The Principles of Future Care Planning

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Learning Objectives

1. To understand what is meant by future care planning
2. To understand what is meant by Anticipatory Clinical Management Planning
3. To have an awareness of the tools available to support people
4. To think about how we introduce discussions about future care planning

Which Plan is which?

	Present Needs	Future Needs
Personal Plans	Personal Needs	Advance Care Plan
Clinical Plans	Clinical Care Plan	Anticipatory Clinical Management Plan

Universal Principles for Advance Care Planning

NHS England, March 22

The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.

The person has personalised conversations about their future care focused on what matters to them and their needs.

The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals.

The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.

The person has the opportunity, and is encouraged, to review and revise their advance care plan.

Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

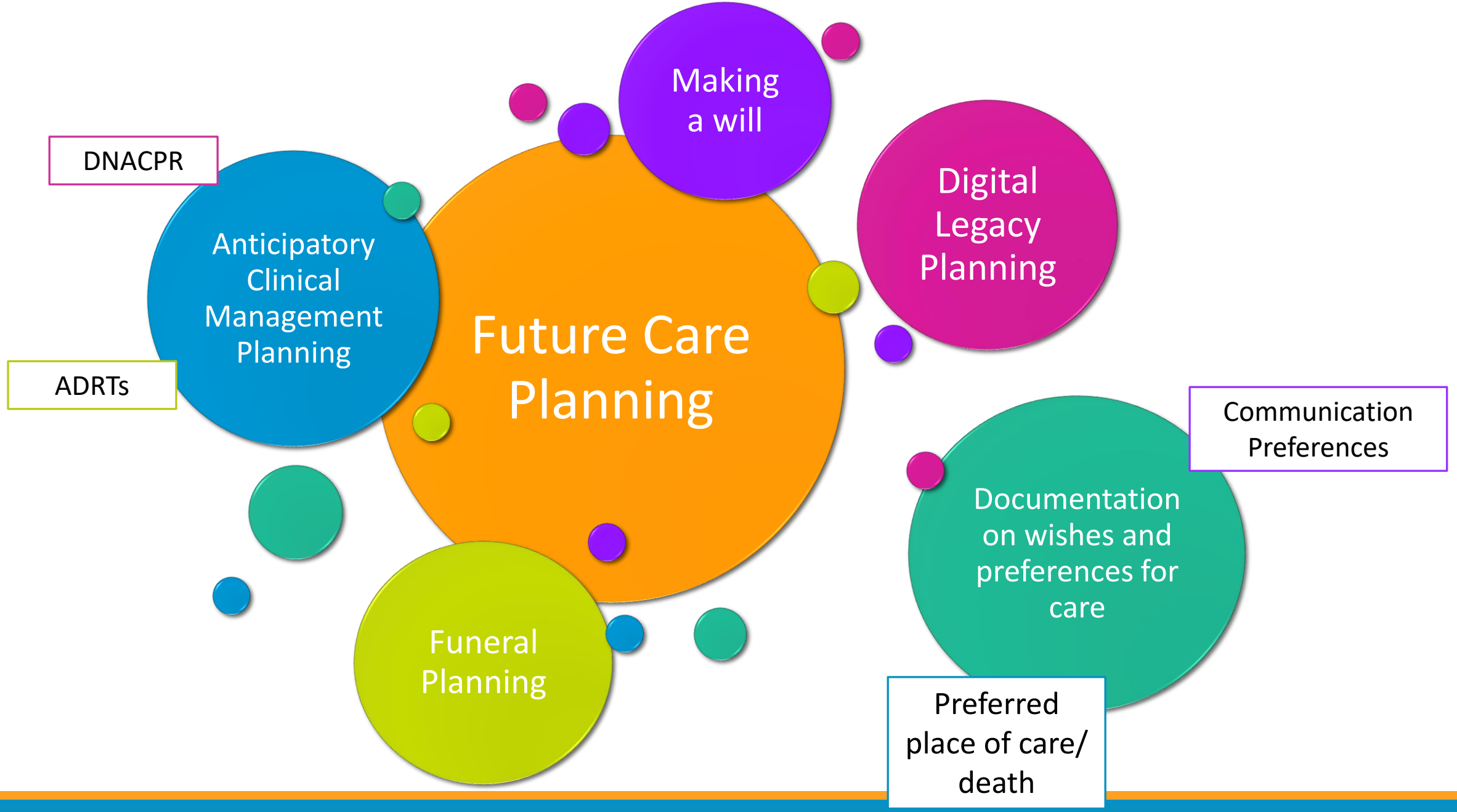
Who might benefit from ACP discussions?

