NHS

National Treatment Agency for Substance Misuse

Good practice in care planning

National Treatment Agency for Substance Misuse

July 2007

The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

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1 Executive summary

During 2005/06, the first joint Healthcare Commission and NTA substance misuse themed Improvement Review took place. The review assessed the performance of 149 local drug strategy partnerships against national standards and focused on two key areas: provision of community prescribing services, and care planning and co-ordination.

Eleven core criteria, made up of 33 questions, were developed and used to assess each DAT partnership's prescribing and care planning. Each criterion was scored on a four-point scale from "weak" to "excellent". Each drug action team partnership and mental health trust received a cumulative criteria score (to a maximum of 38) and an overall score between one and four. The Healthcare Commission have published the full national results – including overall score, total score and the scores for each of the 11 criteria – for every DAT partnership area in England.

After the scores were ratified, the main focus of the Improvement Reviews was to target the worst-performing areas to help them plan for improvement. However, the NTA also wanted to learn from the areas that scored well on care planning and prescribing. From these, it would be possible to learn about good practice in care planning and prescribing practice, and the factors in their local treatment systems that contributed towards making these areas perform well.

The NTA went through a process of identifying a number of areas that scored highest on care planning, and interviewed them about their practice. Across the interviews, a number of common themes were identified, which appeared to have contributed to effective care planning and prescribing. The interviews also enabled some case studies to be written on specific partnership areas that had features considered to be worth sharing as good practice examples.

From the interviewed areas, a number of factors believed to contribute to good performance on care planning were identified. At first, these factors may seem to be obvious things that all DAT partnerships and treatment services should be doing. However, given that one of the overall findings of Improvement Reviews was that care planning could be better and almost half of partnerships were "weak" on all service users having a care plan, many areas may not have even been doing the obvious. Therefore, most areas should be able to benefit from the findings set out in the report.

The factors we believe to have influenced good performance in care planning are summarised in sections 1.1–1.3.

1.1 Structures and systems

- **Treatment systems responsive to user needs**
  High-scoring areas included those that encouraged service users to remain in treatment by making it easier for them to re-enter treatment quickly if they dropped out of substitute prescribing or detoxification.
- **Good clinical governance and clinical leadership**
  All the areas interviewed reported that they had good clinical leadership from doctors with a strong commitment to good-quality drug treatment. They also reported strong clinical governance, with robust structures and key procedures, such as clinical audit, in place.
- **Effective local forums and meetings**
  Most DAT partnerships had a number of local forums and meetings in place which were thought to contribute to a "healthy" DAT partnership and had a positive impact on care planning (for example, shared care monitoring groups, joint commissioning groups and providers' forums).
- **Well-integrated criminal justice services**
  One common feature of all areas interviewed was criminal justice drug services that were well-integrated with drug treatment services. These services were sometimes run by the main drug service provider, or were well-integrated with the main drug treatment service providing prescribing and other local treatment agencies.
- **Good interface between community treatment and Tier 4 treatment**
  This was one of the weaker areas in care planning across the interviewed DAT partnerships, although there was some evidence of good practice.
- **Access to the full range of drug treatment services**
  Most areas stressed that in order for care planning to be comprehensive, properly client-centred and allow choice, there should be access for clients to the full range of drug treatment services, as described in Models of Care (NTA, 2006a).
- **Good information sharing protocols**
  Having good information sharing protocols that supported easy transfer of information between services seemed to help the care planning process in all areas interviewed.
- **Good systems for recording, sharing and monitoring care plans**
  All high-scoring areas pointed to good systems for recording and monitoring care planning. Some areas had moved fully or partially to computerised systems for recording care planning information.
- **Regular audits of care planning**
  All the areas interviewed carried out regular audits of care planning. Regular audit of care planning systems had helped to sort out discrepancies (such as variable quality of care plan completion) and identified shortcomings and issues that needed to be improved.

- **Integrated care pathways in place**
  Some areas had developed specific integrated care pathways linked to care planning. These care pathways were designed to help move clients through the treatment system, act as a guide to individual care planning and encourage inter-agency working.
- **Structural and historical factors**
  The success of some areas was thought to be related to factors unique to certain areas and non-transferable in terms of good practice, for example the way treatment systems had developed, the location and structures of treatment services, and whether there was one single large treatment provider.

1.2 Partnership working

- **Good relationships between commissioners and service providers**
  All of the areas reported that a key factor in their successful performance was a good relationship between commissioners and treatment service providers. This involved collaborative partnerships, with supportive commissioners and responsive services.
- **Good partnership working between drug services**
  All the areas reported good partnership working between all providers of drug services and a strong shared vision about how treatment should work locally, including care planning.
- **Good links with local partners responsible for wraparound services**
  All the areas had good links with other key local partners, providing wraparound services that drug users could access as part of their care plans. These services included housing, employment and social care. Some areas operate structures such as local forums or groups, consisting of a range of stakeholders, to encourage better partnership working.

1.3 Building good-quality drug treatment

- **Skilled and competent staff**
  It was considered vital that drug treatment services have a range of skilled and competent staff to deal with the range of issues that clients present throughout the care planning process. Most areas had trained new staff on care planning to ensure they had an understanding of care planning and a commitment to it.
- **Regular, performance-focused staff supervision**
  Directly related to the skills and competence of drug treatment staff is the importance of regular supervision between practitioners and line managers. This supervision (one-to-one and in groups) was underlined by most of the areas as being vital to enabling good-quality care planning.
- **A strong user involvement ethos**
  All the areas interviewed had a strong user involvement ethos, from strategic to practitioner level, and saw service user involvement as an integral part of the development of care plans, with clients as the central focus of care planning, review and ongoing treatment.
- **Local commitment to care planning**
  In all areas, there was a strategic commitment to care planning, with staff in management, the DAT partnership and other strategic positions committed to regular reviews. This included a commitment to care planning in primary care. This commitment was manifested in local systems set up to ensure that clients received good-quality care planning.
- **Keeping the care plan simple**
  A common feature was an expressed desire to keep the care plan simple. Keyworkers' reported aims were to start by tackling only a few of the main issues identified in a clients' assessments, with the intention of enabling clients to focus on their most important issues. Keeping the care plans simple also helps clients meet their goals and gives them a sense of achievement.
- **Rapid access to treatment**
  Most of the areas reported low waiting times for treatment. Although there was not thought to be a direct link between good care planning and short waiting lists, it was generally believed that they were both features of a good-quality treatment system.

2 Background

2.1 Joint Improvement Reviews

During 2005/06, the first joint Healthcare Commission and NTA substance misuse themed Improvement Review took place. The Healthcare Commission's Improvement Reviews look at whether healthcare organisations are striving to improve the care and treatment they provide to patients. The reviews focus on aspects of health and healthcare where there are substantial opportunities for improvement, and help organisations to identify where and how they can perform better. An Improvement Review involves two key areas of activity:

- A comprehensive assessment of the performance of each organisation taking part in the review
- Follow-up work targeted at those organisations deemed to be in greatest need of improvement.

The substance misuse Improvement Review (2005/06) assessed the performance of 149 local DAT partnerships against national standards and focused on two key areas:

- Provision of community prescribing services that provide specialised drug treatment, including planning of care and prescribing of drugs to treat drug misuse
- Care planning and care co-ordination – the processes that need to be in place to ensure that drug treatment services work together effectively to meet service users' individual needs

Within these two areas, the Improvement Review developed 11 criteria that are core to community prescribing and care planning. The criteria were developed in collaboration with a wide range of professionals (including service providers, service users, commissioners and other experts) and included access to community prescribing services, procedures to administer and manage the use of controlled drugs, and the involvement of service users in the planning of care and treatment. Thirty-three questions assessed how well local DAT partnerships performed against these criteria. Each criterion was scored on a four-point scale from "weak" to "excellent". This review was the first of three reviews of substance misuse to be conducted by the NTA and the Healthcare Commission, and its findings contributed to the Healthcare Commission's 2005/06 annual health check (an annual performance rating of each NHS organisation).

2.2 Care planning – criteria and scoring

There were 11 criteria developed for the Improvement Review on care planning and prescribing. Criteria 1–6 focused on community prescribing. Criteria 7–11 were developed for assessing care planning and were:

- Criterion 7: Service users are integrated partners in the whole treatment planning process and are fully informed about the range of treatment options, choices and access available
- Criterion 8: Service users have rapid, equitable and flexible access to an appropriate range of drug treatment services
- Criterion 9: Service users have a personalised care plan that incorporates a comprehensive assessment of their physical, psychological, social and legal needs and preferences
- Criterion 10: Service users pathways through treatment are clear, co-ordinated and continuous
- Criterion 11: Services have systems in place to minimise client "did not attend" (DNA) and dropout rates, and support clients being retained in treatment.

