

**Adult**

**Care and Support Plan**

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| **Personal Details** | |
| AIS Number: |  |
| Customer Name: |  |
| Address: |  |
| Date of Birth: |  |
| NHS Number: |  |

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| **Reablement** | | | | |
| Are you starting Reablement? | Yes | ☐ | No | ☐ |
| Are you being discharged from Hospital? | Yes | ☐ | No | ☐ |
| Are you being discharged from Reablement? | Yes | ☐ | No | ☐ |
| Are you being discharged from Intermediate Care? | Yes | ☐ | No | ☐ |

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| *Please read this section carefully, it explains how the local authority will use and share the information about you that is collected on this form.*  **Data Protection Act 1998**  The information collected on this care and support plan will be used to ensure that your eligible needs for care and support can be met.  The local authority may need to share your information with other people within the local authority such as the direct payment support service or the welfare rights service or providers of support, and outside the local authority with health professionals involved in your care or providers of care and support. We will not do so without your consent unless there are legal reasons for this, such as to prevent a crime or safeguard vulnerable people.  The local authority is also required to provide statistics to the Government; however your personal details will not be included in these statistics. This support plan will be stored securely and may be kept for up to 6 years. You have the right to see any information we hold about you at any time.  **Consent to share the information on this form**  Once this care and support plan has been completed, your social worker or care coordinator will ask you to sign to say that you agree to the information being shared. You will be told who may receive the information and if you do not wish certain information to be shared or certain people or agencies to have your personal information you may say so and this will be recorded within your consent.    You will be able to withdraw your consent at any time by contacting your social worker or care coordinator. |

**Consent to Care & Support Planning** *– to be completed by the service user unless they lack capacity to consent, in which case it should be completed only by anyone with authority – the Lasting Power of Attorney for Personal Welfare or a Court Appointed Deputy.*

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| I consent to the care & support planning arrangements to determine how my eligible care and support needs will be met.  I consent to the local authority sharing this support plan and, if necessary my contact details, with appropriate individuals or agencies in order to arrange appropriate care and support.  I understand that if I do not give consent or only allow certain agencies to be contacted the local authority may not be able to fully meet my care and support needs.  I have been told who will be consulted and who information might be shared with.  If there is information that you do not wish to share or people you do not wish to see it please say so below before signing. |

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| **Signature:** |  | Date: |  |

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| **Role**  **(if not signed by individual)** |  |

**Decision Making –** *this section is to be completed by the social worker or care coordinator*

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| **Consider if there are any decisions in the care and support planning process and care arrangements that the person may lack the capacity to make; if so complete separate record of capacity assessment for each decision.**  **Best Interest Decision – Care and Support Planning**  If following the MCA capacity assessment a Best Interest decision is made, please state who was consulted, their views and any areas of disagreement. State the decision made in the persons best interests with reasons  If the care and support planning is to go ahead say who will support the individual with this (this may be a family member, a friend or an independent advocate). Give the name, contact details and relationship to the individual. Refer to independent advocacy service if there is no informal support available |
| Signature of decision maker: Date: |

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| Consider if the person is likely to have substantial difficulty being involved in the process of Support planning and if so whether there is someone informal that is appropriate to support them to be involved.  If not refer for independent advocate.  *State the person who will be supporting the individual below* |

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| **Who is involved in completing this support plan?** | | | |
| You may want someone such as a family member, your care management worker or an advocate to help you complete your support plan. Please detail this below: | | | |
| **Name:** |  | **Name:** |  |
| **Address:** |  | **Address:** |  |
| **Relationship:** |  | **Relationship:** |  |
| **Telephone No:** |  | **Telephone No:** |  |

**ABOUT ME:**

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| **My Life (My life history)** |
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| **What you need to know about me to support me well and to keep me safe** |
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| ***Eligible needs – from Outcomes not achieved*** | ***Describe the particular support the person needs to achieve the outcomes*** | ***Who will meet this eligible need for support informally e.g. carer, volunteer?*** | ***Specify eligible need for support to be met by the Local Authority*** | ***How is the personal budget to be spent?***  ***eg direct payment, virtual, mixed or care home placement*** |
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| **Managing and maintaining nutrition** |  |  |  |  |
| **Maintaining personal hygiene** | Personal Outcomes section  within AIS |  |  |  |
| **Managing toilet needs** |  |  |  |  |
| **Being appropriately clothed** |  |  |  |  |
| **Being able to make use of the home safely** |  |  |  |  |
| **Maintaining a habitable home environment** |  |  |  |  |
| **Developing and maintaining family and other personal relationships** |  |  |  |  |
| **Accessing and engaging in work, training, education or volunteering** | Personal Outcomes section  within AIS |  |  |  |
| **Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services** |  |  |  |  |
| **Carrying out any caring responsibilities the adult has for a child** |  |  |  |  |

**Please note: This section should relate to the outcomes identified within the Assessment or the review**

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| **Personal Budget Details** | | | | | | | | |
| *(Not applicable if you are in receipt of Reablement services, Residential Care, Intermediate Care or Independent Supported Living)* | | | | | | | | |
| Indicative Personal Budget | Annual    £ | Weekly  £ | | Actual Budget: | | Annual  £ | | Weekly  £ |
| **Personal Budget type:** | **Direct Payment** | | **LA Managed (Virtual)** | | **Mixed Budget** | | **Emergency / Hospital Discharge** | |
| Please tick | ☐ | | ☐ | | ☐ | | ☐ | |

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| **Provide a breakdown of how the care will be provided** |
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| **Provider (If Known)** |  |

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| **How will I manage my life, support or budget if something unexpected happens (please include contingencies)** | | |
| How will you manage if support is unavailable or if you become unwell? Include within the plan times you may need additional support (e.g. if you or someone who supports you is unwell) | | |
| **Description** | **Responsibility** | **Contingency** |
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| Is a Carers Emergency plan in place? | Yes | ☐ | No | ☐ |
| Has a Carers Assessment been offered? | Yes | ☐ | No | ☐ |

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| **Risk Management** |
| Summarise any risks within the care and support plan |
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**Agreement to Care and Support Plan**

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| **To be signed by Service User** |
| **Personal Budget Agreement: for commissioned/virtual care and support only (delete if not applicable)**   * I agree to pay my assessed contribution (if any) to the local authority on request * I agree to give 7 days’ notice to the council of any changes of circumstances including change in service required, hospital stays, financial changes etc. |
| **Personal Budget Agreement: Cash via Direct payments or Mixed (delete if not applicable)**  I confirm that I have received the booklet “User Guide to Direct Payments” from my care coordinator or social worker. I will read this booklet and I will have the opportunity to go through the content of it and ask questions from the direct payment support officer when they visit |

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| **Signature:** |  | **Date:** |  |

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| **Role**  **(if not signed by individual)** |  |

Note: The can only be signed by the service user and their authorised person if they have one of the nominated person if using direct payments

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| **For Local Authority Use** |
| * The Personal Budget/Care & Support Plan has been agreed by the local authority * The Care and Support Plan delivers an appropriate package of support to meet the eligible needs of the individual * Any identified risks including contingencies are covered within the plan * The Care and Support Plan will be reviewed within 6 – 8 weeks/annually and then at least annually unless a change in circumstance requires one sooner than this   Details of the Worker assisting you with your support plan is below: |

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| **Workers Name:** |  | **Phone Number:** |  |

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| **Workers Signature:** |  | **Date:** |  |

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| **Review Details** | |
| Date of Review/approximate date if not agreed: |  |
| Please note: A review can take place sooner if circumstances change of if you would like to request a review. | |