Care and Treatment Planning Part 2 Mental Health Measure (Wales) 2010
Powys Teaching Health Board Mental Health and Learning Disabilities Directorate

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	June 2017
2	Minor changes to reflect best practice in Care and Treatment Planning	Nov 2019

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ENGAGEMENT & CONSULTATION

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Circulated to the following for Consultation

Date	Role / Designation
Jan 2019	Clinical Director Mental Health
Jan 2019	Consultant Psychiatrists
Jan 2019	CMHT and OPCMHT Team Managers
Jan 2019	Director of Primary and Community Care & Mental Health
Jan 2019	CRHTT managers
Jan 2019	Head of Complex and Unscheduled Care
Jan 2019	Assistant Director Of Mental Health
Jan 2019	Head of Nursing Mental Health
Jan 2019	Head of Learning Disabilities
Jan 2019	Head of CAMHs
Jan 2019	Ward managers
Jan 2019	Head of Occupational Therapy
Jan 2019	Head of Local Primary Mental Health Support Service
Jan 2019	CSP Policy and Care Services PCC

Evidence Base

Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?

- Mental Health (Wales) Measure 2010
- Schedule 2 of the Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011
- Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
- Mental Health Act 1983 Code of Practice for Wales. Welsh Assembly Government (2008)
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS)
- All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults (2014)
- Safe Management of Mental Health In-patients. Welsh Assembly Government circular: CNO(2008)01 / CMO(2008)01
- National Control and Restraint Association (General services) (NCRGSA)
- British Institute of Learning Disabilities (BILD)
- NMC The Code for Nurses and Midwives - (NMC 2015)
- Data Protection & Confidentiality Policy (2013)
- Consent to Treatment Policy (2011)
- Social Services and Well being (Wales) Act 2014
- Human Rights Act 1998
- Care Standards Act 2000
- Safeguarding Vulnerable Groups Act 2006
- Providing Medical Care and Treatment to People who are Detained Guidance. British Medical Association (October 2007)
- Health and Care Standards 2015
- Children's safeguarding audit
- All Wales safeguarding action plan
- General Data Protection Regulations

Health and Care Standards 2015

Theme 1 Staying healthy
1.1 Health promotion, protection and improvement

Theme 2 Safe care

2.1 Managing risk and promoting health & safety
2.5 Nutrition & hydration
2.6 Medicines management
2.7 Safeguarding children & adults at risk

Theme 3 Effective care
3.1 Safe & clinically effective care
3.2 Communicating effectively
3.3 Quality improvement, research & innovation
3.4 Information governance & communications technology
3.5 Record keeping

Theme 4 Dignified care
4.1 Dignified care
4.2 Patient information

Theme 5 Timely care
5.1 Timely access

Theme 6 Individual care
6.1 Planning care to promote independence
6.2 Peoples rights
6.3 Listening and learning from feedback

Theme 7 Staff and resources
7.1Workforce

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement**
Age	x				This document been developed to support Professionals eligible to undertake Care and Treatment Planning in accordance with part 2 of Mental Health Measure (Wales) 2010. It has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender, sexual orientation, race, religion / belief or human rights
Disability	x				
Gender	x				
Race	x				
Religion/ Belief	x				
Sexual Orientation	x				
Welsh Language	x				
Human Rights	x				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? No
Have you identified any training and / or resource implications as a result of implementing this? Requirement for workforce eligible to conduct the role of Care- Coordinator under Part 2 Mental Health Measure (Wales) 2010 WARRN Risk Management Training

1 Policy Statement

Powys Teaching Health Board and Powys County Council are committed to full compliance with the Mental Health (Wales) Measure 2010.
This policy is to be read in conjunction with

- Code of Practice to parts 2 and 3 of the Mental Health (Wales) Measure 2010
- Mental Health Inpatient Operational Policies
- Community Mental Health Teams Joint Operational Policy
- Social Services and Well Being Act (Wales) 2014 Policy

2 Introduction

The Mental Health (Wales) Measure 2010 is a piece of legislation made by the National Assembly for Wales. It has the same legal status as an Act of Parliament.

