

The Supportive Care Plan (SCP)

Information and advice for patients

Palliative Care

What is the supportive care plan (SCP)?

The supportive care plan is an end-of-life care plan that is used to ensure that anyone with an advanced life-limiting illness receives the best possible care, and that their wishes are at the centre of all decision-making in the last months, weeks and days of their life.

The supportive care plan is set out in a document which is used by healthcare professionals to guide how care is planned and delivered. This document will guide healthcare professionals to consider with you if some treatments are beneficial to you or not and to plan care appropriately.

We all have different ideas and thoughts about how we would want to be cared for in the last months and days of life. The focus of the supportive care plan is firmly on assisting you to live as well as possible, and to support you in any decisions you may make while you are in the last months, weeks and days of your life.

How will the supportive care plan benefit me?

If you choose to start the supportive care plan after discussing it with your care team, they will then talk to you about where you would like to be cared for and any concerns about symptoms you have. The plan ensures that your care is focused on your wishes and addressing your concerns. Your wishes will always be at the centre of any decisions made about your care and we will be encouraging you to be involved in planning your care.

The supportive care plan will not stop you having treatment but it will ensure that your wishes are the priority when planning your care.

While you are on the Supportive care plan we will continually reassess and modify your plan of care to ensure that your symptoms are managed and that your wishes are met wherever possible.

How will my wishes and care plan be recorded?

All of the information relating to your care will be recorded in the supportive care plan document. The document will be kept in your medical notes when you are in hospital. When you are at home the document will be kept safe, such as with the district nurse notes.

In the document we will record:

- Where you would like to be cared for
- What your wishes are
- Who is involved in your care and their contact details
- Your plan of care
- How and when we will review your care

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Keeping all of this information in one place will allow everyone involved in your care to understand your needs and your wishes, even when your GP and the team who usually care for you are not available.

What to do if you have more questions

If you have more questions about the supportive care plan or your plan of care, please speak to the ward nurse looking after you or your district nurse.

Sources used for the information in this leaflet

Department of Health, End of life care strategy, 2008

Further information

For more information about our hospitals and services please see our website www.swbh.nhs.uk, follow us on Twitter @SWBHnhs and like us on Facebook www.facebook.com/SWBHnhs.

If you would like to suggest any amendments or improvements to this leaflet please contact the communications department on 0121 507 5303 or email: swb-tr.swbh-gm-patient-information@nhs.net



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