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Mental Health Services/SocialServices

CARE PLAN AGREEMENT (CPA)

THIS PLAN IS AN AGREED CONTRACT OF THE SERVICES REQUIRED TO MEET YOUR ASSESSED NEEDS

Portsmouth HealthCare NHS Trust	**Hampshire County Council Social Services Department**
Hospital Number:	**Client Reference No:**

Name:	**DOB:**
Address:	
Telephone/Contact No:	

Keyworker: InPatient: **Job Title** **Base: Gosport War Memorial Hospital** **Bury Road GOSPORT PO12 3PW** **Tele/ Contact No: 01705 524611 Extn:**	**Keyworker: OutPatient:** **Job Title** **Base:** **Tele No:** **From Discharge Date:-**

GP: **Address:** **Telephone No:**	**Psychiatrist:** **Address:**

Your Carer/Relative has been consulted in this plan: YES/NO

Carer/Relative Name:
Address:

Telephone No:

Care Plan Agreement

IDENTIFIED NEED/S **(Please take into account the following):- Mental Health/Medication, Risk Factors, Relationships, Support & Social Networks, Physical Health (inc. Sensory/Mobility), Religious/Cultural, Accommodation, Employment/Occupation, Finances, Carers/Relatives Needs,**

Services to be Provided: Indicate if Residential Home/Nursing Home, long term or short term.

Identified Need	Action to be Taken	Who/Which Agency i.e. Health/SSD
(1) DIAGNOSIS:-		
(2) RISK:-		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		

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Care Plan Agreement

Location	Start Date	Review/End Date	Providers Contact Name & Telephone Number
			(1)
			(2)
			(3)
			(4)
			(5)
			(6)
			(7)
			(8)
			(9)

DATE OF CPA:
Those present at Care Planning Meeting (Names and Agencies as appropriate),

Interpreter:	**Contact Number:**	**YES/NO**
Advocate:	**Contact Number:**	**YES/NO**
Other **Please State:**	**Contact Number:**	**YES/NO**

Outcome; Steps to be followed in the event of relapse.

Steps to be followed if the client fails to attend for treatment of other planned commitments.

Action to be taken if the clients relative/carer can no longer provide assistance and support.

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Services that would hav ebeen desirable, but not available (for Planning purposes-

Any other comments:-

Date, Time and Venue of Next Review:-

LEGAL OBLIGATION

- Significant Risk of Suicide YES/NO
- Significant Risk of Violence to Others YES/NO
- Significant Risk of Severe Self Neglect YES/NO

If yes to all or any of the above, the named person should be considered for entry onto the Supervision Register

- If being discharged from Inpatient Care
- has Supervised Discharge Sec 25a been considered? YES/NO

LEGAL STATUS

	Guardianship
Section 117	Supervised Discharge Section 25a
Section 17	Sup Reg.
Section 37/41	Hospital - 6 months or longer
CPA (Medium)	CPA (Full)

AGREEMENT

I have read my Care Plan Agreement. I have discussed this with my keyworker to whom a copy will be sent. The information on this agreement can be shared with my representative and/or involved professional staff.

Signature..... Keyworker Signature.....
Date

Service Users/Keyworkers Comments:	Send copies to:	Tick
	1. GP	☐
	2. Patient	☐
	3. CPN	☐
	4. Social Worker	☐
	5. Relative/Carer	☐
	6. Other	☐

If you have any further queries about your Care Plan Agreement, or your circumstances change, you should contact your keyworker, as indicated on the front page of this agreement. If you have specific comments or complaints, please ask your keyworker who will advise you what you can do.

Carer/Representative Signature

.....

Systems Input		
File	Date	Initials

CPA6

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Mental Health Services
Hospital No:

CPA/Care Management
Client Reference No:

(TO BE COMPLETED BY SOCIAL WORKER OR CARE MANAGER)

Request for Finance

Clients Name:	**DOB:**	
Application of Eligibility Criteria **Category One** • **Anyone whose physical, mental or emotional problems mean they are a risk to themselves or others** • **Anyone whose physical, mental or emotional state would markedly worsen, or who would need residential care, without immediate help** • **Anyone faced with immediate severe problems because of family breakdown** • **Children whose development has been seriously imparied by abuse, neglet or lack of stimulation** • **Anyone who is dependent on alcohol or drugs and wants help in tackling this problem** **Category Two** • **Anyone who may become a risk to themselves or others if they do not get help.** • **Anyone whose independence is greatly reduced because they are ill, are about to leave hospital, or have a physical, mental or emotional difficulties.** • **Anyone who has social or emotional problems caused by such factors as a major upheaval in their ife, addiction, isolation, or lack of stimulation.** **Category Three** • **Anyone who is not at risk, nor having severe difficulties, but whose ability to cope would be increased if they had help.** • **Anyone for whom help would prevent any difficulties getting worse.**		**Comments:**

	Name	**Signature**
You (as service user)	.....	.....
Carer/Representative	.....	.....
Care Manager	.....	.....
Budget Holder	.....	.....

NATURE OF REQUEST

What	Period (from/to)	Cost (per week/month/one off	Max. Total Cost	Provider Name and Address for Payment	Finance Action Completed
			Total Cost of this Request		

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Community Review Sheet

Clients Name: **DOB:**

Address: **Telephone/Contact Number:**

Date of Review:

Those Present:

Changes made since last Planning/Review Meeting:

N.B. If these changes are significant, then a reassessment of need and new Care Plan should be completed.

Was a new Care Plan completed? YES/NO

Clients Signature.....

Keyworkers Signature.....

Service Users/Keyworkers Comments

Carer/Representatives Signature.....

Date, Time & Venue of Next Review

Send copies to:- Name

GP .....

Patient .....

CPN .....

S/W .....

Relative/Carer .....

Other .....

Systems Input

File	Date	Initials

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Discharge From After-Care

This section must be completed when the patient is discharged from after-care

Once this section is completed, copies of this form must be sent to everyone involved in the patient's after-care.

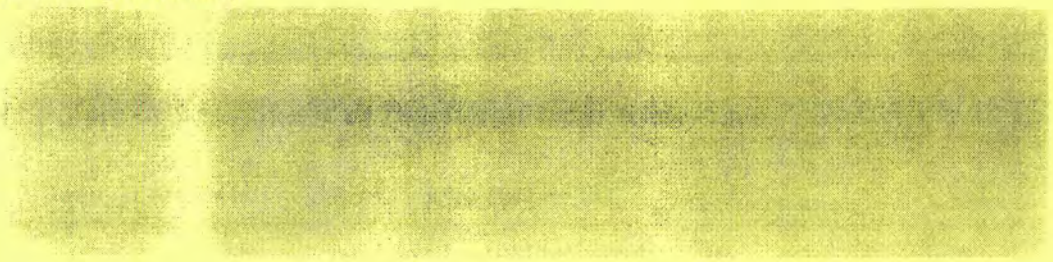
Name:

Address:

Contact Number:

Certificate of Agreement to Discharge from After-Care

The patient was discharged from after-care on _____
because *(give reasons)*



Signed **Print Name**

On behalf of the Health Authority **Title**

Signed **Print Name**

On behalf of the Local Authority **Title**

A copy of this form was sent to: *Date Sent*

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Mental Health Services
Hospital No:

CPA/Care Management
Client Reference No:

Transfer of Responsibility for Patient's After-Care

This form must be completed if the patient is to be moved to the care of another health or local authority.

Once this is completed, copies of this form must be sent to those involved in the patient's after-care and who have a need to know.

Responsibility for the patient's after-care remains with the current health and local authorities until the new authorities have signed the certificate of agreement.

(a) Responsibility for the patient's after-care transferred :

from ☐ Health Authority to ☐ Health Authority

from ☐ Local Authority to ☐ Local Authority

on ☐

Certificate of Agreement to After-Care

Signed — Print name

On behalf of the current Local Authority — Title

Signed — Print name

On behalf of the current Health Authority — Title

Signed — Print name

On behalf of the new Local Authority — Title

Signed — Print name

On behalf of the new Health Authority — Title

Signed — Print name

A copy of this form was sent: *give date*