Leeds and York Partnership NHS
NHS Foundation Trust

CPA
Care Programme Approach

My Wellbeing and Recovery Plan

Your review is about you. It's about checking how things are going and agreeing what's going to happen next. Your Care Plan describes your goals and actions that you and others are taking to support you in meeting your goals.

Service user name:

People involved in my review/care plan:

Review context (for example - why the review is taking place, what you want to get out of it, how you are involved in your review):

Mental Health/Learning Disability (what does 'good' mental health look like for you? How are you doing now? What help would you like? What doesn't help? What information do you need about your mental health?)

Goals:

Who is doing what and when?

Staying physically well (how is your health? Weight? Smoking? Exercise? What are your physical health concerns? When did you last have a check up at the GP? Are you up to date with health screening – smear, dental, eye check?)

Goals:

Who is doing what and when?

My medication (what's your view of your current medication? What are the side effects, if any? Do you need help with taking your medication? Are there any issues in getting you prescription?)

Goals:

Who is doing what and when?

Making the most of my time (how do you fill your day? What do you like to do? What would you like to de doing in the future? What would help you reach your goals? What's getting in the way, if anything?)

Goals:

Who is doing what and when?

People important to me (If you have a carer, who is it - this might be your partner, a friend or a relative? Have they had a carers assessment – would they like one? What information do they need? What's your view on sharing information and including your carer in discussions?

Goals:

Who is doing what and when?

My money (How are you coping with money? What is your income source? What, if any, are your concerns about money?)

Goals:

Who is doing what and when?

Where I live (What is your home situation at present? Is your housing settled? Do you need help with keeping your home? What help do you need with housing?)

Goals:

Who is doing what and when?

Supporting parents & safeguarding children (Do you have children under 18yrs? Do you live with or have contact with under 18's? What support, if any, do you need with parenting/ caring for children? What support might your child/children need? If you need extra support at particular times – school holidays, when unwell etc how do you get it? Are there other services involved in supporting your family?)

Goals:

Who is doing what and when?

Moving on (What's your view on moving on from mental health services? What support do you need in your local community? Do you have any concerns about moving on from services? When would you like to move on from services?)

Goals:

Who is doing what and when?

There may be other areas that you want to talk about and plan for at your review. Here are some areas that might be important to you:

- **Substance use**

Goals:

Who is doing what and when?

- **Engagement & Diversity**

Goals:

Who is doing what and when?

- **Mental Health Act, capacity & legal issues**

Goals:

Who is doing what and when?

- **Safeguarding**

Goals:

Who is doing what and when?

- **Staying Safe**

Goals:

Who is doing what and when?

Contingency Plan

Action to be taken where at short notice either the Care Co-ordinator is not available or part of the Care Plan cannot be provided.

Crisis Plan

A crisis plan is about realising when you might be becoming unwell and understanding what helps you during this time; what makes things worse and about what people, including yourself, can do to help you. Your crisis plan also helps crisis services offer you help that is meaningful to you.

1: What are your triggers? (What has caused you to become unwell in the past – this might be life events; changes to your circumstances; relationship issues for example)

2: What are your early warning signs? (What are the signs that you are becoming unwell? What might you be doing or saying? What changes when you are becoming unwell? – this might be sleep, restlessness, concentration, mood, conversation, appetite, being around people)

3: What helps you to cope & what help do you need? (What has worked in the past? Who helps to support you – family, friends, peer supporters, online help, phone support? What helps you feel better – music, going out for a walk, meeting/calling friends, early night, hobbies? What makes things worse? What arrangements do you have/prefer for caring for your dependents if you have any – children, pets, parents?

4: What is your preferred emergency action plan? (It may be that step 3 is enough for you to get back on track; if not, then what is your preferred way of getting help to keep you safe and well?)

What happens next?

- Your care plan will be typed up and you will be given a copy to check.
- When you are happy with your care plan, you, and others involved in your care plan – with your agreement, will be given a final copy.
- Your care plan will be reviewed again in the future – you and your care coordinator can agree when this will be.

Care coordinator name and signature:

Service user name and signature:

Next review date is by: .....

Review Information [for clinician use]

Have any decisions been made in the individual's best interest due to lack of capacity or is there a valid Lasting Power of Attorney? Yes □

Does the individual have mild/moderate learning disability(meet the Green Light criteria)? Yes □

If the individual has an Advance Decision or Statement, where can this be found?_____

The need for Section 117 entitlement should be considered during the review, is the entitlement to continue? Yes □ No □ Not entitled to 117 aftercare □

Alternative name for My Wellbeing & Recovery Plan: will print as My Wellbeing & Recovery Plan if left blank _____

Is the individual in agreement with the plan? Yes □ No □ Some of it □

All individuals should be given a copy of their plan; the plan was given on:

A copy of the plan is usually sent to the people involved in the individuals care and support, including the GP. The individual prefers the following person/people to not receive a copy: