

CLINICAL GUIDELINE

Advance Care Planning

Guideline Number	CLG170
Version:	V10
Purpose:	To ensure that all Trust staff are aware of the broad legal and ethical issues related to the use of Advance Statements and Decisions
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Impact Assessments:	This Guideline has been subjected to an Equality Impact Assessment. This concluded that this guideline will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V2	Nov 2008	NHSLA policy revision by Paul Ryder
V3	Dec 2010	Policy revised by Tina Kukstas
V6	Aug 2012	Policy review by Tina Kukstas
V7	Dec 2014	Policy review by Tina Kukstas and amalgamation of procedural guidance (previously a separate document) into the policy
V8	Jan 2017	Policy review by Tina Kukstas
V8.1	Jul 2019	Policy transferred to revised new format
V9	10/08/2020	Policy Review
V10	24/08/2023	Policy Review by Jane Higgins - References to 2g Trust have been removed, the guideline has been updated to reflect that it applies to physical health settings as well as mental health settings so that it can be used across all areas of the Trust. The MCA statement has been updated. Some sentences clarifying the legal status of advance decisions and details in relation to LPAs have also been added.

SUMMARY

This guideline and its associated procedure set out clear guidelines to ensure that there is a system in place which informs and trains staff, service users and carers about the use of Advance Care Planning within the Trust.

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ABBREVIATIONS

Abbreviation	Full Description
GHC	Gloucestershire Health and Care NHS Foundation Trust
EPR	Electronic Patient Record
ADRT	Advance Decisions to Refuse Treatment
WRAP	Wellness Recovery Action Plan
LPA	Lasting Power of Attorney
GP	General Practitioner
SWASFT	South Western Ambulance Trust
WMAS	West Midlands Ambulance Service

1. INTRODUCTION

The guideline relates to all forms of Advance Care Planning that service users wish to make about their future treatment preferences for both physical and mental health care.

An Advance Care Plan could be an Advance Statement, an Advance Decision or any document which details planning arrangements for care or treatment such as an end of life plan. This guidance outlines details relating to Advance Statements and Advance Decisions. An Advance Statement provides an opportunity for service users to make their preferences and wishes known in relation to the type of treatment and care they would like to receive should they become unwell. An Advance Decision is a way for service users to inform Trust staff of treatment(s) that they refuse in specific circumstances.

Any Advance Statement or Advance Decision can be helpful when service users have an episode of illness and lack capacity to make decisions in relation to their treatment and care.

2. PURPOSE

The overall aim of the guideline and procedural guidance is to ensure that all Trust staff are aware of the broad legal and ethical issues related to the use of Advance Statements and Decisions and ensures that risks (legal or otherwise) associated with their use are minimised.

This guideline will be applied to all service users 18 years and over.

3. SCOPE

This guideline applies to all Trust staff, who have a duty to abide by and promote the use of this guideline.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of, and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on [MCA Compliance below](#).

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is

proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9/section/1).

- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9/section/4).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/organisations/office-of-the-public-guardian).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. GUIDELINE DETAIL

Advance Care Planning:

There are a number of ways that a service user might want to plan for their future. Advance care planning is a broad term which includes Advance Statements and Advance Decisions as well as end of life planning.

Advance care planning is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record choices about their care and treatment. This may include an Advance Decision to refuse a named treatment in specific circumstances. The purpose of advance care planning is that it can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide should their illness progress.

Mental Capacity Act

Under the terms of the Mental Capacity Act 2005 formalised outcomes of advance care planning might include one or more of the following:

Advance Statements

An Advance Statement is a way for service users to make their wishes and views known in relation to any future care and treatment they may need and to give staff information about them and the way they can be affected when they are unwell. This can be helpful should they have an episode of either physical or mental health illness and find it difficult at that time to communicate clearly their wishes. Trust staff must take these preferences into account if they know that an Advance Statement exists either expressed verbally or in a document. This is

especially relevant when the service user can no longer express their views and preferences due to their illness. However, although consideration should be given to an Advance Statement and where possible wishes complied with, an Advance Statement is not legally binding.

