**Record of first Dynamic Support Pathway (DSP) Meeting**

This is to be completed during the first DSP meeting. All sections of this form should be discussed and recorded during the meeting.

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| **Individual’s details:** | | | | |
| Name of individual | |  | | |
| NHS number / Local Authority PIN / BT No | |  | | |
| DOB | |  | | |
| **DSP meeting details:** | | | | |
| Current RAG rating | |  | | |
| Chair | | ND Patient Assurance Team member: | | |
| Lead professional | |  | | |
| Date and time of meeting | |  | | |
| Form completed by | |  | | |
| **Attendees** | | | | |
| **Name** | | **Role / Relationship with individual** | | |
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| **Current situation** | | | | |
| Please include key events or changes in presentation. | | | | |
| **Safety, risks and safeguarding** | | | | |
| Is the individual ‘safe’ in their current environment and with this level of care? Are all risks (including those to/by the individual) being managed? Are care and support measures meeting the needs of the individual? How are these risks being mitigated?  Is there a contingency plan in place / who can arrange this if not? Has this plan been provided? Is everyone assured that these plans are working as intended? Are there any safety concerns? Has the individual been made to do something that has made them feel uncomfortable and/or unsafe? Does the individual have someone they can talk to if they are worried about themselves or their family/friends? | | | | |
| **Accommodation** | | | | |
| Where is the individual currently living? Is their placement currently at risk/has notice been given? Is accommodation appropriate and meeting the needs of the individual? Is accommodation environmentally suitable/adapted as required e.g., sensory adaptation, bath/shower/wet room? | | | | |
| **Physical Health** | | | | |
| Are there any physical health needs contributing to the increased risk? (If yes please provide details). How is their sleep?  Are all physical health concerns being managed appropriately? Is the individual receiving their Annual Health Check? | | | | |
| **Medication** | | | | |
| Are they involved in decisions about their medication? Has the individual received a recent medication review including STOMP/STAMP/Lester Tool? Has there been any new medications or recent changes in medication? Is the individual currently compliant with their medication care plan? If not, what contingencies are in place? | | | | |
| **Views of the individual** | | | | |
| What are the views of the individual and what are they hoping for as an outcome of being on the DSP? Does the individual wish any family and/or carers to be involved? What are the longer term hopes and goals of the individual? | | | | |
| **Parent, Family and/or Carer involvement** | | | | |
| Please include details of relevant parent, family and/or carer involvement. What are the views of the family and/or carer and what are they hoping for as an outcome of the individual being on the DSP?  Do any members of the family have any mental/physical health conditions/disabilities? Are there any possible upcoming changes to family and/or carer support and what impact may this have? | | | | |
| **Parent, Family and/or Carer Support** | | | | |
| Is there any impact on the family (including siblings) and/or carer(s) due to this individual’s current presentation? What support is currently being provided to the family and/or carer(s)? Has a Carers assessment been completed? Do the family and/or carer(s) require any additional support? | | | | |
| **Health and Social Care Support** | | | | |
| Is the individual receiving appropriate care and support? Are they involved in decisions regarding their package of care and support? Are they able to access activities of interest? Is a reassessment of need required? | | | | |
| **Advocacy Involvement** | | | | |
| Is this individual entitled to independent advocacy? Does the individual have access to an independent advocate? | | | | |
| **Rights and Legal Frameworks** | | | | |
| Please provide details of any restrictions and legal framework currently in place. Are the rights of the individual being respected? | | | | |
| **Education (if applicable)** | | | | |
| Attendance? When was the individual last in education? What are the barriers to attending education? Is an EHCP Plan in place? If “yes” when was this last reviewed? What are the plans for future education? | | | | |
| **Looked after Child (if applicable)** | | | | |
| Is the individual a looked after child? Are they currently placed out of area? If the individual is placed out of their originating area, is this affecting their wellbeing? What arrangements are in place to monitor the wellbeing of the individual? Is an independent advocate involved in the care of the individual? When was the last Review Health Assessment held? Are there any outstanding actions from the Health Action Plan? | | | | |
| **Escalation to a CTR/CETR** | | | | |
| Is escalation to the ‘Red’ rating on the DSR required and a CTR/CETR being requested? Please outline the rationale for this request. | | | | |
| **Changes or increases in commissioned services** | | | | |
| As a result of this meeting, have any changes or increases to the existing care package been recommended? If so, a completed Urgent/Interim SEAL application should be submitted to the ICB and the appropriate Local Authority using the email addresses below:  County Cases   * ND Patient Assurance Team: dhcft.ndpat@nhs.net * Derby & Derbyshire ICB: ddicb.ommissioningforindividuals@nhs.net * Derbyshire County Council: asch.sealfunding@derbyshire.gov.uk   City Cases   * ND Patient Assurance Team: dhcft.ndpat@nhs.net * Derby & Derbyshire ICB: ddicb.commissioningforindividuals@nhs.net * Derby City Council: PanelandMinuting.Support@derby.gov.uk | | | | |
| **Gaps in Service** | | | | |
| Have any gaps in services been identified? If so, please describe below. | | | | |
| **Action Plan** | | | | |
| **Task** | **Responsibility** | **Timeline** | | **Outcome** |
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| Agreed RAG rating following meeting (please tick). Please refer to the ‘Guidance for Professionals’ for the Risk Matrix | | | | |
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| **Next Steps** | | | | |
| If Red, has a C(E)TR request been sent to ND Patient Assurance Team? | | Yes/No | | |
| Is a safeguarding referral required? | | Yes/No | | |
| Is a follow-up DSP meeting required? | | Yes/No | | |
| Nominated Chair and note taker for follow up DSP meeting | |  | | |
| Date of next DSP (if required) | | Add date and time | | |
| ND Patient Assurance Team to distribute completed notes to attendees within 1 working day | | | | |
| **Each agency should ensure a summary of agreed actions from this meeting is entered onto their internal case management recording system pending distribution of the meeting record.** | | | | |