Within each criterion there were a number of questions, which contributed to the score for that criterion. Each DAT partnership and mental health trust received a cumulative criteria score (the maximum possible score was 38) and an overall score (from 1–4). The full national results, including overall score, total score and the scores for each of the 11 criteria, have been published for every DAT partnership area in England on the Healthcare Commission website www.heathcarecommission.org.uk.

2.3 Rationale for the briefing and methodology

An important part of the work of the Improvement Review was targeting the poorest-performing areas to produce action plans for improvement. When each DAT partnership area was scored (overall and total scores), the worst-performing DAT partnerships (around ten per cent) were targeted to receive additional help to improve the way they provide and commission drug treatment services. These areas had to produce a detailed action plan to demonstrate how they could improve the areas where they were rated as "weak". The NTA and Healthcare Commission provided resources to facilitate this process.

The NTA regional teams have used the results of Improvement Reviews to inform their work with local DAT partnerships, as part of their ongoing work of performance managing the partnerships through the treatment planning process. In particular, DAT partnerships that scored "1" for any criterion had to produce an action plan on how they were going to improve that area. These action plans were incorporated into the treatment planning process.

The NTA also wanted to take advantage of having identified those areas that scored well in the national benchmarking exercise – i.e. those that performed well on care planning and prescribing. From these it was possible to discern what good practice could be learned about care planning and prescribing practice, and the factors in the local treatment systems that contributed towards making these areas score highly.

There was a process of selection, which involved looking in more detail at the scores across and within the criteria for care planning and prescribing. This produced a shortlist of DAT partnerships, which were interviewed to obtain more information on their drug treatment systems and care planning and prescribing practice (for more information on these areas, and how they were selected see Appendix 2). There was a range of different partnerships – urban and rural, areas with well-established treatment services, those with newer services, areas with one main provider and others with a wide range of service provision.

The interviews were usually conducted with a range of key staff in the local drug treatment systems, including joint commissioning managers, DAT partnership strategy managers, clinical leads, other clinicians and service managers, and user representatives. The nominated NTA deputy regional manager for the DAT partnership was also interviewed. Most of the interviews took place with these key staff together, while some were carried out with individuals over the telephone.

Across the interviews, a number of common themes were identified that appeared to contribute towards effective care planning and prescribing. These are set out in section five of this briefing. There are also a number of case studies from specific partnership areas that have features and practices that were considered worth sharing as good practice examples.

3 Summary of the 2005/06 Improvement Review results

3.1 Results of the 2005/06 Improvement Reviews

The results of the Improvement Review showed that although the majority of local DAT partnerships scored "fair" overall, improvements could be made across all areas of community prescribing services, and care planning and care co-ordination.

A total of seven partnerships scored "excellent", 33 scored "good", 106 were "fair" and two were "weak". The highest total score by any partnership was 35 (out of 38) and the lowest was 15. Table 1 shows the distribution of overall scores and Figure 1 shows the distribution of the total scores across all DAT partnerships.

The scores demonstrated that there was scope for improvement, particularly in relation to the consistent use of care planning. All service users in structured treatment should have a comprehensive assessment of their needs and a personal care plan outlining the best course of treatment for them. The Improvement Review found that not enough service users had a care plan, with 48 per cent of local DAT partnerships being "weak" in this area, and 32 per cent scoring "fair". In particular, the level of risk assessment was low, with 70 per cent of partnerships scoring "weak" when assessing and managing risks for service users. Recent research (NTA 2006c) has confirmed that the satisfaction of service users is strongly linked to having an up-to-date care plan, which they understand and feel involved in, meets their individual needs and is reviewed regularly and as necessary. It is therefore crucial that services improve the way they explain and agree care plans with service users.

3.2 Details of results by care planning criteria

3.2.1 Criterion 7: Involving service users

This criterion was measured by rating providers' support for involving service users, the provision of information to them about the range of services available, service user involvement in treatment planning and delivery at a strategic level, the experience

	Local DAT partnerships		Mental health NHS trusts		Primary care trusts	
	Number	Percentage	Number	Percentage	Number	Percentage
1. Weak	2	1%	0	0%	6	2%
2. Fair	106	71%	34	61%	210	69%
3. Good	33	22%	21	37%	73	24%
4. Excellent	7	5%	1	2%	13	4%

Table 1: Distribution of overall Improvement Review scores across DAT partnerships

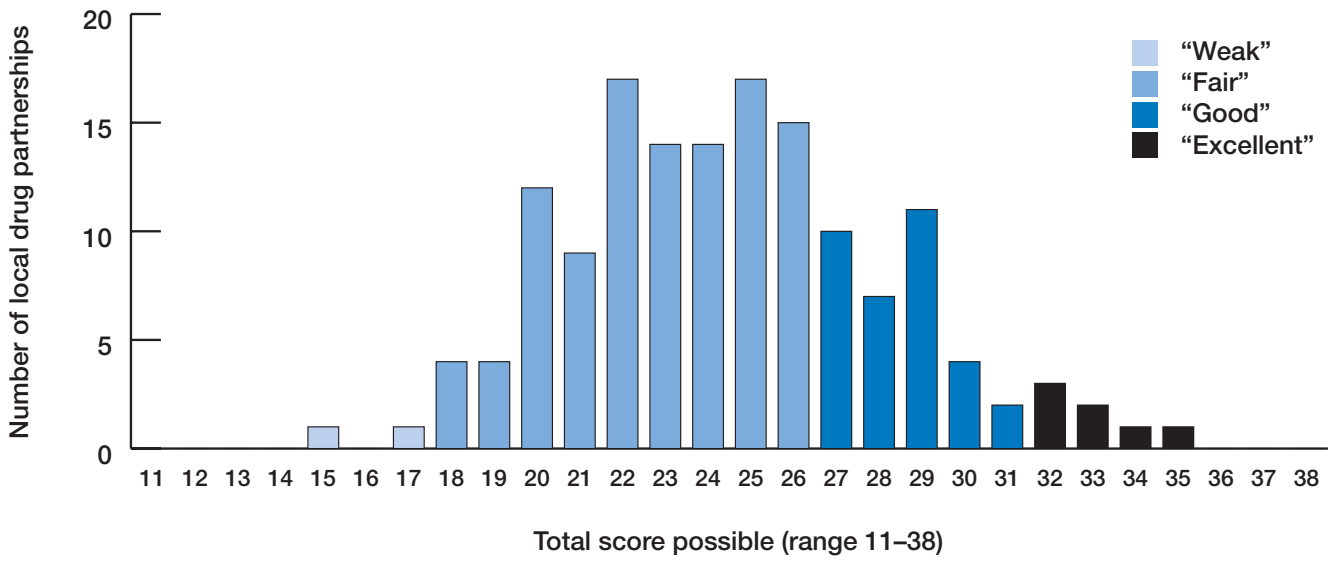

Figure 1: Distribution of scores across partnerships

of service users in having their views taken into account, and their involvement in care planning. The results showed that some systems are much better developed than others, with seven per cent of local DAT partnerships scoring "weak" but 37 per cent of partnerships scoring "good" or "excellent".

3.2.2 Criterion 8: Access to treatment

This criterion was measured by the length of time that people waited for access to drug treatment service interventions. It was also measured by the availability and accessibility of the full range of treatment options to the whole local DAT partnership population, as described in Models of Care (NTA, 2006) and reported in treatment plan returns produced annually by local DAT partnerships.

Performance statistics collected by the NTA show that average national reported waiting times for drug treatment in England have fallen from an average of 9.1 weeks in December 2001 to 2.4 weeks in September 2005. However, 66 per cent of local DAT partnerships had two or more interventions that were not meeting the target of a three-week waiting time. In particular, there was still a need for continued improvement, particularly around better access to residential rehabilitation and inpatient treatment services.

3.2.3 Criterion 9: Assessment and care plans

This criterion was measured by asking all structured community services to supply the documents they used for care planning, triage, comprehensive assessment and risk assessment. The documents were scored against a set of best practice expectations for comprehensive assessment and risk assessment drawn from national guidance. The score attributed to the local DAT partnership was based on the combined percentage across services. A score of "weak" was given if a combined percentage of less than 70 per cent of the standards were in place.

Fifty per cent of local DAT partnerships were scored "weak" and 23 per cent were scored "good" or "excellent" for comprehensive assessment. Seventy per cent of local DAT partnerships were scored "weak" on risk and 15 per cent scored "good" or "excellent" for risk assessment.

3.2.4 Criterion 10: Pathways through treatment

The measures used to assess this criterion were the existence of key policies to enable inter-agency working (such as information-sharing policies), personal experience of referrals to support services, (for example employment and housing), the existence of clear and appropriate protocols for care planning and care co-ordination across agencies, and how regularly care plans were reviewed.

The results showed that 15 per cent of the services did not have a policy to ensure that information could be shared, rather than repeatedly gathered from the same person. Thirty-six per cent of services did not have a policy on care co-ordination. Almost three-quarters of local DAT partnerships reported having excellent policies, which involved reviewing care plans within the first three months and at six-monthly intervals. However, over a third of people in structured services reported that they did not have a care plan (or didn't know if they did) and 32 per cent said that their care plan had not been reviewed in the last three months. The satisfaction of service users is strongly linked to having an up-to-date care plan, which they understand and feel involved in, meets their individual needs and is reviewed regularly

The results of the service users' satisfaction survey (NTA, 2006c) suggested a strong link between recent and regular reviews of care plans and user satisfaction.

3.2.5 Criterion 11: Did not attend (DNA)/drop-out system

This criterion was measured using nationally collected data on retention of service users in the local DAT partnership treatment system and successful discharges from treatment. (Successful discharge is defined as treatment completed, treatment completed drug-free, or being referred on.) There has been a national focus on increasing retention rates, which has led to vast improvements in this area, with 72 per cent of local DAT partnerships improving on the 2004/05 national average for retention. Nevertheless, there were still a minority (14 per cent) of local DAT partnerships that scored "weak" on these measures, performing worse in 2005/06 than the national average for 2004/05 and not showing significant improvement.

3.3 Recommendations for care planning from the 2005/06 Improvement Review

Specifically with regard to care planning, the recommendations made in the Improvement Review report were:

- All services review their assessment and care planning tools, making use of best practice guidance from the NTA
- All services ensure that they develop individual care plans for service users, involving them in the development and regular review of the plan. They should also ensure that the comprehensive assessment of each person who accesses treatment adequately covers any aspects of risk and looks at how these risks will be managed
- Service users and carers should be involved in all stages of the treatment process, including developing individual care plans, planning of new services, feeding back on treatment, and monitoring the quality of services.

Further information on the results of the Improvement Review can be found in Improving Services for Substance Misuse: A Joint Review (HC & NTA, 2006)

4 Factors influencing good performance in care planning

From the interviews with key contacts from selected DAT partnership areas, a range of qualitative information was gathered. There were recurring themes in these areas that were thought to have contributed to their good scores in the 2005/06 Improvement Reviews. These themes are described in this section.

4.1 Structures and systems

These factors are all related to specific structures and systems that the interviewed areas had in place. Some of these structures and systems were general and not directly related to care planning, while others had been set up with care planning improvement in mind. However, all of these were thought to have had a positive influence on care planning in these areas.

4.1.1 Treatment systems responsive to service user needs

Interviewees stressed the importance of treatment systems that put clients at the centre of treatment. For example, many of the areas interviewed stressed the importance of allowing people to re-enter drug treatment quickly after dropping out. The aim was to avoid "penalising" clients for dropping out and lengthy waits for clients re-entering the treatment system, which could lead to them disengaging from treatment altogether, or increasing their risks of drug-related harm.

It was reported that the level of re-assessment when clients re-entered treatment in these circumstances varied according to how long the client has been out of treatment. If clients were known to services and had been out of treatment for a short time, their original care plans could be used as the basis for further assessment, particularly as several factors remain consistent (for example, positive hepatitis C status).

In such areas, responsive treatment systems were designed so that clients could attempt detoxification with the explicit understanding that they could easily return to the maintenance programme if they failed. This was thought by some to lead to more clients attempting detoxification, particularly if they believed that they are not going to find it difficult to get back into maintenance treatment. Areas stressed that it was important to get clients stable and back on their prescriptions before addressing wider care plan issues.

Some areas also highlighted the importance of being responsive to clients starting treatment and gave the clients an initial care plan as soon as possible, often when they were still only accessing Tier 2 services. An initial care plan could be developed to facilitate preparation for structured treatment and to

understand client needs better, and could then be built on when clients started prescribing or other structured treatment.

4.1.2 Good clinical leadership

It was considered essential that treatment services within DAT partnership areas had good clinical leadership to provide effective treatment, including effective care planning. The areas that scored well in Improvement Reviews all had good clinical leadership with a strong commitment to good-quality drug treatment. Across the areas interviewed, features of good clinical leadership included:

- A clearly designated clinical lead or director (a consultant psychiatrist or other doctor) responsible for the strategic clinical development of the local treatment system. This also sometimes included developing local clinical guidelines for drug treatment involving prescribing interventions. The lead doctor would usually be supported by other key doctors and other medical staff as appropriate
- Although there was a clear overall clinical lead, all the lead doctors from different services or parts of the treatment system worked closely together within a defined structure. This often meant regular meetings to discuss strategy and development.
- Within the structures there were different reporting mechanisms for all the doctors working in substance misuse treatment. Clear policies and procedures had been agreed to ensure that treatment services ran consistently well.

Some areas had worked hard to attain good clinical leadership where it had been lacking in the past and had seen marked improvements as a consequence. Some partnerships had made an effort to invest in clinical teams to build capacity for the future. In other areas, strong clinical leads had led to a marked increase in GP involvement in primary care drug treatment. It was believed in most areas that good clinical leadership had contributed to scoring highly on care planning.

4.1.3 Good clinical governance

All the interviewed areas also pointed to good clinical governance structures, which were thought to help overall service cohesion and performance. These included:

- Robust local governance structures (usually the clinical governance arrangements for the mental health trust) applied to drug treatment services. This included adoption of the "seven pillars of clinical governance" in some areas.
- Arrangements such as regular meetings of clinical leads and other clearly defined meeting structures across different levels of management in the trusts, to manage clinical governance issues, clinical guidelines and protocols
- Linking up the different existing clinical governance frameworks, usually between mental health trusts and primary care trusts, to ensure consistency
- Having a clinical governance framework specifically for substance misuse in line with Standards for Better Health (DH, 2004; see Appendix 1, section 6.3).

Clinical audit

An important part of clinical governance is clinical audit, which is particularly relevant to care planning. In the areas interviewed, this involved a range of approaches including:

- Substance misuse services being audited as part of trust-wide audits, or targeted specifically
- Regular audits of all types of drug treatment (for example, every three months)
- Internally and externally run audits, and a peer audit approach where a treatment service from a particular area is audited by trust staff from other areas
- Reviews of the whole local treatment system
- Learning lessons from investigations into serious and untoward incidents.

Audits could be large or small, as appropriate (for example, audits on staff caseloads and spot checks on case files), and were carried out by different people depending on what was being audited.

The results of these audits were generally presented to a range of audiences including commissioners, the joint commissioning group, the primary care trust (PCT) and drug services, and acted upon appropriately.

Se section 4.1.10 for further information on care plan audits.

Supervision

Another important part of clinical governance relating to care planning was reported to be clinical supervision. The better-performing areas ensured that all drug treatment staff had regular supervision where their practice was reviewed and monitored by their clinical supervisor or manager. This was usually done by looking at a selection of client case notes or care plans. There was a focus on performance monitoring of staff members, as well as providing information to support them with particular parts of their work (for example, working with difficult clients). There is more information on staff supervision in section 4.3.2.

For further guidance on clinical governance in drug treatment service, see the briefing Clinical Governance in Drug and Alcohol Treatment (NTA, forthcoming).

4.1.4 Effective local forums and meetings

Most partnerships had a number of local, formal forums and meetings in place which, when they functioned well, were believed to contribute to a "healthy" DAT partnership and have a positive impact on care planning. These included:

Clinical governance groups that took different forms, depending on the area and the trust. All featured regular meetings to ensure that clinical governance was being applied. Most had a higher-level group with senior staff from different sections of the trust, while others had different levels of governance groups under the senior one. Some areas had substance misuse-specific groups looking at governance, linked to the joint commissioning group and the shared care monitoring group

All areas had shared care monitoring groups (SCMGs) and a number of these incorporated governance issues. They mostly met quarterly and generally comprised local senior doctors (often psychiatry consultants and GPs involved in shared care), shared care staff, and representatives from the PCT, local pharmaceutical committee and the DAT partnership.