The Measure is divided into 6 parts and 2 schedules. The main legislative requirements relating to mental health service provision are detailed in

Parts 1-4.

- Part 1 – Local Primary Mental Health Support Services
- Part 2 – Coordination of and Care and Treatment Planning for Secondary Mental Health Users
- Part 3 – Assessments of Former Users of Secondary Mental Health Services
- Part 4 – Mental Health Advocacy
- Part 5 – General
- Part 6 – Miscellaneous and supplemental
- Schedule 1- Consequential amendments to the Mental Health Act (1983)
- Schedule 2- Repeals

This policy is written in relation to Parts 2 and 3 of the Measure, which are specifically targeted at Secondary Mental Health Services. Since Parts 2 and 3 relate to coordination of Care and Treatment Planning (CTP), and Assessments of former users, this policy is entitled "Care and Treatment Planning Policy".

2.1. Relevant Patients

Parts 2 and 3 are specifically related to a relevant patient. This is defined in the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 as:

- An individual for whom a mental health service provider is responsible for providing a secondary mental health service; or,
- An individual who is under guardianship of a local authority in Wales; **or**
- An individual for whom a mental health services provider has decided that they would provide secondary mental health services if that individual cooperated with the provision of such services.

3. Aims & Objectives

The policy aims to ensure that:

- Relevant patients and their carers are involved in the planning, development and delivery of care and treatment to the fullest extent possible through an approach which support Individual Recovery and one which recognises a person's strengths and aspirations.
- Attention is paid to working to identify, address and avoid inequalities in the operation of the Measure.
- Ensure that relevant patients are treated with dignity and respect.
- There is clear communication in terms of disability, language and culture to ensure relevant patients and carers are truly involved and receive the best possible care and treatment.
- In relation to the Welsh language, this means that all possible steps will be taken to ensure that bilingual (Welsh and English) services are available.
- Care and Treatment is comprehensive, holistic and person-focused.
- Care and Treatment Planning is proportionate to need and risk.
- Care and treatment is integrated and coordinated.
- Care and Treatment is outcome focused using the S.M.A.R.T (Simple, Measurable, Achievable, Realistic and Time constrained) approach
- Care and Treatment plans must accommodate the outcomes of the SSWB Act (although CTP supersedes SSWB Care and Support Plans when a person is in secondary mental health services).
- Eligible care coordinators are appointed for relevant patients.
- There is effective coordination of provision of Mental Health Services.
- Care coordinators work with relevant patients and Mental Health Services to produce the prescribed care and treatment plan. This must be a single document.

- Any actions that are specified but undeliverable due to lack of resources are reported to the mental health service providers via the Unmet Needs process.
- All appropriate parties receive written copies of the care and treatment plan (including specified cases without the consent of the relevant patient to whom the plan relates).
- Care and treatment plans are reviewed and revised in specified circumstances and the consultation in connection with relevant parties involved in care.
- Requests for assessment by further users of secondary mental health services are met in a timely manner related to the identified level of urgency.
- The written arrangements for Part 3 of the Measure are adhered to. This includes entitlement of former users, the provision of a summary report of assessments to service users, actions following assessment and referrals relating to housing and well being services.

4 Scope

This policy applies to all staff working for Powys Teaching Health Board and Powys County Council within the Mental Health and Learning Disabilities working age services.

5 Definitions

- **CAMHS** Child and Adolescent Mental Health Service
- **CoP** Code of Practice
- **CTP** Care and Treatment Plan
- **LPMHSS** Local Primary Mental Health Support Service
- **PCC** Powys County Council
- **PTHB** Powys Teaching Health Board
- **SSWB** Social Services and Well Being Act (Wales) 2014
- **WARRN** Wales Applied Risk Research Network
- **GP's** General Practitioners

6 Responsibilities

As Parts 2 and 3 of the Measure apply to all individuals who are accepted into Secondary Mental Health Services, it is important to identify the services provided by PTHB and the PCC within working age Secondary Care. Any mental health services that are not specified under the Part 1

Primary Mental Health Scheme are considered secondary mental health services. This list currently includes:

- Inpatient Units
- Crisis Resolution / Home Treatment Teams
- Community Mental Health Teams
- Learning Disability services (partial)

- CAMHS (partial)
- Psychology
- Dementia Home Treatment Team

The Measure provides for an expanded statutory scheme of independent mental health advocacy under part 4. Evidence suggests that advocacy can lead to an improved experience in mental health services for individuals, including the potential for advocacy to create choice, improve involvement in decision making and promote access to a range of services. Such advocacy will assist service users in making informed decisions about their care and treatment. The processes for involving advocacy should be imbedded in practice throughout all part 2 processes.

All elements of the services provided by PTHB and PCC will be reviewed periodically to ensure they are delivered in a proportionate manner.

7 Staff Group or Specific Role

Care Coordination

The professional requirements to be met in order to perform the role of care coordinator are as follows: (CoP 3.26)

- A qualified Social Worker (registered with either the Care Council for Wales or the General Social Care Council)
- A first or second level Mental Health or Learning Disabilities Nurse (registered in sub part 1 or sub part 2 of the register maintained under article 5 of the Nursing and Midwifery Order 2001)
- An Occupational Therapist (registered in Part 6 of the register maintained under article 5 of the Health Professions Order 2001)
- A Practitioner Psychologist (registered in Part 14 of the register maintained under article 5 of the Health Professions Order 2001)

- A registered Medical Practitioner
- A Dietician (registered in Part 4 of the register maintained under article 5 of the Health Professions Order 2001)
- A Physiotherapist (registered in Part 9 of the register maintained under article 5 of the Health Professions Order 2001)
- A Speech and Language Therapist (registered in under Part 12 of the register maintained under article 5 of the Health Professions Order 2001)

The professional acting as Care Coordinator is responsible for ensuring the effective coordination and delivery of services identified on the Care and Treatment Plan. This role is detailed further in this Policy.

It is the Care Coordinators responsibility to ensure that the CTP assessment, Care Plan and WARRN documentation remain up to date and are reviewed. Standards for record keeping must be adhered to.

All records must be contemporaneous, accurate and proportionate to the complexity of the case (CoP 3.36).

All service users who are identified as being a relevant patient will have a care coordinator allocated within two weeks.

Any change of the Care Coordinator should involve the service user and take place via a CTP review meeting.

8 Referrals to Secondary Care

All areas should have a process in place to triage the referrals to secondary care from both external agencies and former service users self referring under part 3 of the Measure.

GPs and LPMHSS can refer directly to secondary mental health services. If the referral is assessed as being more appropriate for LPMHSS then a direct referral to that service will be made and the GP informed.

9 Consent

Consent to share information will be discussed and sought with the patient at assessment. If it is identified that consent cannot be gained due to a lack of mental capacity, then a mental capacity assessment should be completed in accordance with the Mental Capacity Act.

10 Assessment

The PTHB/PCC Mental Health and Learning Disabilities CTP Assessment is a multi-agency team assessment and therefore can be completed by any of the qualified professionals within the Secondary Mental Health Service, or by a Social Worker based in the Local Authority.

Part 2 of the Measure does not prescribe a particular assessment process and the duties under part 2 only have effect once an individual is a relevant patient (CoP 2.7).
For relevant patients, the assessment process for agreeing the outcomes to be achieved will identify needs and risks (including vulnerability), alongside their personal strengths (CoP 2.10).

The aim is for the assessment process to establish information from which care and treatment planning and future work can take place (CoP 2.11). Where an individual is a 'relevant patient' within the meaning of part 2, their assessment will identify, describe and evaluate their presenting needs and strengths and how they constrain or support their capacity to live a full and independent life (CoP 2.12).

