Principles of joint care planning

- **Representatives from both health and social care** who are aware of the individual’s impairments and aspirations should be involved in the development of the care plan with the individual.

- **The plan should be owned by the individual** (or their carer if the individual is unable to participate) who must be involved in its development. The document should support the empowering of individuals to have ownership of their own care. The individual should have a copy of the joint care plan.

- **The plan should consider whole person and encompass all of their ongoing issues** including their relationships, finances, leisure etc not just management of the stroke.

- **The individual and carer should receive the right information**, in a format they can understand and at the right time to make informed decisions about what their care plan should comprise.

- **No stroke survivor should leave hospital without one.** All individuals should have the same assessment of need regardless of potential needs. (what if there are no ongoing needs for further care- should the joint care plan be blank? Unnecessary bureaucracy)

- **The care plan should be written in plain English** and contain no jargon abbreviations or medical/ social care terminology.

- **Joint care planning will be enhanced by early active involvement by a representative from social care**

- **The joint care plan written on discharge from hospital should be an evolving document** to be developed as the individuals needs change in conjunction with community providers, primary care, the voluntary sector and social care (any others?)

- **The joint care plan differs from the transfer of care document** in that its primary function is to describe the plan of care the individual needs to continue an optimal quality of life after hospital discharge rather than the transfer of information between health care professionals about services the individual will receive.