**Lincolnshire Integrated Care Board and Lincolnshire Partnership Foundation Trust Joint agency**

**Section 117 Aftercare Health care plan and review for Children and Young People**



**Young Person’s Details**

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| **Name:** |
| **DOB:** |
| **Current Location:** |
| **Home Address upon discharge if known:** |
| **Household contact details:**  **Parent/Carer:**  **Next of Kin if different from above:**  **Address:**  **Telephone:**  **Mobile:**  **Email:** |
| **Gender:** |
| **NHS number:** |
| **Rio number:** |
| **Mosaic number:** |
| **GP name and address:** |
| **Any identified religious or cultural needs:** |

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| **Lead Professional**  **Name:**  **Designation:** | **Work base:** |

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| **Date of review:** | **Which review** |

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| **Detail of the care and support plan and goal review outcome:**  **Legal status upon discharge:**  Guidance- Is the young person Child in Need (CIN), Team Around the Child (TAC), subject to Child Protection Plan (CP), a Child in Care (CIC)  **Family and friends (support network):**  Guidance-Please note the current living arrangements for the young person. If living in the family home who will be living in the household, are there individuals outside of the household that provided a caring or supportive role to the young person, who has the young person identified as part of their support network and how will they be effective in the young person’s recovery, who will the young person be spending time with upon discharge, please consider what support the network will require to help the young person’s recovery.  **Health:**  Guidance- What is the offer of support from health? At a minimum the young person will be placed on CCETT’s Enhanced Care Package and is eligible to receive up to daily contact from the Crisis and Enhanced Treatment Team for a minimum of 2 weeks, include details on the proposed intervention by CCETT and an agreed amount of contact for the initial two weeks post discharge. If the Young Person is open to Core CAMHS or EIP please also list the proposed Care Plan post discharge and please consider the use of Peer Support and Parent Peer Supp  **Social Care:**  Guidance- What is the offer from social care, will there be a period where the child is subject to a Child in Need Plan and if so please detail the frequency of Child in Need Meetings, is there a need for Early Help to support Young Person and Family with adjustment of the Young Person returning home or any other need, please consider whether a referral is needed for Futures4me and any other relevant service/agency that can be accessed via Social Care.    **Education & any other relevant service:**  Guidance- please include the views of the current or proposed educational provider and if the Young Person has an EHCP plan then please invite SEND caseworker to share their views and the offer of support from an education point of view |

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| Family and support network.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |

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| Health input to care plan.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |

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| Social care input o care plan.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |

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| Education input to care plan.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |

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| Behaviour.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Cognitive development.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Mental health and emotional well-being.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Communication.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Medication effectiveness.  Any change to medication regime since last review. |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Nutritional goals.  Current goal: |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Other section 117 aftercare needs please state domain heading.  Current goal(s): |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |
| Who will provide support: |

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| Crisis plan update. |
| Is there any change to the current plan yes/no. |
| If yes, please describe the change below. (if the goal is reached please note this below if no care plan is required). |
| Goal achieved.  New care plan. |

**Traffic Light System Safety Planning to be completed jointly by the ward, young person, family/ carers and community teams:**

**Please use this form to give a comparison for development since discharge as the young person moves toward well being.**

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| **Colour** | **What does this mean?** | **What can I do to support myself?** | **What do I need other people to do to support me?** |
| **Green**  Guidance: What does the Young Person’s ‘Best Day’ look like. How do they feel emotionally and physically? What are their thoughts? |  |  |  |
| **Amber**  Guidance: this is when the Young Person is starting to notice a decline in their mental health and well-being. What are the different feelings and emotions from Green? What does this type of day feel like to the Young Person? What can the Young Person and others do to help them go back into a ‘Green’? |  |  |  |
| **Red**  Guidance: What does the Young Person’s ‘worse day’ look like? How do they feel physically and emotionally? What symptoms do they have? Is there a particular person or activity that can support them? How can they get back into Amber with support from others? |  |  |  |

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| Needs not related to section 117 aftercare.  Please specify, the need and which agency is supporting the need. |
| Need: |
| Need: |
| Need: |

**Young person’s views of their care:**

**Please note whether and how the young person contributed to the care plan review, plus their view of the Section 117 care plan.**

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**Parent/ Carer views of the proposed S117 care package offered:**

**Please note how parent/ carer views were ascertained to contribute to this care plan review, plus their view of the Section 117 care plan.**

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Providers approached and costings where a service is required

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| Name of provider: |  |
| Cost of package: |  |

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| Name of provider: |  |
| Cost of package: |  |

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| Name of provider: |  |
| Cost of package: |  |

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| Name of provider: |  |
| Cost of package: |  |

**Participant details**

Involved professionals to enter details of their designation and organisation.

The individual and their relations leave the organisation box empty.

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| Name of lead Professional (print): |  |
| Designation/Relation: |  |
| Organisation: |  |
| Contact details: |  |
| Signature: |  |

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| Name: |  |
| Designation /Relation: |  |
| Organisation: |  |
| Contact details: |  |
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