The assessment process should also ensure that the relevant patient is encouraged and facilitated to make clear their views and their ambitions for the future. It is crucial for the joint production of a care and treatment plan that, where possible the assessment process engages the relevant patient collaboratively, although it is recognised that this might not be possible in all cases. Where a relevant patient lacks the capacity, or refuses to cooperate in the assessment process, this should not prevent efforts continuing to engage or involved the relevant patient as much as possible. Where practicable and appropriate the views of any carers or significant others should also be sought and recorded (CoP 2.16).

WARRN risk formulation tool is a multi agency tool and can be completed by any registered professional member of Secondary Mental Health who have completed the 2 day WARRN 'Asking Difficult Questions' course. As part of the discussion of the assessment at the MDT, the WARRN must be considered.

11 WARRN

A WARRN Risk formulation will be completed with all relevant patients with families/ carers where appropriate, to identify, document and manage risk. The WARRN risk formulation tool is a multi agency tool and can be completed by any registered professional member of Secondary Mental Health service who have completed the 2 day WARRN 'Asking Difficult Questions' course. As part of the discussion of the assessment at the MDT, the WARRN must be considered. The WARRN will be updated at a minimum yearly but should be reviewed when the assessment or care plan is updated.

Those completing the WARRN risk formulation will ensure that they gather information from all available sources. Information can be received from family members and carers without the consent of the patient, as long as the rules of confidentiality are not breached.

12 Care and Treatment Planning

All relevant patients require a current Care and Treatment plan.

Timescales for the completion of the Care and Treatment Plan are outlined in the relevant sections 13.1 (community) and 13.2 (inpatient) below. The Care and Treatment plan should be completed using the Powys Teaching Health Board prescribed format from the Welsh Government. The Care and Treatment plan will identify how the needs and risks identified in the assessment will be met and must give consideration to at least one of the following eight areas of life:

- Finance and Money
- Accommodation
- Personal Care and Physical Wellbeing
- Education and training
- Work and occupation
- Parenting or caring relationships
- Social, cultural or spiritual
- Medical and other forms of treatment including psychological interventions

When a review takes place the Care and Treatment Plan will be updated and the Review documentation completed. A copy of the care plan will be sent to the relevant patient and copied to the GP and those involved in the delivery of the care plan. A CTP review must take place at least annually.

For guidance on the provision of the Care and Treatment plan see the Code of Practice for the Mental Health Measure (CoP 4.91).

The Welsh Community Care Information System will be introduced in 2019 and the CTP forms will be incorporated within this system.

13 Process for Mental Health/Learning Disability Teams

13.1 Community Mental Health/Learning Disability Teams

- A Care Co-ordinator should be allocated within two weeks of the patient being accepted into secondary mental health services or for learning disabilities, being identified as a relevant patient.
- The Care Co-ordinator will work collaboratively with the patient and with service providers to complete a comprehensive assessment and develop a care and treatment plan within 6 weeks of being appointed as care coordinator. Upon completion of the care plan, the document should be signed off and distributed to all involved parties within two weeks (CoP 4.87).
- On accepting a patient into Secondary Mental Health Services the review date should be set for six weeks hence.
- It is the care coordinators responsibility to ensure that plans and risk assessments are updated to include the next review date, identified care coordinator and all CTP documentation.
- When the role of Care Coordinator is passed to another professional, the Care and Treatment Plan must reflect the Care Package from this point forward. The existing care coordinator will be responsible for arranging the CTP review and involving the new Care Coordinator. The new Care Coordinator will create the CTP documentation and ensure it is distributed. The new Care Coordinator should be identified on the front of the care plan and should sign as the Care Coordinator.
- As required by the Mental Health Measure, all service users subject to Section 117 Aftercare will remain Relevant Patients and will require the continued involvement of appropriate members of the multi disciplinary team.

13.2 Inpatient settings

- When patients who are not previously known to secondary mental health services are admitted to inpatient units, they will not automatically be considered a relevant patient until they have

undergone a period of assessment by ward staff. For mental health wards, the assessment period can take up to 7 days at which point a decision should be made as to whether a person will be considered a relevant patient.

