PERSONAL PLAN OF CARE

Full Name:	
Address:	Plan effective from:
	Review required by:

The purpose of your Personal Plan of Care is:

- To set out our agreement with you about what you want to happen as a result of your assessment (i.e. outcomes)
- To list your needs in relation to the above outcomes
- To describe the arrangements for the services which will be provided – what and when etc.
- To give you a list of the people/agencies who will be supporting you and their contact phone numbers
- To help us, when we review your plan, to see if everything is going well and achieving what you want

Our commitment to quality services(to be monitored at subsequent reviews):
Service and support providers must provide support that:

- Makes you feel that you are ***listened to***
- Makes you feel ***valued and respected***
- is ***flexible*** and gives you ***choice***
- Is ***reliable*** and ***timely***
- Is ***responsive*** to your changing needs on a daily basis

What you want to happen as a result of this plan (we call these *outcomes*):
Tick all that apply to you and add any additional ones

You will:

1	Feel safe and secure	
2	Live where you want to, in an environment comfortable to you	
3	Have control over your daily life and routines	
4	Have satisfying things to do	
5	Have good social contacts	
6	Have your care needs met in an acceptable way	
7	Stay as healthy as you can	
8	Have improved health/reduced symptoms	
9	Improve your skills and/or learn new ones	
10	Be more able to get around your home and community	
11	Maximise your income, and control of your money	
12	Have your carer(s) supported in their caring role	
13		
14		
15		

Need No.	Assessed needs and risks	Risk Level	Action Code	Specific outcome to be achieved	Describe/ quantify how need will be met and by whom	Start date	Service Delivery (SD) Treatment (T) Manual Handling (MH) plans needed?

Identification label

Patient/client name…………………………………………...….   Domain completed by…………………………………………………   Date ___/___/___

Hospital No:…………………………………………………….. NHS No:………………………………………………...SS No:……………………………………

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Powys

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OUTLINE SUMMARY OF SERVICES TO BE PROVIDED ON A *REGULAR* BASIS

	Morning	**Lunchtime**	**Afternoon**	**Evening**	**Night**
Mon					
Tues					
Wed					
Thurs					
Fri					
Sat					
Sun					

(For details, see Service Delivery, Treatment, and Manual Handling Plan) Change d to equal spacing of lines

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List of agencies and individuals (e.g. carers) providing support	Contact phone Number(s)

List of additional emergency numbers and key contacts	Contact phone number
NHS Direct	08 45 46 47
Social Services 'Out of Hours'	08457 573818
Community Equipment Service (for collection of unwanted equipment etc.)	
Equipment repairs (electrical e.g. stair lift, tracking hoists etc.)	
Equipment repairs (non electrical e.g. bath board, toilet frame, chair raisers etc.)	

Emergency/Contingency Plans (Specify arrangements to be made for people, property, pets etc.)

Risks, if any, that the patient/client has chosen to accept (e.g. rather than accept recommended services)		
Is a Choice and Risk Management Plan required?	**Yes**	**No**

Additional information for service providers (E.g. individual preference, cultural issues etc.)		
Is a Provider Briefing Sheet required?	**Yes**	**No**

Financial contribution to Powys Social Services List of services for which there may be charges (*if this section is completed a social services financial assessor will visit and assess your financial contribution)*

Service Deficiencies?	**Yes / No**	*(If yes, complete page 12)*

Agreement: patient/client

If you are in agreement with your plan please sign below

Signature:	Date:

If the patient/client is unable or unwilling to sign their agreement, please record the reason:

If you do not agree with your Plan, please discuss this with your Care Manager/Care Coordinator. If you cannot reach an agreement with them you can request a reassessment by another worker or you may use the complaints procedures of Powys County Council or Local Health Board.

If you would like to change your Plan, for example when you have information about your financial contribution, please contact your Care Manager/Care Coordinator.

Consent to Share Information

With your consent, your Plan may be shared with your carer(s), and the people/agencies listed on page 8. If you do not want any of these to receive your Plan, please list your exclusions below	
Name of person/agency **not** to receive your Plan:	
Signature:	Date

Plan completed by

Name of assessor:	Job Title/agency
Signature:	Date:

Approved by Manager (Powys Social Services only)

Name:	
Signature:	Date:

Administration

Personal Plan of Care form *given* to patient/client by assessor?	Yes	No
	Date:	
Personal Plan of Care form *sent* to patient/client by assessor?	Yes	No
	Date:	
Personal Plan of Care form *given/sent* to all agreed provider(s) by assessor? *	Yes	No
	Date:	

If a copy of the Personal Plan of Care is given to a provider, it should be accompanied by a copy of the Basic Personal Information form

Service Deficiency form

	Name	Team
Assessor/Reviewer		
Line Manager		

No suitable service available/provided

Outcomes, needs not being fully met	Comment on any reason for the deficit and suggestion as to the type of service that is required

Service available/provided, but outcome/need not able to be fully met

Current service available, provided	Outcomes, needs not able to be fully met	Comment on why the outcomes/needs are unable to be fully met and suggestion as to how existing service could be improved	
		Quality issue	Quantity issue

SSD Panel/LHB Comm. Team comments/recommendations