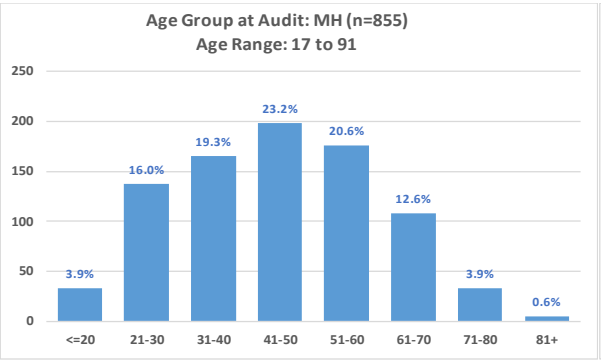


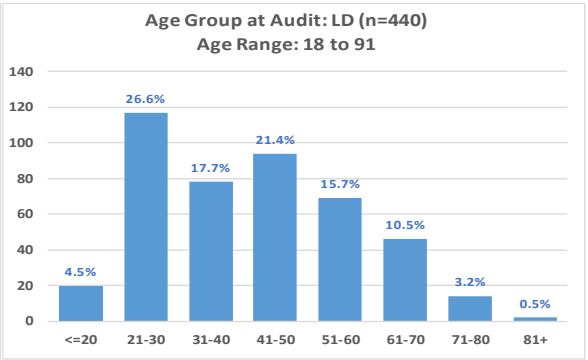
Age Groups

The population of Wales as a whole is 3,113,150 (mid-year 2016). The table below represents the percentages apportioned to each age group. The rise shown in the 51-60 group is reflected more in the 41-50 group in both MH and LD patients in the audit data.



All Wales % by age group	21-30	31-40	41-50	51-60	61-70	71-80	81+
	13.1%	11.4%	13.0%	13.4%	12.1%	8.3%	4.7%





Age Range and Gender