What should be included in collaborative care plans?

Understanding the plan

Multidisciplinary treating teams, people with lived experience and carers must have a clear understanding of the following.

- Why are we doing this?
- What are we planning to achieve?
- How are we going to do it?
- Who will do it?
- Where will it be done?
- When will it be done by?

Developing the plan

In developing the care plan it should:

- focus on people's **strengths and wishes**
- include the **person's role** in the plan
- reflect the individuals **cultural and ethnic background** as well as their gender, sexuality, race, economic disadvantage, age, religion/spirituality, and disability
- consider the role of any **family or carers** who are involved
- include **clear outcomes** that are person-centred
- include interventions that directly relate to **person's needs and goals**
- actions that include the **person's own responsibilities**
- consider any **safeguarding** issues for children or vulnerable adults
- consider **safety** issues
- include **crisis and contingency** arrangements
- give the date of the **next planned review**
- cover **transfer** details if appropriate
- identify any **unmet needs**
- acknowledge **areas of difference** or disagreement

Understanding outcomes

It would be further useful for multidisciplinary treating teams to understand the following.

- What the person would like from services?
- What he/she would like to achieve?
- How they feel this could be achieved?
- How they feel they could contribute?
- Who the service user feels comfortable for you to talk with and to further gain permission?
- How families and carers are involved and supported?

Reviewing the plan

When undertaking a **review** it is important for multidisciplinary treating teams to understand the following.

- What is the person's view on progress?
- What was achieved and what helped them get there?
- What didn't work and why?
- How can we improve outcomes (may require development of new goals or update existing goals to be more reflective of a person's current mental health state)?
- Confirm whether all team members listed on the care plan are still relevant with assessment of whether their roles have changed?
- When does it make sense to review again?
- The person and their support network should be part of the review process where all involved should have equal opportunity to openly discuss the plan. Any differences or disagreements should be clearly document as required.

Reference

Oxleas NHS Foundation. Writing Good Care Plans: A good practice guide.