These are relevant for any individual who wishes to plan for their future care or who may be at increased risk of losing their mental capacity in the future, including:

- People facing the prospect of deteriorating health due to a long-term condition or progressive life limiting illness, e.g. dementia, frailty, kidney, heart or liver failure, lung disease, progressive neurological conditions, incurable cancer
- People with declining functional status, increased burden of illness or persistent physical or mental health symptoms
- People facing key transitions in their health and care needs, e.g. multiple hospital admissions, shifts in focus of treatment to a more palliative intent, moving into a care home, etc.
- People facing major surgery or high-risk treatments, e.g. bone marrow transplant
- People facing acute life-threatening conditions which may not be fully reversible

What sort of things do you think someone might want to discuss or plan for in the future?

Group Discussion


Future Care Planning
Making a will
Digital Legacy Planning
Anticipatory Clinical Management Planning
DNACPR
ADRTs
Documentation on wishes and preferences for care
Communication Preferences
Funeral Planning
Preferred place of care/ death

Anticipatory Clinical Management Planning

This is a proactive clinical management plan prepared in advance for a clinical situation, predicted or thought likely to occur, to allow conversation and preparation for the future.

Anticipatory Clinical Management Planning

Part of future care planning

Not just about limiting treatment

Should include what people DO want as well as what they DON'T

These are not "decisions made in advance" but they provide guidance which may support clinical decision making at a future date

Anticipatory clinical management plans are made by clinicians (with patient and family input)

Advance Care Planning (ACP) is patient led

Can be advisory or legally binding (ADRT)

Advance Care Planning- The Clinician's Role

The GMC say ACP discussions should cover:

a. the patient's wishes, preferences or fears in relation to their **future treatment and care**
b. the **feelings, beliefs or values** that may be influencing the patient's preferences and decisions
c. Who the patient would like to be **involved in decisions** about their care
d. Wishes on **emergency interventions** e.g. CPR
e. the patient's **preferred place of care** (and how this may affect the treatment options available)
f. needs for religious, spiritual or other personal support.

Can also cover what they want after death

What to include in ACPM

CPR Decisions

Treatment Escalation Plans

Plans for the management of specific anticipated scenarios e.g.

- Falls
- Aspiration/ Infections
- Existing medical conditions

Who should be involved in decision making (inc LPAs)

ADRTs

Place of Care inc PPD

Plans for anticipated symptoms including anticipatory medications

Advance Statements

An advance statement is **not legally binding** but it is useful to inform and guide decision making in the future if the person subsequently loses their capacity to make decisions about their care.

Includes information about:

- Wishes, preferences and priorities
- May include the nomination of a named spokesperson

There are several different documents that can be used to capture anticipatory clinical management plans in L&SC. (Including ReSPECT, Deciding Right and other locally developed tools)

Advance Decisions to Refuse Treatment

ADRT is a written statement (can be verbal except for life-sustaining treatment)

Informs others about treatment a patient doesn't wish to have

Cannot be used to demand treatment or end life

Must be over 18yrs and have capacity

For life-sustaining treatment, CPR and ventilator decisions they must be:

- Written down
- Signed by the patient/ someone on their behalf
- Witnessed

May become invalid if LPA appointed afterwards

Contents of an ADRT

Must be specific to the treatment and circumstances

Needs to include a statement such as

‘I refuse this treatment even if my life is at risk as a result’

Can create own or use a template

Other recommended contents for all:

- Identifying details/ features
- GP contact and whether they have a copy
- A statement saying it should be used if pt lacks capacity
- The decision
- Dates and signatures

Lasting Power of Attorney

Legal document- must be registered with the Office of the Public Guardian

Allows a patient to appoint one or more people to make decisions for them

Must be over 18yr and have mental capacity to appoint one

2 types of LPA:

- Health and Welfare
- Property and Financial Affairs

Process is different in Scotland and NI

LPA for Health and Welfare

Can be used for decisions like:

- A patient's daily routine, e.g. washing, dressing, eating
- Medical care
- Moving into a care home
- Life-sustaining treatment

Can only be used when the patient lacks capacity

Can have one or more attorneys

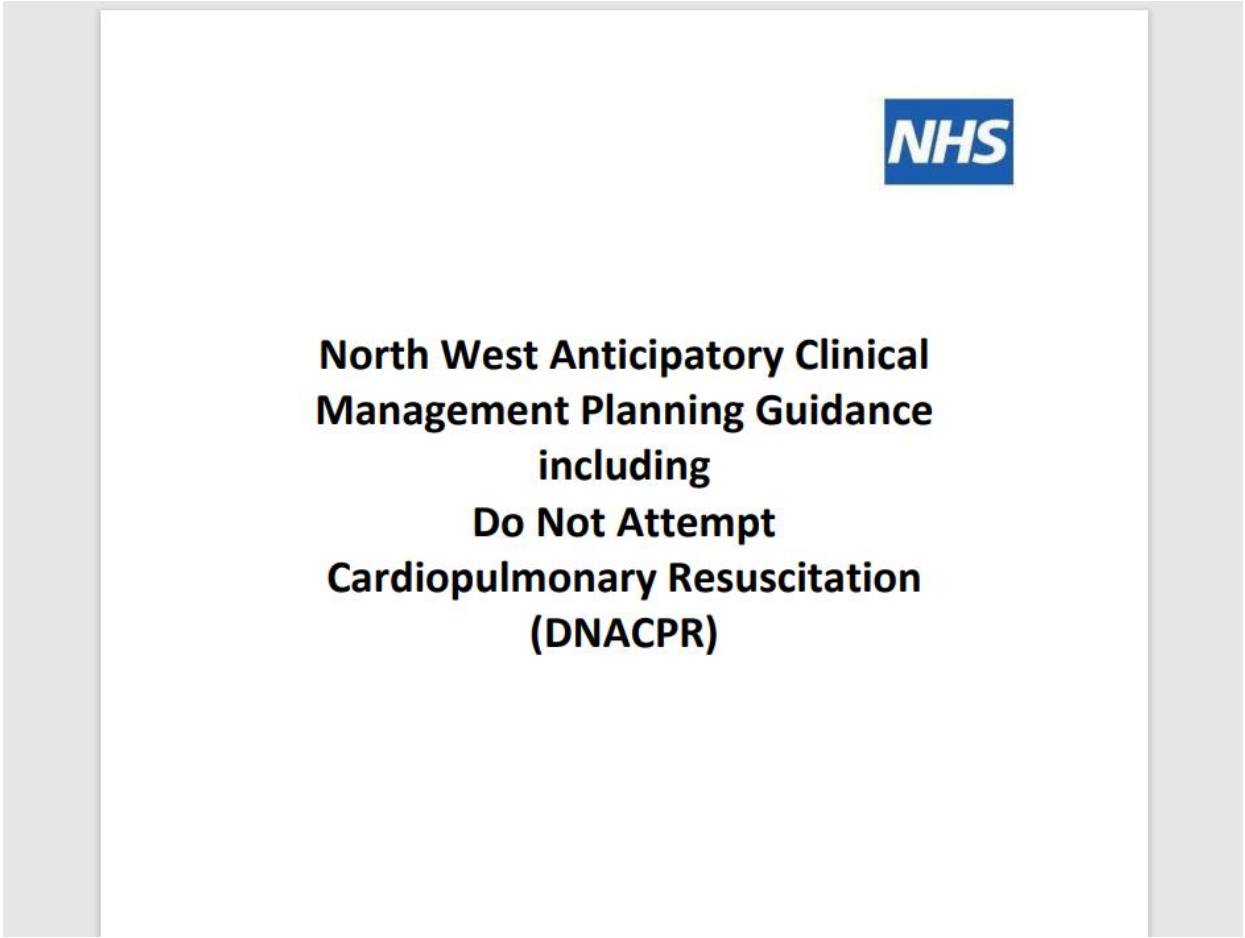
If more than one then can be appointed to make decisions:

- Jointly (All attorneys must agree the decision)
- Severally (On their own or with others)

Can include decisions for life-sustaining treatment or not.

Need to see the LPA paperwork or ask the patient/ family for the LPA access code

NW Guidance Available



Advance Care Planning

A voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for future care. These are likely to involve a number of conversations over time and with whoever the person wishes to involve.

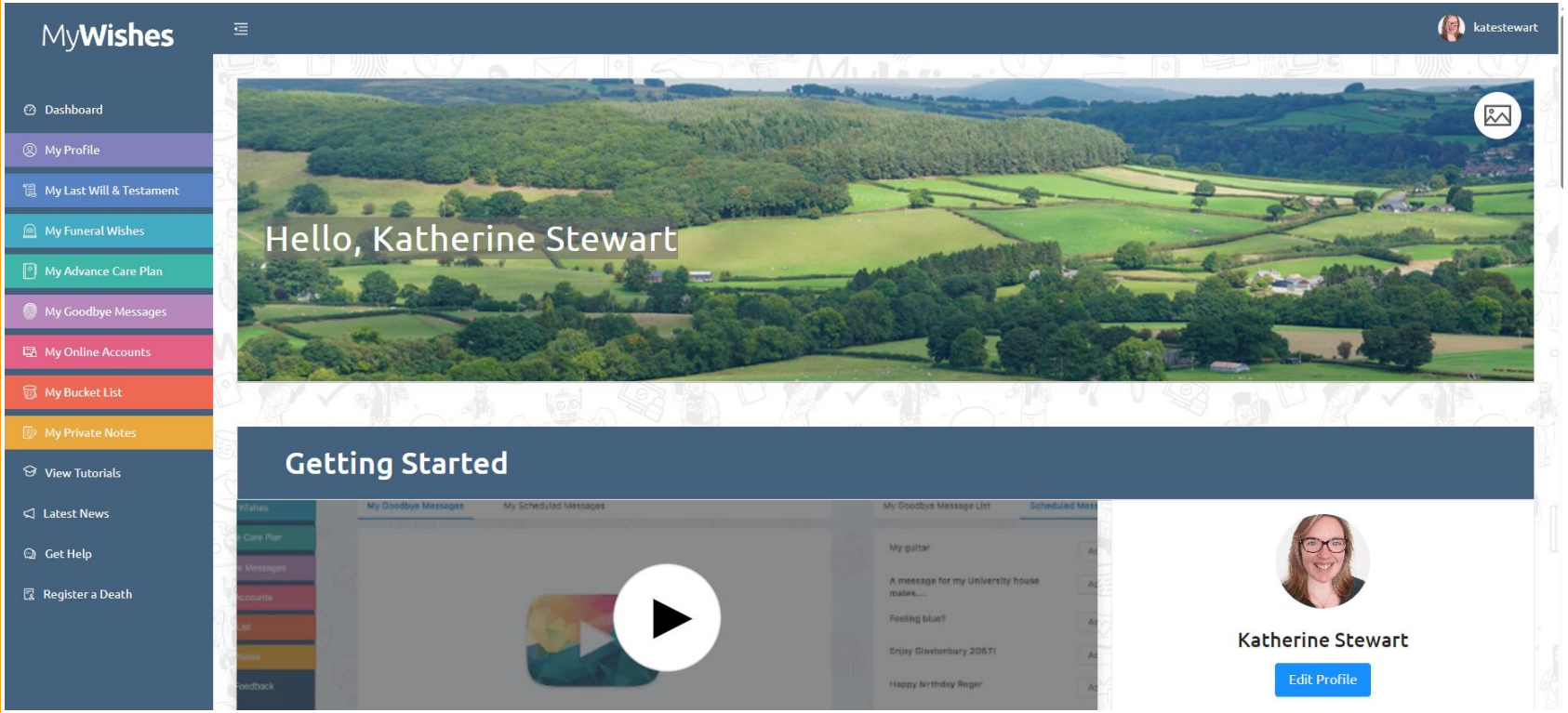
Areas of ACP people may wish to consider

May overlap with ACMP

- Religious and Spiritual wishes both before and after death
- Goodbye messages and memory boxes
- Funeral Planning
- Writing a Will
- Digital Legacy Planning
- Financial Planning
- How to make their wishes and preferences known (e.g. music, food and drink)
- Planning for things they wish to do/ Bucket List
- Who they want involved in their future care

Advance Care Planning Tools: MyWishes

SCAN ME



Finances

SR1 Medical Report Form

- This has replaced DS1500
- Enables pts to claim under special rules- depending on the benefit they get:

Get faster, easier access to some benefits

Get the highest rate of some benefits

Do not need to have any medical assessment

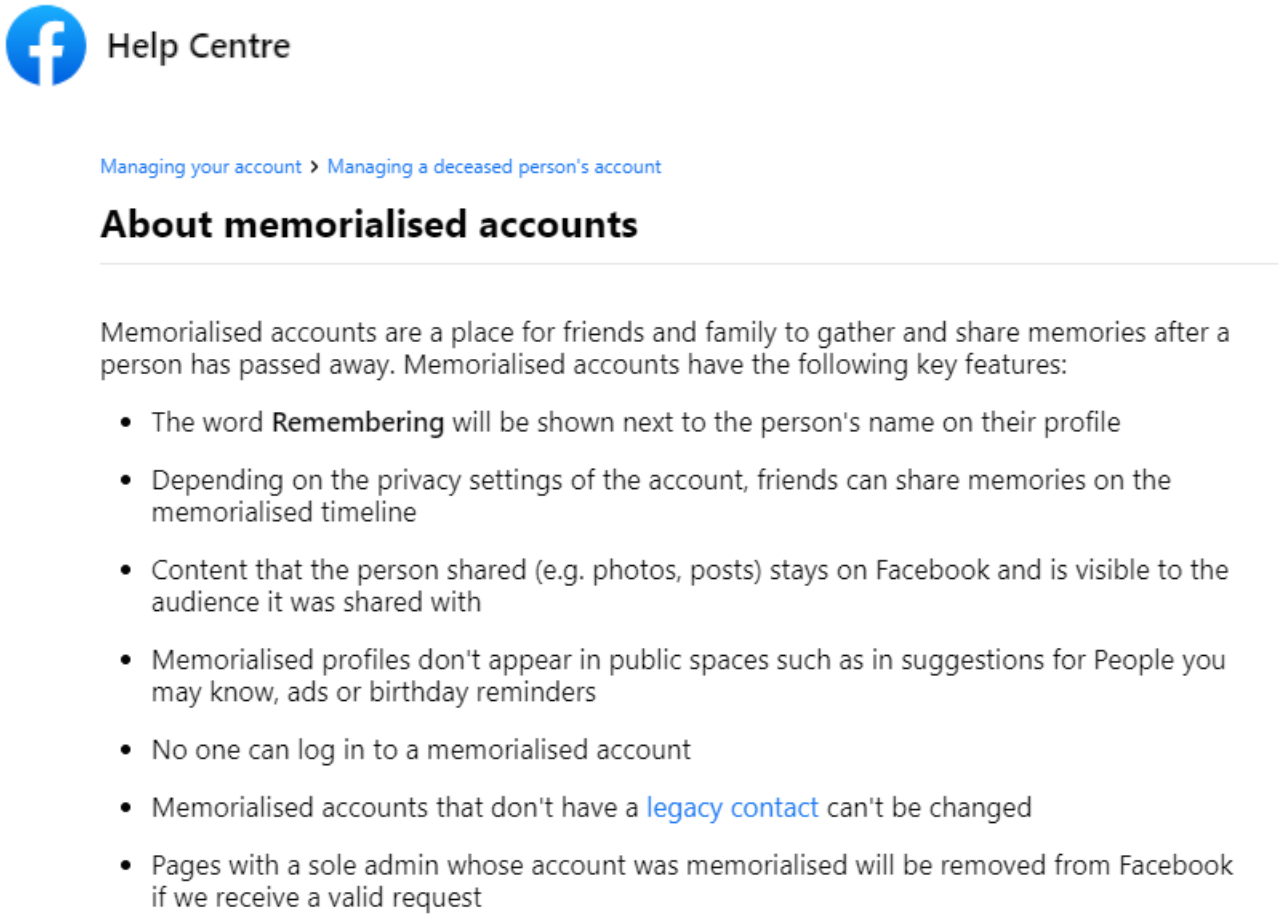
https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/proving-good-quality-care/benefits-information

Digital Legacy Planning

"People should leave clear instructions about what should happen to their social media, computer games and other online accounts after their death," – **The Law Society (UK)**

- Who has photos and videos on their phone? Who else can access these if something happened to you?
- Do you have paper bills or do they come to your email?
- Who else can (or should) access your emails if you died?
- Do you have any social media accounts- what would you want to happen to them?
- What about other online accounts?
- Do you have any online assets such as books, music or cryptocurrency?

The Digital Legacy Association



Social Media Accounts

Many allow for ‘memorialisation’ of accounts.

Others require a nominated person to request their closure or removal.

How would you introduce discussing future care plans with someone?

GROUP DISCUSSION

Starting Conversations

What do you understand about what is happening to you / your health?

Do you want to talk about / have you thought about what will happen to your health in the future?

Do you have any strong feelings about treatments that you would or would not want to receive?

Have you had any thoughts about what might be important to you in the future?

Have you been able to discuss your plans for the future with friends or family members?

Mayfly Course

Further ACP and Communication Skills Training

Run across the NW with funded places available.

Communicating Decisions and Information

Care needs to be coordinated and wishes shared for this to work- GMC requirement to share info

Clear documentation needed in:

- Discharge letters
- Clinical letters

EPaCCS (Electronic Palliative Care Coordination Systems)

A means to capture and share information from people's discussions about their care.

Aim of this is to ensure that any professional involved in that person's care has access to the most up to date information, including any changes to their preferences and wishes

The core record is usually kept by the General Practitioner in their electronic system and information sharing agreements put into place to allow relevant professionals involved in the person's care to view and therefore be aware of the individual's palliative and end of life personalised care plan

EPaCCS GP record visible across Lancashire and South Cumbria through the shared care record (formerly LPRES)

Questions?