All users of Trust services should be encouraged to make Advance Statements about any care and treatment they may need from the Trust in the future. When new referrals are accepted by services within the Trust a discussion about Advance Statements should be part of the initial care planning process.

Examples of templates for Advance Statements of wishes and preferences:

- Crisis and contingency planning such as 'Rainy Day Care Plan / WRAP (A Wellness Recovery Action Plan)
- Personal Safety Plan
- Advance Statement (Compassion in dying): [Advance statement – Compassion in Dying](#)
- Gloucestershire 'Planning for Your Future Care' document (page 4): [Advance Care Planning Guide 2014.pdf \(gloucestershireccg.nhs.uk\)](#)

NB: A summary of any Advance Statements or signposting to where these are stored can be identified within the ReSPECT form (part 2).

Choice:

The Trust is committed to respecting service user choice. Where possible, as part of the Best Interest process where a person does not have capacity, Advance Statements should be respected and followed when making Best Interest decisions. There may be occasions where wishes and preferences within an Advance Statement are not considered by the Decision Maker to be in the person's Best Interests. Where preferences and wishes have been considered and are not able to be followed due to them not being in the person's best Interests this should be documented within the Best Interest Decision documentation in the electronic patient records following the relevant step by step guidance.

Advance Decisions to Refuse Treatment:

Advance Decisions are legally binding upon a healthcare professional if valid and applicable to the circumstances at hand, except in for patients detained under the Mental Health Act 1983. A healthcare professional acting contrary to a valid and applicable Advance Decision leaves themselves exposed to legal liability.

Difference between Advance Statements and Advance decisions:

It is important to note the legal distinction between a statement that contains wishes and preferences a patient might express or have expressed to inform best interests (an Advance Statement) and a statement to refuse treatment (an Advance Decision).

Trust Staff must give due consideration to Advance Statements when determining decisions in the best interests of a service user who lacks capacity to take that decision themselves. However, an Advance Statement is not legally binding on the healthcare professional. A healthcare professional is not obliged to comply with an Advance Statement if he/she feels that it is not in the service users' best interests to do so.

In contrast, an Advance Decision is legally binding upon a healthcare professional if it is deemed to be valid and applicable. A healthcare professional acting contrary to a valid and applicable Advance Decision leaves themselves exposed to legal liability.

Key Points on Advance Decisions

- An Advance Decision only applies to refusals of treatment. You cannot have an Advance Decision positively requiring treatment to be given.
- An Advance Decision does not apply to the provision of basic care to keep a service user comfortable.
- The service user must have been 18 years of age or over at the time of making the Advance Decision.
- The service user must have had capacity to make the Advance Decision at the time of making the Advance Decision.
- The Advance Decision must clearly specify the treatment to be refused.
- The Advance Decision must clearly specify the circumstances in which a refusal of treatment will apply (although non-scientific language will be acceptable).
- The Advance Decision can be withdrawn or amended at any time if the service user has capacity to do so.
- The Advance Decision only comes into force when the service user lacks capacity to make a decision.
- The Advance Decision must be valid and applicable at the time it is being relied upon to be legally binding.
- An Advance Decision that relates to non-life sustaining treatment does not have to be in writing or witnessed, it can have been verbally expressed by the person. Good practice is to note in clinical records and care plans any verbal Advance Decisions that are made.
- An Advance Decision will not be applicable to life sustaining treatment unless it is verified by a statement to the effect that it is to apply to that treatment, even if life is at risk.
- An Advance Decision refusing life sustaining treatment must be in writing, signed by the service user and witnessed.

Advance Decisions Regarding Treatment for Mental Disorder

MCA Code of Practice: 9.37 Advance Decisions can refuse any kind of treatment, whether for a physical or mental disorder. But generally, an Advance Decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the Mental Health Act 1983, (2007) when treatment could be given compulsorily under Part 4 of that Act. Advance Decisions to refuse treatment for other illnesses or conditions are not affected by the fact that the person is detained in hospital under the Mental Health Act. For further information see chapter 13 MCA Code of Practice.

Examples of templates for Advance Decisions:

- Advance Decision (Compassion in dying): [Living will \(advance decision\) – Compassion in Dying](#)
- Gloucestershire 'Planning for Your Future Care' document (Page 8): [Advance Care Planning Guide 2014.pdf \(gloucestershireccg.nhs.uk\)](#)

NB: A summary of any Advance Statements or signposting to where these are stored can be identified within the ReSPECT form (part 2).

Lasting Powers of Attorney

An LPA is a legal document that appoints one or more people to act for a person, if in the future that person becomes incapable of managing for themselves. It must be created while the person has capacity and is capable of understanding the nature and effect of an LPA.

There are two types of LPA:

- 1) A Property and Affairs LPA – which gives the attorney authority to make decisions about financial affairs.
- 2) A Personal Welfare LPA – which gives the attorney authority to make decisions about healthcare and personal welfare.

Key points about LPAs

- A property and affairs LPA can come into effect before the person loses mental capacity, so that if they are physically unable to access their funds someone can do it on their behalf.
- A Personal Welfare LPA can only come into effect when the person has lost the mental capacity to make specific health and welfare decisions.
- An LPA for Property and Affairs cannot be used to make decisions about health and welfare and a Personal Welfare LPA cannot be used to make decisions about Property and affairs.
- An LPA of any type is not valid unless it is registered with the Office of the Public Guardian.

Information about LPAs can be found at: [Lasting and enduring powers of attorney forms - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/forms/lasting-and-enduring-powers-of-attorney-forms).

You can check if an LPA has been registered with the Office of the Public Guardian at: [Searching our registers of attorneys, deputies and guardians - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/forms/searching-our-registers-of-attorneys-deputies-and-guardians).

Other Forms of Advance Care Planning

Another form of advance care planning includes End of Life planning (which can take the form of putting affairs in order, making a will, and funeral planning).

Not everyone will wish to undertake Advance Care Planning. Less formally, the person may wish to name someone whom they wish to be consulted if they lose capacity. For those people who have capacity and who wish to participate, advance care planning can be an integral part of the wider care planning process.

The guidelines promote and work within the following principles:

Good Clinical Practice: The Trust recognises that Advance Statements and Advance Decisions reflect good clinical practice to assist service users to identify preferences and choices should he or she become unwell. Whilst a service user may wish to write their own Advance Statement/Advance Decision, it is good clinical practice to ensure that it is either discussed or written with the assistance of an advocate or healthcare professional, ideally the person working most closely with them, who is involved with care planning procedures. This is particularly important with ADRT (advance decisions to refuse treatment) to ensure they

are legal.

Valuing the Service User's Experience: The Trust recognises that a service user is often the 'expert' in determining the sort of treatment and interventions that may be needed if he or she becomes unwell. Service users may wish to include their family members / carers in their decision making.

The Community Mental Health Framework (CMHF), Single Assessment Process (SAP) and Health Action Planning (HAP): The Trust will expect staff to be proactive in encouraging service users to consider producing an Advance Statement/Advance Decision at appropriate times. Its production will be central to current CMHF/SAP/HAP arrangements. Service users should be automatically asked at the point of their care plan review if they would like to develop or review an Advance Statement/Advance Decision as part of crisis and contingency planning. This will encourage open discussion and a clear expression of a service user's views and preferences.