- Joint commissioning groups were responsible for the commissioning of all local substance misuse services and were made up of representatives from the DAT partnership, PCT, local authority and criminal justice bodies. Some areas had sub-groups feeding into the JCG or other linked groups for consultation and implementation
- Providers' forums took various forms, some of which were for networking, consultation, information sharing and promoting joint working. Others were in place to help to develop the treatment plan and to feed local information to the DAT partnership or joint commissioning group. Some of these groups were focused on specific issues such as housing and young people's services.
- Other groups were also reported, such as forums for sharing good practice, information sharing and treatment audits, service user groups and pharmacy-related groups (for example, working with local pharmacists on training issues).

These groups and forums had a greater or lesser specific focus on care planning depending on the area and local priorities – for example, there was generally more focus on care planning for substance misuse in the providers' forums and the joint commissioning groups. However, across the interviewed areas, all these local structures were thought to be positive factors in their treatment systems, helping to improve a range of issues including care planning.

4.1.5 Well-integrated criminal justice services

One common feature of all areas interviewed was criminal justice drug services that were well-integrated with drug treatment services. These services were sometimes run by the main statutory drug service provider, or were well-integrated with the main prescribing service and other local treatment agencies.

With regard to care planning, all areas ensured that Drug Interventions Programme (DIP) clients were subject to the same standard of assessment, care plans and clinical systems as non-criminal justice clients. All the services involved in the criminal justice system worked well together. The interviewed DAT partnerships were keen to stress that the same clinical governance arrangements applied to all clients, including DIP clients, and all service users should get the same quality of treatment and care planning.

Some areas had found that locating criminal justice drug services and treatment services in the same building helped integration and joint working processes.

4.1.6 Good interfaces between community treatment and Tier 4 treatment

One of the weaker areas in care planning across the interviewed DAT partnerships seemed to be the interface between community and Tier 4 treatment (inpatient treatment and residential rehabilitation). Not all areas had managed to implement an effective system for care planning the transition to inpatient treatment, residential rehabilitation and beyond into aftercare, although there was some evidence of good practice in this area. This included:

- Clients only being referred to residential rehabilitation if there was a care plan that identified the need for rehabilitation and that also showed aftercare clearly set out in the plan
- Assessments for residential rehabilitation carried out by skilled and competent staff. If funding was provided through community care, the community care assessment team either had dedicated substance misuse resources or conducted the assessment in conjunction with the local community drug team
- When clients went to Tier 4 treatment, their care plan would be passed to the staff at the Tier 4 service, who would use the care plan to build on the residential treatment component for the duration of their stay. During this time, particularly if the client was in residential rehabilitation that involved a longer stay, the case would continue to be held at the community service. Clients were often visited or contacted by their community keyworker or care manager, who was involved in reviewing the care plan and resettlement plan when the client left the treatment centre
- Care plans were developed while clients were in Tier 4 treatment, so that they would be supported though detoxification, residential rehabilitation and on into aftercare. This was handled by either the social services care manager or the original community drug team keyworker, but it was

thought to be essential that someone took specific responsibility for the aftercare

4.1.7 Access to the full range of treatment services

Most areas stressed that in order for care planning to be comprehensive, properly client-centred and allow choice, there should be access for clients to the full range of drug treatment services. All DAT partnerships may claim to have access to a full range of services, but on closer inspection this is often not straightforward. Some areas have limited access to some service types, particularly Tier 4 services. This was even evident in some of the areas interviewed, which had scored well on care planning.

As always in drug treatment, client choice in treatment was thought to be important and needed to be balanced against assessed need. Sometimes, access to the full range of services was affected by issues that were reported to be beyond the control of the DAT partnership. This may be particularly relevant to rural areas with relatively poor transport links, and this was seen in some of the areas interviewed. However, there were examples given of attempts by DAT partnerships to overcome this kind of difficulty, for example using locally based clinics with outreach services, better use of primary care drug treatment in areas that had no local specialist service, and using a mobile needle exchange.

4.1.8 Good information sharing protocols

Having good information sharing protocols that supported easy transfer of information between services seemed to help the care planning process in all areas interviewed. Some areas had worked on agreeing information sharing protocols and systems across local partnerships, and making them work. In areas with only one main service provider, there were no issues with inter-agency information sharing and confidentiality. Other areas with more than one main provider had usually worked hard to consult on and produce information sharing policies across all the services working with drug users. This did not always mean that services shared the same policy, but there were agreements on what information could be shared with the client's consent. Staff from individual services worked closely to develop good working relationships to make the transfer of client files and information easier and safer.

Good information sharing protocols were generally thought to have helped the care planning process to be smoother and prevent the hold-ups and misunderstandings that might have arisen if all the relevant information for the client was not available to practitioners and keyworkers in different agencies. Furthermore, the introduction of an information sharing system helped the development of consistent forms in some areas, which in turn led to more effective care planning.

4.1.9 Good systems for recording, sharing and monitoring care plans

All areas that scored well in the 2005/06 Improvement Reviews had good systems for recording and monitoring care planning. Even some areas that were not entirely satisfied with the quality of their care planning pointed to their systems as making a significant contribution to their high scores.

Some DAT partnership areas had moved fully or partially to computerised systems for recording care planning information. One DAT partnership that had made a successful transfer to an electronic care planning system described the system (see case study 5.3 for more details) as being integral to their care planning performance. This system was in place in treatment services throughout the area, enabling treatment staff to have access to clients' care plan information from different sites, making it easier to have access to information about the client and reducing the need for staff to carry sensitive client information between services.

Having different caseloads for different levels of need helped services in the interviewed areas focus and clarify appropriate referrals, and as a consequence improve care planning. Clients would be assessed as having a particular level of need, and would be allocated a keyworker with the skills and competence to be able to work with them effectively. This type of caseload system was also used to ensure that keyworkers had a mix of clients with different levels of need.

Computerised care planning systems were again found to help with this type of case management, by allocating clients to the most appropriate caseload. An example of a computerised case management system is set out in case study 5.3. This type of system operates from assessment through to care plan reviews, and prioritises client need by a system of scoring. The system is standardised but is not rigid and allows keyworkers flexibility in working with clients across a range of different treatment interventions.

Other DAT partnerships had implemented less technical systems, such as an agreed area-wide assessment system and care plan structure. In some cases, this also involved client information, care plans and other related paperwork being shared between different provider agencies. In DAT partnerships where care plans were not fully shared, individual agencies retained their own care plans for each client, but clients had documents that summarised the care plan that they can share with other agencies for information.

These systems allowed care planning information to be recorded and care plans and caseloads to be monitored.

All the DAT partnerships interviewed had care plans routinely monitored through staff supervision, with line managers checking care planning quality with practitioners.

4.1.10 Regular audits of care planning

All the DAT partnerships interviewed carried out regular audits of care planning in at least some of their services. It was reported that regular audits of the care planning system had helped to sort out discrepancies, including variable quality of care plan completion, and identified shortcomings and issues that needed to be improved. Services were then able to take the necessary actions to improve their care planning. These audits were usually done differently in each DAT partnership and included the following types:

- A specific annual audit of the local treatment system. The audit looks at different issues each year, but care planning has been a consistent theme. Where care planning was found to be lacking, services had to produce action plans to improve it. This has led to a marked improvement in care planning across DAT partnership areas. (See case study 5.1 for more details.)
- Regular clinical audits in the local NHS mental health trust directorate. Some DAT partnership areas used a team responsible for audits in NHS trusts, which covered care planning in drug treatment
- Some issues, such as serious and untoward incidents – for example unexpected death and drug errors – can trigger reviews. Some DAT partnership areas reported that if this happened, the care plans were audited for issues that may not have been picked up in care planning. These types of reviews would usually be covered by the mental health trust governance system
- Some services, including voluntary sector services, carried out other locally focused and arranged audits, such as peer audits and QuADS audits, on services in their organisation or DAT partnership area, in collaboration with local substance misuse commissioners.