- NB. If the person is admitted for treatment for less than seven days this should not exclude them from being considered a relevant patient if they are identified as having a serious mental illness.
- If the patient is not currently known to the Secondary Mental Health Service an inpatient care coordinator will be allocated and complete a CTP assessment. As soon as it is identified that a Community Care coordinator will be required on discharge this should be discussed at MDT and a community care coordinator allocated.
- If the patient already has a community care coordinator they will remain the care coordinator throughout the period of admission, unless it is deemed no longer appropriate for them to do so. Those patients with a community based care coordinator will have a named clinician allocated on admission.
- The inpatient named clinician will complete the care plan documentation whilst the person is an inpatient, with the exception of the discharge care plan, however the community care coordinator must be fully consulted and sign off the care plan with the patient. The community care coordinator should remain in touch with the patient during admission and attend CTP reviews where possible.
- During the inpatient admission, those services which are being provided as part of the community care plan, but which are not being delivered during the patient's admission, will be suspended. Prior to discharge the review should consider whether it is appropriate for these services to recommence post discharge or whether other services are required.
- A care and treatment plan should be created within one week of admission and as a minimum be reviewed prior to leave or on discharge. Care and Treatment plans should be updated during reviews as an inpatient. The timing of these and whether the review should be formal or informal should be based on individual risks and needs.
- Prior to discharge from an inpatient setting all CTP documents must be updated including any Section 117 arrangements. The community care coordinator will be responsible for the production of the community care plan prior to discharge. A patient must not be discharged into the community without the prior knowledge of the care coordinator and a completed care and treatment plan to be implemented in the community. It is good practice for the patient to be provided with a copy of their care plan prior to leaving the ward.

The community care coordinator is responsible for signing, distributing the CTP plan and ensuring that the arrangements on discharge are clearly communicated to those involved in the delivery of the care and treatment plan, including all services/agencies and individuals involved including Learning Disability and Substance Misuse services.

- If a relevant patient is being discharged from the ward but does not require further Secondary mental health services, they will be provided with the discharge care plan, informing them of their rights under part 3 of the Measure, and outline how their needs will be met in Primary Care. This information will also be provided to the GP and available on electronic system.
- To ensure safe discharge from inpatient settings, all individuals discharged from hospital who will remain in receipt of secondary mental health services (CoP 5.21) will be contacted by a mental health professional within 48 hours discharge from the ward (this is in keeping with the findings of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Mental Health Measure Parts 2 & 3 Code of Practice). It is recommended that each ward will have a process for contacting service users within 48 hours of discharge. The process should have an audit trail.
- Those who are assessed and are not identified as a relevant patient will be provided with a letter from the ward informing them of this. This letter will also be provided to the GP.

13.3 Crisis Resolution Home Treatment Teams (CRHTT)

- Patients who require the interventions provided by CRHTT will have received a CTP assessment to identify such needs. If the patient already has a community care coordinator they will remain the care coordinator throughout the CRHTT intervention. The care coordinator should maintain contact with the patient during the period of CRHTT involvement. If a patient is new to Secondary Mental Health Services, CRHTT will allocate a care coordinator as soon as the person is assessed as meeting the criteria for a relevant patient.
- In the case of a patient who is new to Secondary Mental Health Services and a community care package is proposed, a care coordinator must be allocated by the community care team. The care coordinator must attend CTP reviews within the CRHTT including the discharge meeting or be involved with the development of the community care plan.

- The Community Care Package may remain ongoing or be suspended as appropriate.
- In order to safely discharge a patient from CRHTT a CTP review must be held. Should the patient continue to receive a community care package the care coordinator must lead in the development of this plan.
- All CTP documents should be updated prior to discharge.

13.4 Discharge from Secondary Mental Health Services

- In the case of a patient who is being completely discharged from Secondary Mental Health Service, a discharge CTP meeting must be held. Should a care and treatment plan exist it must be evaluated and a discharge from SMHS letter / care plan given to the patient, this explains entitlement under Part 3 of the Measure.

14 Service users disengaging from service provision

Care and Treatment planning was introduced in part to ensure that those with a serious and enduring mental illness were not lost to services and therefore not receiving the support that they needed. However it must be recognised that some service users will choose not to accept the care being offered or to participate in the process of CTP, or to maintain any contact.

