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Care planning and co-ordination: imperfect solutions in a complex world.

Editorial

Care planning and co-ordination are central to the delivery of comprehensive mental health care especially where individuals have complex health and social care needs. Although the terms are often used together they clearly imply different sets of processes, practices and ultimately experiences for individuals using and working in services. Care planning involves professionals (nurses, doctors, social workers and others) and the person needing care collaborating on goals, making shared written records and agreeing when to review progress. Related to care planning, but distinct from it, care co-ordination is a development from case management research showing the benefits of a single professional worker co-ordinating activities, pulling together comprehensive community care, engaging the person and ultimately providing oversight and continuity so that the person gets the help they need. Care co-ordination is needed because the care system is exceptionally complex. With contributions to care being made by people from an array of backgrounds, located in geographically dispersed workplaces, coordination is necessary so that duplication and gaps are avoided and lines of communication are maintained. It also offers opportunities to address concerns about risk. Care co-ordinators navigate the system, harnessing resources and plotting paths to meet needs. In the UK, institutionalised forms of care co-ordination involving the use of written care plans, named workers and care reviews have existed for more than two decades (DoH, 1990) and (for a time at least) the introduction of the care programme approach (CPA) led to the creation of a new verb: 'to CPA'. However, despite these being the focus of government policy and legislation, evidence for the use of care plans and for care co-ordination remains thin on the ground. Perhaps surprisingly this has not prevented mental health care planning

and co-ordination being cited as a model of good practice for other long term conditions fields (Kings Fund, 2013).

In this special issue we have brought together papers that provide new evidence on care planning and co-ordination. We do this in a context in which the weight of expectation on these two interrelated processes remains heavier than ever. In guidance and policy care planning and care coordination are no longer purely technical administrative processes. Both are seen as vehicles for care which is underpinned by values commitments: principally to collaborative service user-centred working, and to recovery. This special issue goes some way to finding out how far these aspirations are being realised. The collected papers demonstrate the breadth of endeavour in this field and attest to the ubiquity of care planning and care coordination in all mental health settings. Our own research in community mental health and acute inpatient services in England and Wales (Simpson et al., 2016) shows that care planning often fails to adequately involve people using services and for many the care plan is little more than a piece of paper produced for organisational purposes with little relevance to the care experience. Care plans bring administrative burden for nurses, and frequently are not seen to significantly contribute to the care of the person. The co-ordination of care is often hampered by limited resources, frequent restructuring and imposition of targets that skew priorities for care delivery. Service users value high quality therapeutic relationships suggesting that the focus on paperwork, targets and efficiency is hindering rather than helping care. Barrett and Linsley (2017) provide a strong case for refocusing work away from paperwork and towards active dialogue with the person and their families. More radically perhaps, McKeown et al, (2017) liken the focus on care planning and co-ordination to an exercise in 'cooling out' protagonists who might otherwise have much to complain about. They argue that in engaging in apparently rational processes of care planning, mental health nurses may end up disempowering service users and damaging the relationships they have.

Care plans have come to be seen as indicative quality measures, supposedly demonstrating whether or not key elements of policy are being met. Much attention in the UK has focused on just this with national audits of care planning and inspections by national bodies highlighting repeated problems with the Care Quality Commission (CQC 2013:5) noting a "significant gap between the realities observed in practice and the ambitions of the national mental health policy". Care plans and their contents as measures of quality have been refashioned as targets for services. Kelman and Friedman (2009) note that unintended dysfunctional consequences of targets can lead to effort substitution (reducing effort in areas that will not be measured) or gaming (making performance appear better

than it is). A focus on ensuring the paperwork is complete in place of spending time on the relational aspects of care is perhaps one consequence. A target of ensuring that 95% of care plans are signed by the service user while neglecting to assess if care plans are co-produced and actually delivered is one example (DH 2001). Distortions in performance against set targets should prompt us to appreciate that for care plans to be meaningful they must become active representations of real care delivery and not simply window dressing for audit purposes. Care plans that are genuine, personal and have recovery-focused goals and plans for their achievement are what are needed.

What does this all mean for practice, policy, education and research in mental health nursing? It first tells us that care planning and co-ordination are complex tasks, best undertaken by practitioners possessing relational skills and system knowledge. A strong tradition of service user focused monitoring and research on mental health services already exists and opportunities for partnership should be grasped. The current knowledge base cautions us against excessive bureaucratisation but also reminds us that if care planning and care co-ordination did not exist they would immediately need to be (re)invented lest the care system collapse in a heap of disorganisation. More potently it highlights that this is a field ripe for investigation. As the papers in this special issue show there remains further scope for mental health nurses to engage in producing this new knowledge.

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