4.1.11 Integrated care pathways in place

Some of the DAT partnership areas interviewed had developed specific integrated care pathways linked to care planning. These care pathways were designed to help move clients through the treatment system, into other parts (for example, shared care and structured day programmes), act as a guide to individual care planning and encourage inter-agency working. Some DAT partnership areas reported that clients' care plans would reflect a specific care pathway, but this may change depending on what is agreed at care plan reviews. Smooth passage through care pathways was helped by having low waiting times or having clients allocated to the most appropriate caseload when they enter treatment.

4.1.12 Structural and historical factors

The success of some DAT partnership areas was thought to be related to the way treatment systems had developed. Effective care planning was considered to have been helped by factors unique to areas and non-transferable in terms of good practice. These factors were usually related to the location and structures of treatment services and included:

- Areas that had single large statutory service providers, which simplified issues such as governance, information sharing, policies and procedures, computerisation and joint working
- DAT partnerships that shared boundaries with PCTs and mental health trusts were thought to have an advantage, because they had common care systems, policies and procedures
- Well-established local drug treatment systems (providers and commissioners), with a tried and tested history of responding to drug problems in the area that worked with other agencies across the partnership.

Although some DAT partnership areas with one main service provider scored highly in the Improvement Review, this did not mean that areas with a wide variety of different service providers did not do well. Case study 5.5 looks at one DAT partnership with a wide diversity of provision which performed highly on care planning.

4.2 Partnership working

The following factors are all concerned with partnership working of different types between service providers and other stakeholders in drug treatment, and how these partnerships were believed to have helped to improve care planning.

4.2.1 Good relationships between commissioners and service providers

In all of the DAT partnership areas interviewed, a key factor in their successful performance was thought to be a good relationship between the commissioners and the treatment service providers. At a basic level, this meant that the treatment services and their staff were well known to the commissioners. It also meant a collaborative partnership between the commissioners and the providers, with the commissioner being supportive rather than confrontational and the services being responsive. This relationship was thought to be critical to the health of the local treatment system and areas thought that the development and maintaining of good relationships was the responsibility of commissioners and providers. The areas interviewed also reported that they had stable funding structures and that services usually received appropriate funding.

4.2.2 Good partnership working between drug services

All the interviewed DAT partnership areas reported good partnership working between all the providers of services to drug misusers. These included partnerships between the providers of drug treatment services as well as providers of other related services such as health, social care, housing, education and employment.

There was usually a strong shared vision about how treatment should work locally, including a vision for effective care planning. There was a commitment to partnership working at a strategic level (DAT partnership and service management) that translates through to close collaboration at the practitioner level. Sometimes, this was facilitated by regular meetings at senior management and DAT partnership levels, and forums at a practitioner level.

Many of the areas had good partnership structures or inter-agency forums in place to facilitate effective joint working, including working together on care planning. Some areas had less formal structures or systems for care planning, but still had close working between agencies with good knowledge of clients in the area.

As well as the structures for partnership working, the areas had effective processes in place that worked well. Even in areas with less formal structures to facilitate partnership working, there were established relationships that enabled different agencies to work together. This was particularly relevant in the areas with treatment systems that had been in place for a long time. In these areas, there was a long history of individuals and services working together, and informal structures for joint working and inter-agency liaison.

Part of the effective partnership working was good co-ordination of keyworking and case management. In some areas, this included the following:

- Organisations providing drug treatment having a joint care co-ordination protocol that all agencies have signed up to
- Local service practitioners meeting regularly, formally or informally, to discuss case issues and plan care co-ordination
- Sharing buildings helped with partnership working, as informal liaison outside of meetings could happen on a more regular basis and workers were able to build up good relationships with each other more easily
- As well as structures such as meetings and joint protocols, processes to enable better communication between different treatment providers were also in place to enable good partnership working.

4.2.3 Good links with local partners responsible for wraparound services

All the interviewed DAT partnership areas had good links with other key local partners, which although they were not directly involved in drug treatment, were nevertheless significant because they provide important wraparound services that drug users could access as part of their care plans. These services included housing, employment and social care.

Some areas operated structures such as local forums or groups – consisting of stakeholders including service providers, housing services, agencies involved in training and education (such as Progress2Work) and the police – to guide development of these wraparound services for drug users. The forums also encouraged better partnership working.

These areas also had processes in place for engaging these local partners. This included regular meetings, as well as personal contacts built up by DAT partnerships and treatment staff across DAT partnership areas.

There were examples of good links with local supported housing teams. If housing was a particular issue for some service users, ways were developed to facilitate access to housing and provide a direct route in for clients. These housing access issues would be included in the clients' care plans. One example is an area where part of the local council supported housing team is seconded to the drug service, so they are managed and supervised by the treatment service manager. These housing workers advocate on behalf of the client.

These wraparound services can also include organisations providing social activities, which may be incorporated into some clients' treatment or care plans. Examples include sports and fitness facilities, and – in one area – art and culture schemes brought in from the local authority.

4.3 Building good-quality drug treatment

The following factors are grouped together as they are all important in building good-quality drug treatment. Issues such as staff competence, the importance of good-quality care planning and waiting times have all been issues on the NTA's agenda in recent years in the drive to improve the quality of drug treatment in England.

4.3.1 Skilled and competent staff

It was considered vital that drug treatment services had a good range of skilled and competent clinical and non-clinical staff, to deal with the range of issues that clients present to drug treatment with, as part of the ongoing care planning process.

With regard to care planning, the most effective teams were reported to be multidisciplinary ones that brought a range of different skills to deal with a range of problems. It was considered

important that clients' needs were fully addressed in the care plan, across the four domains, and that the approach used is not just "medical" or "social". There was a recognised need to have a good range of resources (including medical, psychosocial, general healthcare and other social support) available in each DAT partnership area to deal with the most complex of cases.

Local services found that the various skills and competences of the staff should be taken into account when allocating caseloads. Some areas had implemented systems for managing caseloads and appropriately allocating clients to the most suitable caseload according to levels of need after assessment. It was reported that these systems also helped to ensure that workers didn't have too many clients on their caseload, an uneven mix of clients, or clients they didn't have the skills to deal with.

Most areas had trained all new staff on care planning as a matter of priority to ensure they had an understanding of care planning and a commitment to it at the outset. Other areas identified training issues for existing treatment staff, so that poor care planning practice could be improved.

Staff retention also seemed to be important. One of the success factors in a number of areas was thought to be consistency and stability in staffing. This was particularly evident when clinical leads had been in place for a while and were known and respected by the local treatment staff. There were a number of examples where established staff had built up good working relationships within and across treatment services, and developed knowledge of and respect for fellow professionals. This also enabled clients to see the same practitioners and build up longer-term relationships with them – an important factor in their engagement and retention in treatment.

4.3.2 Regular, performance-focused staff supervision

Directly related to the skills and competence of drug treatment staff is the importance of regular supervision between practitioners and clinical supervisors or line managers. This was underlined by most of the DAT partnership areas interviewed as being vital to enabling good-quality care planning.

Supervision was reported to take place both in groups and in one-to-one supervision sessions. The group supervision happened at team meetings, where particular and problematic cases were discussed, and peer support was available. These types of meetings were more task-focused.

The areas interviewed consistently described good-quality supervision as consisting of one-to-one sessions between manager and keyworker and being concerned with performance monitoring of the staff member, as well as their development and providing support with particular parts of their work (such as working with difficult clients). As part of each supervision session, the supervisor would look at a selection of the keyworkers' care plans or case notes, and discuss individual cases – this is to support the worker and to assess the quality of care planning. If a manager feels that the care plans are not sufficiently good enough, there are normally policies and procedures or competence frameworks in place to address this, which usually involve specific training on care planning to help staff improve. One area commissioned a programme of care planning training and monitored the effectiveness of that training.

4.3.3 A strong user involvement ethos

All the DAT partnership areas interviewed had a strong user involvement ethos, from strategic to practitioner level. The areas that scored well in the Improvement Review saw service user involvement as an integral part of the development of care plans, with the users as the central focus of care planning, review and ongoing treatment. All areas stressed how important it was that the care plans were written with the service user and that they were partners in planning their care. This is a key factor and emphasis of the NTA's Care Planning Practice Guide (see Appendix 1, section 6.4 for more details). Some areas had care plan audits where service users have clearly said that they were involved in writing the care plans, that users were aware that they had care plans and that they understood the purpose of having one.

In some areas, this emphasis has been helped by active service user groups and some DAT partnerships have employed service user co-ordinators or equivalent. One of the functions of these posts has been to raise awareness among service users and user groups about care plans, and raise expectations among users that they should have them. In one partnership, the co-ordinator had been speaking to clients in waiting rooms about care plans, and together with the users group also produced a laminated information sheet so that service users knew about care plans and their right to have one (see case study 5.2 for more details).

One DAT partnership had involved user forums to help with feedback about drug treatment. Another way for services and DAT partnerships to get useful user feedback, as reported by some interviewed areas, is through the standard complaints procedures that should be in place in all drug services. In these areas, these procedures were backed up by a genuine commitment to act to resolve complaints and their ultimate aim was to help improve services, as well as resolve any individual client issues with the service.

Many areas stressed that in addition the users' rights and the need to involve them centrally in treatment, services also need to be clear with the user about their responsibilities to the keyworker and treatment service – for example, making sure they are aware of how often they must attend.

4.3.4 Local commitment to care planning

In all interviewed DAT partnership areas, there was a local strategic commitment to care planning across agencies, with staff in management, the DAT partnership and other strategic positions committed to clients having a care plan that was regularly reviewed. This commitment was manifested in local systems that had been planned strategically and set up to ensure that clients receive good quality care planning. This often involved local target setting on care planning.

The national target is that by 31 March 2008, 95 per cent of all clients in drug treatment will have an identifiable written care plan that tracks their progress and is regularly reviewed with them. However, many DAT partnerships, including many of those interviewed, had set themselves targets of everyone in treatment getting a care plan, and recording and monitoring that this happens.

As well as a commitment at strategic level, there was also a commitment at practitioner level to care planning and care plan review for all clients. Areas that performed well on care planning developed a strong culture of ensuring that all clients had care plans, recording this and making sure that the plans were reviewed regularly. It was reported that staff generally believed that assessment and care planning were not one-off processes, and that these should happen throughout the treatment journey. This staff commitment was usually built through the staff supervision structures, and provision of training where required.

Building this commitment was not always easy. In some areas there was reported initial resistance to increased paperwork, but through information, training and supervision, the people leading the drive to improve care planning enabled treatment staff to more clearly link assessment and care planning and underpin their practice. In doing this, they have been able to help providers and practitioners to more fully embrace care planning as an essential part of their ongoing client work. Where staff competence and commitment to care planning have been issues, some DAT partnerships commissioned specific training to increase the skills and motivation of service staff. In particular, some areas found it useful to emphasise, through information and training, the finding from the NTA user satisfaction survey that there was a link between clients having a regularly reviewed care plan and their satisfaction with treatment. This, along with other improvements focused on client-centred treatment, has helped to demonstrate that consistent care planning and review were always done with the service user's benefit in mind.

Audits of care planning had also been helpful in giving evidence of lack of good-quality care planning to highlight weak areas and therefore demonstrate to service managers the need for change and improvement, and show exactly which areas needed to be improved.

In some areas, the challenge to services' commitment to care planning has been reinforced by service user representatives. They have been actively working with services – for example, through user groups and talking to clients in clinics – to ensure that clients know they should have a care plan they are involved in writing and reviewing, and that services make sure this happens.

As well as a commitment to care planning, it was thought to be important that keyworkers enter the correct data relating to care planning into the case management system. There were a number of examples of a partnership's NDTMS (National Drug Treatment Monitoring System) data incorrectly recording a lower percentage of people with care plans than actually had plans in place.

4.3.5 Commitment to care planning in primary care

All the DAT partnership areas interviewed showed a real commitment to the implementation of shared care services across the DAT partnership area. This ranged from Wirral, which had 100 per cent coverage, to areas with a less GP involvement in primary care drug treatment, but still meeting targets for shared care coverage.

There was also a commitment to effective care planning within shared care. However, there was a variety of methods used for care planning and keyworking with clients in primary care drug treatment. In most of the areas interviewed, the keyworkers from the specialist services were the ones who drew up care plans, reviewed them, and were responsible for the ongoing keyworking with the clients. However, in doing this they liaised very closely with the GPs and GPs with special interest (GPwSI) in the area.

Other areas had more direct involvement from GPs in the care planning process, with GPs as keyworkers or managing clients with the support of keyworkers. The keyworkers would also liaise with the substance misuse nurses as part of the care planning process. The GPs would usually deal with their clients' general health issues as well as their drug-specific problems, as part of their ongoing healthcare and care planning.

4.3.6 Keeping the care plan simple

One of the common features of the well-performing DAT partnership areas was an expressed desire to keep the care plan simple. In these areas, many keyworkers' reported aims were to start by tackling a few of the main issues identified in the comprehensive assessment. The intention was to enable the client to focus on their most important issues, to keep the care plan simple, to help clients meet their goals and to give them a sense of achievement. This was found to help increase self-efficacy and empower clients to address the other issues in their care plans.

Nevertheless, all the areas interviewed considered conducting a comprehensive assessment and identifying issues across the four main domains (drug and alcohol use, physical and psychological health, offending and social functioning) as being essential. This was found to help raise practitioners' awareness of a number of drug-related issues and identify the wider range of health and social needs in addition to the clients' more obvious drug use problems. These needs could then be tackled incrementally, with the most pressing needs seen to first. The most important issue was generally considered to be getting an opiate-misusing client stable on prescribed medication, after which their wider range of needs would be addressed.

In all this assessment work, all the areas stressed that the process should be client-led. They thought that it should be the client, guided by the keyworker and other appropriate drug treatment staff, who should be making the choices about what are the most important issues to tackle in the care plan.

Some areas have used pictorial or diagrammatic care plans, which have helped clients to visualise the treatment process more clearly and therefore understand it better (see case study 5.4).

4.3.7 Rapid access to treatment

Most of the DAT partnership areas interviewed reported low waiting times for treatment. Although there was not thought to be a direct link between good care planning and short waiting lists, it was generally believed that they were both feature of a good treatment system. DAT partnerships had worked hard to improve their treatment systems, and focused on care planning, it was no surprise that the waiting times were also low. Furthermore, rapid access for clients was viewed by some as important in helping to engage clients in drug treatment and therefore assist client involvement in care planning in some areas..

5 Good practice in care planning – case studies

5.1 Devon

5.1.1 DAT partnership clinical lead post

Devon Drug Action Team has created a post of clinical lead, who sits on the DAT partnership and provides clinical knowledge and expertise, and a direct link to the treatment providers. This person leads on a range of clinical and related issues across the DAT partnership, including quality issues, care planning, the GP shared care scheme, needle exchange, drug-related deaths and clinical governance. In addition to these, one of the main functions of the post is to lead an annual peer audit of drug treatment across the county. Another role is to agree funding for residential rehabilitation treatment.

5.1.2 Care plan audit

Devon DAT conducts an annual peer audit of its drug treatment services, in partnership with Torbay DAT, so the audit covers both DAT partnership areas. It operates on the basis of peer audit and the Devon clinical lead, along with a colleague from Torbay, leads the audit. Six volunteers undertake each service audit, including two from the service being audited and two from other services (usually one from the statutory service and one from the voluntary sector service).

The first peer audit was done nearly four years ago. For this audit, some basic data collection identified some key themes, which included care planning, waiting times and time in treatment. The audit is now carried out annually. An early audit highlighted the poor quality of care planning, so it was decided that a specific audit was needed. Therefore, care planning has been a theme of the audit for three years.

The DAT partnership has developed a template for the audit and developed standards and protocols for each of the audit themes. Evidence for the care planning part of the audit came from case-notes, policies and procedures, staff questionnaires, service user questionnaires and focus groups. Devon has worked closely with Torbay to develop the template and questionnaires and have undertaken the audits together.

The themes for the audit each year are usually a combination of identified local priorities and national priorities (for example, linked to NTA initiatives and the joint NTA and Healthcare Commission Improvement Reviews). The DAT partnership decided on service user and carer involvement, harm reduction, care planning (care co-ordination and case note review) and workforce development as the key themes. These themes were then taken to the management of each of the treatment agencies in Devon to be discussed. One encouraging aspect of this process was that the

views of treatment staff were broadly in agreement with those of service users.

Each year, as a result of the audit process, the treatment services produce action plans to improve the areas where they only partially met the requirements. Service providers report that they have found the audit "a useful learning process" rather than "a rigid 'inspection' process". The audit is intended to be robust but supportive and has enabled services to focus on the important improvement issues, and identify the things that need to be changed (for example, improving the quality of client case notes).

Another result of the audit is that it has helped to get the message through to all treatment staff, that assessment and care planning are not a one-off process, and should happen throughout the treatment journey.

