Information about your care plan

You have been given this leaflet because a care plan has recently been created for you or for someone who you are a carer for. You may also have an existing care plan that has recently been updated.

A partnership of:

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Your care plan and your summary care record

You will already have what is known as a Summary Care Record (SCR), unless you have chosen not to do so.

Your Summary Care Record is the basic information about your health such as the medicines you are taking, your allergies and any bad reactions you may have had to certain medicines. It also includes your name, address, date of birth and unique NHS Number which helps to identify you correctly.

An SCR is held electronically and is used to provide healthcare professionals with any information they wouldn't otherwise have. For example, when you're visiting an urgent care centre or being admitted to a hospital, staff could view your SCR and discover you are on a particular medication or have allergies.

Important information from your new care plan will also be added to your SCR so that in an emergency you can be looked after in the agreed way.

If you have registered at your GP practice for online services, you will be able to see the information that is included in your Summary Care Record by logging in to your online services or by using the app. Alternatively, ask at your GP practice.

What is a care plan?

A care plan is an agreement between you, the patient, and your GP, to help manage your health, care and support day to day.

The plan will be based on what you want, so you're in control and will focus on the elements of care, support and treatment that matter most to you, your family and carers.

Who gets a care plan?

The majority of patients are those that have been identified as being at high risk of an admission to hospital, and can also include:

- patients with long term conditions such as COPD, diabetes, dementia
- vulnerable patients
- patients approaching the end of their life

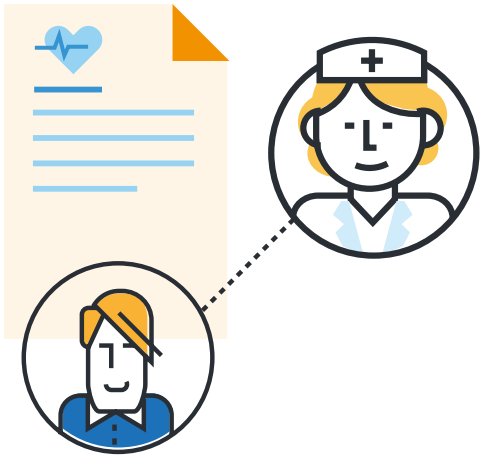
Why have a care plan?

You do not have to have a care plan, but your GP or nurse may feel that it would make a positive difference to you.

Having a care plan in place can help avoid a health crisis and reduce the risk of being urgently admitted to hospital. A care plan can give you and your family peace of mind.

What does a care plan do?

All patients now have a named GP who has overall responsibility for co-ordinating their care. The care plan will set out how the patient's health and care needs will be addressed, with more support and treatment provided by the community, reducing the risk of being admitted to hospital.



The plan will usually include the following:

- Relevant medical information: conditions, diagnosis, latest test results and significant past medical history
- Details of medication you take
- What you would like to happen with your care in an emergency
- Your choices about resuscitation
- Consent to share information with other health care professionals such as hospitals, ambulance service
- Details of your next of kin
- Medication changes you may need if you are approaching the end of your life
- Information for the out of hours service and ambulance paramedics

You will receive a paper copy of your care plan, which you should keep in a safe place.

What does this mean for patients and carers?

Once the care plan has been agreed, you will be given a copy of the care plan to keep safe in your home. You also need to let your family and any carers know that you have a care plan and where they can find it.

It is important to tell other healthcare professionals that you have a care plan and show it to them. If you become ill everyone can see what actions were agreed between the you and your GP to best manage these situations.

What happens next? Reviewing the care plan

If you have a care plan and you are unfortunately admitted to hospital as an emergency, or if you need to attend A&E, your GP will review what happened, so they can understand why you had to go to hospital. If the GP thinks it could have been avoided, they will take actions to try and ensure it doesn't happen again.

You or your carer can also advise the GP of any changes or updates that you feel should be included in the care plan; for example you may change your mind about resuscitation.

Each time a change is made to your care plan you will receive a new printed copy .

Want more information?

If you think you, or your loved one would benefit from having a care plan in place please contact your GP practice or if you are online, visit www.nhs.uk/healthrecords