**Advance Care Planning**

**Frequently asked questions**

**What is Advance Care Planning (ACP)?**

ACP is the opportunity to talk to a person, their family and those who care for them, about what matters to them. These conversations are then recorded in a plan which describes their future health and care preferences and priorities should they become unwell or no longer have the capacity to tell others what they would like.

**What might an ACP include?**

An ACP describes an individual’s future preferences and health priorities should they become unwell or no longer have the capacity to tell others what they would like. It may include specific care that could support them closer to home; it may include receiving their care in a specific health setting if their needs change, including hospital, for appropriate treatment; it can also include an informed decision about resuscitation and other interventions.

**Why would someone want an ACP?**

Someone might want an ACP to set out their preferences for their future health and care should they become unwell or no longer have the capacity to tell others what they would like.

**What if someone doesn’t want an ACP?**

If a person doesn’t want an ACP, their wishes should be respected. A person can always discuss having an ACP at a later date or change their mind as and when they are ready to do so.

**Why is it important to have one?**

It’s up to every individual to decide if it is important to them to have an ACP. An ACP can help loved ones and those providing care to a person understand their health and care preferences, particularly if they become unwell or no longer have the capacity to tell others what they would like.

**How are Advance Care Plans different to: Personalised Care and Support Plans; Anticipatory Plans; End of Life Plans; and ReSPECT?**

* **A Personalised Care and Support Plan** is way of capturing and recording conversations, decisions and agreed outcomes that makes sense to the person. The plan should be relative, flexible and adaptable to a person’s health condition, situation and care and support needs. It should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective. A personalised Care and Support Plan can also be an Advance Care Plan
* **An Anticipatory Plan** should be considered when a person’s health status is expected to change, often called a clinical management plan. It details how an individual’s health status may change, what to look for and how to manage the change. This type of plan aims to avoid a crisis. It should be discussed and put in place when it can be predicted that a person’s health condition can worsen quickly and this can be reversed with early intervention or when a person requires rescue medication to prevent a long term condition getting worse.
* **An End of Life Care Plan** details the treatment, care and support for a person nearing the end of their life. It should include the relevant details of an advance care plan and include anticipatory care needs. An End of Life Care plan should be considered when an individual is predicted to be in the last year of life.
* **A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)** is a **summary** of **all** personalised care and support plans. It details what should be considered in an emergency situation. It can include attempt resuscitation (CPR) or do not attempt resuscitation (DNACPR). A ReSPECT form should be updated if a person’s health status or the care setting changes, to check the content, make any necessary additions and to update local records e.g. changes to DNACPR status. The ReSPECT process can be for anyone but is most relevant for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest.

**When should someone have an advance care plan?**

Anyone can have an ACP and it can be put in place at any time. Ideally someone should have an ACP before they become unwell and are able to tell others what they would like, this is known as having capacity. However, people who are most likely to benefit from having an ACP might include:

* Someone who is well and chooses to make an ACP
* Someone in their last year of life
* Someone who is very frail (has a Clinical Frailty Scale of 7-9. You can read more about this on the NICE website here <https://www.nice.org.uk/guidance/ng159/resources/clinical-frailty-scale-pdf-8712262765>
* Someone who is a resident in a care home
* Someone who is an inpatient in hospital (acute and community)
* Someone who is very likely to become seriously ill because of Covid-19
* Someone who is considered to be in a ‘vulnerable group’ for example with a multiple long term condition

**When is the best time to do an ACP?**

An ACP can be done at any time but should ideally be in place before a person’s health deteriorates.

**Who can support a person to put an ACP in place?**

Anyone can start a conversation about an advance care plan. The form itself can be completed by any health and care professional competent to do so and ideally trained in having important conversations.

**Who holds a copy of a person’s ACP?**

The original form must remain with the individual. Copies can be made for reference only but the form should be scanned and coded into their GP electronic record (the Summary Care Record) to enable access by all clinicians working in different health settings.

**If an ACP is completed in another setting other than a GP practice, how will it be added to a person’s patient record (Summary Care Record)?**

If an ACP is completed in Shropshire and Telford Hospital NHS Trust (SaTH), SaTH will scan a copy of the form on to their internal patient record system and it will also be added to the GP discharge summary. The person will take the original home with them.

If an ACP is completed in Shropshire Community NHS Health Trust, the person will hold the original and a scanned copy will be emailed to their GP.

If an ACP is completed in a care home or in a person’s own home, the person will hold the original and a scanned copy will be emailed to their GP.

**Who would have access to a person’s ACP?**

Any clinician with an NHS England smartcard can view a person’s ACP if it’s recorded on their Summary Care Record (GP records) and they have given their consent.

**Once an ACP is in place, can it be changed?**

Yes. An ACP is a non-legally binding plan and can always be reviewed and changed.

**Who can trigger a review of an ACP?**

A review could be triggered by the individual or their care provider as long as the person agrees.

**What would trigger a review of an ACP?**

Many things could trigger a review, including the person themselves or a change in their personal situation, health condition or treatment options.

**Who is responsible for updating an ACP?**

An ACP can be updated by any health and care professional competent to do so and ideally trained to have important conversations. The updated form should remain with the individual and a scanned copy should be saved on their Summary Care Record (GP record) to enable access by all clinicians working in different health settings.

**What if a person doesn’t have capacity?**

ACP involves helping people to plan for their future care and support needs, including medical treatment, and therefore to exercise their personal autonomy as far as possible. ACP should be offered to individuals at risk of losing capacity (for example through progressive illness), as well as those who have fluctuating capacity (for example through mental illness).

If someone doesn’t have the mental capacity to carry out advance care planning then a discussion with their family, GP, nurse or social worker can help determine what would be in their best interests.

Previous discussions and activity will help guide decisions about care. If an Advance Decision to Refuse Treatment has been made or a Lasting Power of Attorney appointed, these will have to be taken into consideration/consulted. You can read about the Mental Capacity Act: making decisions on the Government’s website here <https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>

**I am a member of the public, where can I get more information about ACP?**

You can read more about ACP in this [guide about planning for your future care](https://www.dyingmatters.org/sites/default/files/user/Planning_for_your_future_care_FINAL_010212.pdf) or you can talk to your GP.

**I am a health/care professional, are there resources to help me support someone who wants an ACP?**

As a local health and care system in Shropshire, Telford and Wrekin, we have developed a Framework and Toolkit to help our health and care staff to support people who want an ACP. Both of these, as well as some other useful resources, can be found on Severn Hospice’s website [here](https://www.severnhospice.org.uk/advance-care-planning/). This information is regularly being reviewed and updated as we continue to work with our partners and stakeholders, learning from best practice and guidance, and responding to feedback from both local Healthwatch and patient representatives.