The audit has helped to identify staff training needs for care planning, which the DAT partnership is addressing by putting together a specific training package to address these needs.

5.2 Cheshire

5.2.1 User involvement

Cheshire DAT has put a strong emphasis on the importance of user involvement in treatment. It aims to help service users to understand the process and purpose of drug treatment, what the service and keyworker will do for them, and what their responsibilities are.

The DAT partnership employs a service user co-ordinator whose role involves running the county's three main service user groups, getting feedback from service users both from meetings and from spending time with clients in drug treatment services, educating users about the drug treatment system and how it works, and a number of other specific projects.

Service users are also involved on the providers' strategic forum which helps to develop the DAT partnership's treatment plan. This forum is involved in monitoring and review and care planning is on their agenda.

The service user co-ordinator sits on the DAT partnership strategy group, joint commissioning group and three consultation groups (for the three main areas of the county). The consultation groups are operational groups whose membership includes service providers, housing providers, Progress2Work and the police. These groups included care planning as part of their agendas.

A recent survey of service users identified a lack of awareness of care plans. One of the solutions was a laminated information sheet and poster about care plans, which were placed in drug service waiting rooms so that service users knew about care plans and their right to have them. This information sheet, along with the ongoing work of the service user co-ordinator speaking to clients in service waiting rooms, and user group meetings and information sessions, has helped to raise client awareness across Cheshire of the importance of having a regularly reviewed care plan. The services have found that this has been a very positive initiative and many more service users now know what a care plan is, how it should be developed with them, and what to do if they don't agree with it. The DAT partnership believes that the focus they have given to care planning has led to greater user empowerment and involvement in their treatment.

5.3 Rotherham

5.3.1 Electronic caseload management system

Two years ago, Rotherham moved to an electronic caseload management system that recorded assessments, care plans, reviews and related information from all the drug services in the DAT partnership. The system was developed by adding web-based substance misuse components to an existing electronic health records system (EPEX).

The system has helped to link care planning to the client's assessment. As soon as a client makes contact with a treatment service, information is collected. Triage and risk assessment data is added to the system before the client has a comprehensive assessment. This helps to track clients from the first time they enter the treatment system.

The Rotherham treatment providers reported that keyworkers use the four domains as set out in the NTA's Care Planning Practice Guide, identify issues across these domains and set outcomes with clients. All the details of the comprehensive care plan developed with the client are recorded on a single electronic system. Depending on where clients are seen and keyworkers' preferences, this data is either entered directly onto computer during the assessment or recorded on a paper template and then transferred onto computer within 24 hours of assessment. Once the care plan has been finalised, it is locked to prevent alteration by other staff. When the care plan is reviewed, keyworkers will copy their original assessment and make any amendments to the updated care plan (including date of assessments), avoiding them having to retype information that may still be relevant. This means a full audit trail is available for each care plan.

Services in Rotherham aim to keep care planning simple. Although issues are identified across the full range of domains, they are not necessarily all addressed at once. The most pressing needs are dealt with first, and other issues are dealt with as the care plan progresses. However, assessment across all domains and identification of a wide range of issues remains a priority for the treatment services, because they want treatment staff to think more widely than just their clients' immediate drug use. Assessment is seen as an ongoing process and other areas may be added to care plans as clients progress or open up about other issues that may need addressing.

All this information, collected from the drop-in agency and onwards though various assessments and reviews, is kept on the electronic system. The reported advantage of having this data on the system is that drug treatment staff in different parts of Rotherham and different agencies can all have easy access to the same data. It can be accessed from the community drug service, locality services or shared care, making it easier to locate up-to-date information about clients, and reducing the need for staff to carry sensitive client information between different treatment services or sites. All clients are aware and accept that this information is shared across Rotherham's drug services.

When the care plan has been agreed, clients should be able to sign printouts of their care plans and obtain copies if they want them.

DAT partnership and drug treatment staff in Rotherham reported that the electronic case management system has helped to greatly improve their care planning. Some of the improvements they cited include:

- Better quality care planning – keyworkers now take more time to obtain and enter more comprehensive information about clients, using mandatory key fields, in the knowledge that the information can be viewed by all treatment staff
- More structural consistency, with all services carrying out care planning in a similar way
- Since all the relevant, up-to-date information is included on the system, clients don't have to be asked the same questions by different services in Rotherham, making transfers between services more seamless
- The system has simplified care plan monitoring and audit
- The data can be easily analysed across all drug services.

5.4 Salford

5.4.1 Case management system

Salford DAT brought in a consultant in 2004 to help design and implement a care planning system. This system is a comprehensive case management system that assists keyworking throughout the care planning process – from assessment through treatment, care plan review to treatment completion.

When clients enter treatment, work begins on their assessments. The assessment is divided into a range of domains, which are:

- Drug and alcohol (history, problems and dependency)
- Injecting
- Risk behaviour
- Physical health
- Mental health
- Social (family, carers and children)
- Housing
- Employment and benefits
- Criminal and legal.

The system helps to focus the care planning. A client is given a range of scores from 1–5 according to risks across these domains. Clients may identify a large number of issues, but they may decide to focus on only a few of these initially, using the scoring to help decide the priority issues and most pressing needs. The other identified issues that score lower will be kept on the care plan and tackled later.

The scoring system helps the services to see which clients have the most problems and therefore allows them to allocate clients to the most appropriate caseload, and to the most appropriate keyworker. The scores may also determine how a client is worked with (for example, in shared care or specialist treatment) and help identify ongoing client progress through the treatment system.

Overall, the system is standardised but allows flexibility in working with clients. It is currently being linked up to the trust's electronic patient information system (ICIS); when completed, this will improve the usefulness of the system, particularly when the scores and other data are searchable.

Once fully computerised, it is thought that the system will allow easy auditing at a service level, for example picking out the scores for clients, seeing whose caseloads they are on and tracking their progress through treatment. It is also useful from a commissioning perspective, because it enables the commissioner to get an idea of the client caseloads in the Salford treatment services.

Salford is currently developing a number of integrated care pathways that are linked to the case management system. The care pathways are designed to help move people through the system, into other treatment interventions (such as primary care and structured day programmes) and out into aftercare. The client assessment and score will trigger particular events (such as a hepatitis C test) and particular care pathways (for example, dual diagnosis). These will be a linked to an administration system that follows clients through the treatment process.

5.4.2 ITEP

Salford drug services are part of the Bolton, Salford and Trafford Mental Health Trust, which took part in the International Treatment Effectiveness Programme (ITEP), a joint project between the NTA, Texas Christian University and a range of Greater Manchester drugs services. Some psychosocial interventions based on manuals were piloted in the Manchester services. One of the main components of ITEP was training on implementing a node-link mapping tool. This has been built in through supervision and has proved to be a useful tool to assist care planning in drug

services in Salford. Some keyworkers have used the map, drawn up with the client, as the care plan.

Using the ITEP interventions has also helped assist local discussion on the role of the keyworker in drug treatment, their importance of the staff-client relationship and helping direct the client's progress in a holistic way, not just processing prescriptions. It has also helped drug treatment staff to understand the care plan as a more active document.

5.5 Kensington and Chelsea

5.5.1 A wide range of service provision

Kensington and Chelsea is an inner London borough with a broad range of drug treatment services. These include

- Two large NHS community drug treatment services:
  - A community assessment service which operates on a relatively short period of intervention (6–8 weeks) and is a multidisciplinary team that provides daily drop-in treatment with triage, risk assessment and referral for comprehensive assessment
  - A drug treatment centre that provides medium to long-term methadone detoxification (longer than 6–8 weeks), long-term methadone and buprenorphine maintenance, and injectable prescribing. Usually, clients move to this service after care plan review at the assessment service, for maintenance treatment or longer-term detoxification
- A social services substance misuse care management team that carries out community care assessments and purchases packages of care based on individual need. The service manages all referrals to residential rehabilitation, and purchases day programmes and therapeutic aftercare services. They are co-located with the community assessment service
- A shared care scheme. Clients are managed by the GP but supported by the keyworker and substance misuse nurses based at the assessment service. There are a number of specialist GPs carrying larger caseloads. Some clients move from the assessment service straight to shared care.
- A number of voluntary sector agencies – these include a long-established service specialising in working with crack users, a young people's service and an alcohol service.
- Criminal justice services include a rapid opiate prescribing service co-located with the community assessment service, a probation based Drugs Rehabilitation Requirement team and a Drug Interventions Programme team.