If a service user disengages from the mental health services the care coordinator should:

- Make a robust attempt to contact the service user and/or their carer's to determine if their care needs remain and continue to need service provision;
- Call a review meeting of those people involved in the service user's care to consider how to proceed;
- If a service user has moved to another area, contact should be made with the local services in that area and information shared if deemed appropriate;
- Consider the risks posed to self including vulnerability and undertake response to the risks highlighted in the WARRN risk formulation. If risks are identified consideration should be given to the options available i.e. Mental Health Act;

- Consider if the information needs to be shared e.g. with relatives/carers, the mental health service partner agencies, Police, GP, third sector, and any other appropriate services.
- Consider any other options available which will include discharge under part 3 of the Measure.
- The review should document all of the above actions have been considered.
- Every effort should be made to have regular face to face contact with the patient by a member of the team.
- The frequency of contact should be determined by the needs of the patient.
- Attempts to engage should be documented in the case notes and where the patient is not engaging, the care plan should be reviewed and the method being used to engage incorporated into the plan of care and WARRN risk formulation.
- If the patient is high risk and is not engaging, consideration must be given to holding a MAPPA or Section 115 (Crime and Disorder Act 1998) meeting to share information and discuss how to manage the identified risks.

15 Assessment of Former Users of Secondary Mental Health Services

15.1 Adult, Older Age and Adult Learning Disability

Former users of Secondary Mental Health Services who have been discharged from services in the past three years can request an assessment from the service under part 3 of the mental health Measure. The assessment should be undertaken in the same timeframe as a referral from the GP.
For former user assessments under Part 3 the patient must receive a summary report of the assessment within 10 working days.

15.2 CAMHS and Children's Learning Disability

Service users who have been discharged from CAMHS secondary service i.e. identified as a relevant patient whilst under CAMHS are entitled to self refer to adult mental health services at the age of 18.

This applies to those service users discharged from CAMHS under part 3 of the Measure i.e. those reaching the age of 18 years within 3 years of that discharge.

All Service users receiving CAMHS secondary services on or after their 15th birthday should be given details of how to access adult services once they turn 18.

16 Unmet needs

Any needs which cannot be met as a result of a service not being available or not having sufficient capacity should be reported as an unmet need. Where possible an alternative method should be sought to meet the need.

All unmet needs forms should be submitted to the Senior Management Team so that it informs service development.

17 Training

It is intended that CTP update training be provided every three years. This training will be informed by the service user engagement events and by the all Wales CTP advisory group.

18 Health and Care Standard Wales 2015

This policy is a framework which reflects the standards of expected care outlined within the seven themes identified in the all Wales Health and Care Standards April 2015:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

19 Audit

The standards set by PTHB within this Policy and by the Welsh Government within the Measure, Subordinate legislation and its Code of Practice will be monitored on a regular basis via audit and compliance reporting to the Delivery Unit (DSU).

All service areas will be audited internally as a minimum annually. This will include Team managers will also audit the implementation of this policy as part of caseload supervision.

Audit reports will be subject to local scrutiny at CTP Board, Measure Delivery Group, Quality and Patient Safety Team meetings and shared as required in forums that will provide added value to the implementation process.

20 Monitoring Compliance, Audit & Review

Description of how monitoring compliance with your policy will be undertaken.

Monthly Data collection in accordance with Welsh Government requirements Monthly supervision.

Annual spot check audits on each site.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

21 References / Bibliography

- Mental Health (Wales) Measure 2010
- Schedule 2 of the Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011
- Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
- Wales Applied Risk Research Network (WARRN) 2009
- Mental Capacity Act 2005 & Amendments (2007) Code of Practice
- Deprivation of Liberty Safeguards Code of Practice
- NMC The Code of Professional Conduct (2015)
- Mental Health Act 1983 Code of Practice for Wales. Welsh Assembly Government (2008)
- Social Services and Well Being Act (Wales) 2014 Policy