5.5.2 Close collaboration between services

Many of these services have been established for many years and although there is not a formal structure for the organisations to work together on care planning, there are many well-established links between the services, which all work closely together and have a history of collaboration. There are a number of staff members in the various services who have been working in the area for a long time, and there are long-established good working relationships between individuals and services. In addition, there is a low turnover of staff. Furthermore, due to the relatively small geographic area of the borough, service users are usually known across the treatment services, particularly the longer-term clients.

Joint working is helped by regular borough-wide meetings and forums, such as the treatment drug reference group (DRG), a treatment and care providers group and a number of sub-groups looking at specific areas (such as aftercare and housing). There are shared staff training events planned across the agencies in the borough. The DAT partnership runs various events including conferences to give further opportunity for shared learning and collaboration.

5.5.3 Care pathways and care plans

The services in the borough operate a range of care pathways. The care pathways that have been developed encourage inter-agency working, so no single treatment model dominates.

Each treatment agency does its own care planning, with care plan content specific to each service. However, the DAT partnership has an agreed common assessment and care planning framework and tools used by all the treatment services.

There is a borough-wide information sharing protocol agreed by all treatment services, following consultation. Paperwork comes with each individual client at transfer, allowing the service to build upon work already done. It was reported that this helps to develop honest relationships between workers, and transparency about clients needs as they movie between services and tiered interventions.

Each client in Kensington and Chelsea has a named keyworker, along with a GP or specialist doctor. The care plan will highlight the interventions that clients are receiving at each of the different services they attend, with contacts for each relevant service. Clients will often have referral documents that summarise their care plans, which they can take round different agencies, so all services know the interventions clients are receiving and who their keyworkers and doctors are.

At the time of writing, the DAT partnership is currently working towards having a borough-wide care planning document, and care planning is on the agenda in the borough's clinical governance forum.

5.5.4 Care planning through to Tier 4

The specific substance misuse care management team means that care planning through to Tier 4 (residential rehabilitation) is followed through more effectively, with care plans moving into Tier 4 with the service users. When a client is assessed and admitted to residential rehabilitation, the care co-ordination and planning responsibilities are held by the allocated social services care manager, who will carry out regular reviews and manages the resettlement back into the community after rehabilitation. This process was thought to be helped by a collaborative approach across the system particularly between social services and healthcare staff. The stability and consistency in health and social services management and staff support the maintenance of this collaborative approach.

6 Appendix 1: Background – key documents and guidance

Care planning has been a standard concept in healthcare for many years, with the NHS and Community Care Act 1990 (HMSO, 1990) recommending the routine use of care planning in health and social care. Care planning has also been used in the drug treatment sector for a long time, although it has not always been done consistently well. Substance misuse guidance and policy documents have recommended care planning as standard practice since the 1990s.

6.1 Audit Commission reports

The first Audit Commission report on drug treatment – Changing Habits (Audit Commission, 2002) – identified the underdevelopment of care planning at practice level and recommended the need for all drug treatment services to develop individual care plans for service users, as well as the need to improve co-ordination of care of clients with more complex needs.

The second Audit Commission report – Drug Misuse 2004 (Audit Commission, 2004) – identified the improvements made since the publication of Changing Habits, but noted that clients were still often unsure about their treatment and not fully involved as active partners in their care.

6.2 Models of Care

The NTA emphasised the importance of care planning in the original Models of Care for Treatment of Adult Drug Users (NTA, 2002), as well as setting out the requirements for commissioners and providers to improve care planning and care co-ordination in local DAT partnership areas. Models of Care has been updated as Models of Care: Update 2006 (NTA, 2006a). The revised guidance emphasises that care planning is the core component of all structured treatment interventions. It also seeks to simplify the care planning process and identifies care planning as a cyclical process of assessment, delivery and review, responding to the changing needs of service users.

6.3 Standards for Better Health

Models of Care: Update 2006 supports service development towards standard D2 of Standards for Better Health (DH, 2004), which states that patients receive effective treatment and care that:

- Conforms to nationally agreed best practice, particularly as defined in the National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery

- Takes into account their individual requirements and meets their physical, cultural, spiritual and psychological needs and preferences
- Is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- Is delivered by healthcare professionals who make clinical decisions based on evidence-based practices.

Models of Care: Update 2006 contained core quality requirement for providers and commissioners and identified a new quality requirement (QRP 7) for service providers to demonstrate "a care planning approach to deliver positive change in clients' lives."

6.4 Care Planning Practice Guide

The NTA published the Care Planning Practice Guide (NTA, 2006b) alongside Models of Care: Update 2006. The Care Planning Practice Guide is designed to help practitioners and service managers who are providing structured treatment enhance care planning at service level. It provides guidance on:

- Care planning in the context of drug treatment journeys – including through the phases of the treatment journey (engagement, delivery, community integration and treatment completion)
- The whole care planning process – including risk assessment, the four care planning domains (drug and alcohol use, physical and psychological health, offending and social functioning), goal setting, and confidentiality and information sharing
- Care planning across a range of different treatment interventions – including care planning across the phases of treatment journey
- Care co-ordination
- How care planning relates to monitoring, clinical governance and performance management.

The guide also provides some resources such as examples of care plan contents and outcome monitoring tools. The Care Planning Practice Guide is supported by the e-care planning package, which is available at the NTA website, www.nta.nhs.uk.

6.5 Other drugs field standards

The Drug and Alcohol National Occupational Standards (DANOS) (Skills for Health, 2003) specify the standards of performance for people in the drugs and alcohol field. They also describe the knowledge and skills workers need in order to perform to the required standard. The Care Planning Practice Guide refers to the competences that are relevant to particular areas of care planning – engagement, treatment delivery, community integration and treatment completion. These include competences on planning and reviewing integrated programmes of care for substance misusers, delivering services to help individuals address their substance use, supporting individuals' rehabilitation and helping substance users address their offending behaviour.

Many services in the drugs field still use the Quality in Drug and Alcohol Services (QuADS) standards (Alcohol Concern & SCODA, 1999). QuADS outlines standards for care planning and review.

6.6 Evidence for the importance of care plans

The NTA guidance Retaining Clients in Drug Treatment (NTA, 2005) emphasised the importance of care planning in improving retention. The guidance pointed to research from the US, which found that services that responded constructively to clients' needs, gave them the help they required and actively involved them in care planning, did much better in helping clients stay in treatment longer and achieve abstinence.

The NTA's 2005 User Satisfaction Survey (NTA, 2006c) found that clients with care plans that had been reviewed in the last three months were most likely to be satisfied with their treatment. Clients without a care plan were most likely to be dissatisfied with their treatment experience.

7 Appendix 2

The following DAT partnerships were interviewed about care planning:

- Rotherham
- Wirral
- Salford
- Luton
- Gloucestershire
- Devon
- Kensington and Chelsea
- Cheshire
- East Sussex

7.1 Rationale for selection

The DAT partnerships highlighted above were selected by an iterative process to specifically identify those partnerships which scored highly on care planning or prescribing. The rationale was that a partnership may be particularly good at either care planning or prescribing but less good at the other. Therefore rather than merely select the partnerships with the highest overall score, a number of checks were applied to the review data.

The selection process looked at the scores for each criteria within prescribing and care planning, and the scores for the questions which made up the criteria. We noted the DAT partnerships that scored consistently well across a range of criteria, those that scored well across the questions within particular criteria and those that scored badly for any particular criteria.

These criteria were looked at individually. The DAT partnerships which scored the highest possible score for each of the criteria were identified.

The next step was to identify which DAT partnerships appeared in two or more of these tables of high scoring DAT partnerships. The number of criteria tables each partnership appeared in was noted. A number of other factors were also considered for each DAT partnership. These were:

- Whether the DAT partnership scored the highest aggregate across all questions for any particular criteria
- If the DAT partnership scored a '1' (the lowest score) for any of the criteria
- If the DAT partnership was among the top scoring DAT partnerships across the whole Improvement Review.

Applying these factors to the DAT partnerships helped to narrow down a smaller number of partnerships to prioritise for contacting. The DAT partnerships that were selected are those which scored highly on two or more criteria, have scored '2' or above for all criteria, scored well within particular criteria, or scored highly overall in the Improvement Review. This was a process similar to the one used for ranking the position of partnerships in the final Improvement Reviews results table. Therefore, even if a partnership scored well on individual criteria, if they scored '1' for any criterion, they were excluded.

8 References

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