Ownership: An Advance Statement/Advance Decision belongs to the service user who produced it. The service user decides what goes in their Advance Statement/Advance Decision and to whom it is given. Staff will assist service users in the production and use of Advance Statements/Advance Decisions. Staff will suggest locations where copies of an individual current Advance Statement/Advance Decision may be usefully lodged including clinical records or with other agencies such as a GP or A&E department. The Trust will use existing patient information systems to help inform all practitioners involved in the service user's care and treatment both within the Trust and other services about a service user's Advance Statements/Advance Decisions within the parameters of service user confidentiality and service users' preferences. Record the Advance Statement/Decision as appropriate in the electronic clinical record. When working with a service user with a learning disability refer to guidance within relevant documents such as 'making reasonable adjustments to end of life care for people with learning disabilities'.

Partnerships: The Trust will seek to establish effective links with other agencies, organisations and individuals e.g. non statutory providers, police and local authority to assist service users who have or wish to produce an Advance Statement/Advance Decision.

Capacity to make an Advance Decision

At the time of making the Advance Decision, the service user must have capacity to make the Advance Decision. There is an assumption that the service user has/had capacity to make the Advance Decision unless there is a view expressed to the contrary.

Capacity relates to the ability of an individual to make that particular decision.

In order to make an Advance Decision the service user must have the ability to:

- Understand the information relevant to making the Advance Decision (for example do they understand the different types of treatment they are refusing and the consequences of that refusal).
- retain that information.
- use or weigh that information as part of the process of making the Advance Decision.
- and
- communicate their Advance Decision (whether by talking, using sign language or any other means).

If a service user fails any one of the above four elements, they do not have capacity to make the Advance Decision.

The principles of the Mental Capacity Act 2005 in relation to the development of Advance Decisions means that healthcare professionals should:

- assume that the service user has/had capacity to make the Advance Decision unless it is proved otherwise – the burden is upon the healthcare professional to provide evidence of why the service user did not have capacity.
- give all appropriate assistance to the service user (such as ensuring that the information required is given to the service user in the most appropriate format, considering whether there are any particular people that the service user may respond better to) to facilitate them making a capacitated Advance Decision.
- accept the right to make what might be seen as eccentric or unwise decisions – an unwise decision does not necessarily mean that the service user lacks capacity.

When should Advance Care Planning be set up and reviewed?

The Care Co-ordinator has a lead role in providing opportunities and support to service users to consider and complete any Advance Statements and Advance Decisions, as the time and opportunity for considering future wishes and preferences is when a person has capacity to make these relevant decisions.

For example, if a service user has a history of episodes of significant depression/psychosis /anxiety related conditions, the making of any Advance Statements and Advance Decisions is best undertaken during a period of recovery as opposed to during a hospital admission. Every Core Assessment, CPA Review or Care Plan review will provide the opportunity to discuss with service users if drawing up an Advance Statement/Advance Decision may be appropriate.

For Service Users who have conditions which by their nature will result in an on-going loss of cognitive ability such as dementia or have physical conditions which will result in a period where they will lose capacity to make decisions, the opportunity, and advantages to make Advance Statements and/ or Advance Decisions should be advised whenever possible during CPA reviews.

Recording and Communicating Advance Statements / Advance Decisions

Advance Statements / Advance Decisions need to be recorded in the electronic clinical records following the relevant step by step guidance.

The service user may decide to review or amend their Advance Statement / Advance Decision at any time, and it is clearly important to ensure that all copies of the Advance Statement / Advance Decision are the same. Staff will suggest locations where copies of an individual current Advance Statement / Advance Decision may be usefully lodged e.g. in the EPR subsidiary folder and / or with other agencies such as a GP/SWASFT/WMAS or Emergency Department. It will be the responsibility of the Care Co-ordinator to ensure that the latest copy of the Advance Statement / Advance Decision is the one acknowledged by the Trust and other parties. Previous versions must be crossed through with the words 'void, see revised Advance Statement / Advance Decision' written on it. Where the Advance Statement/Advance Decision is written, consideration should be given to a witness signing the document to acknowledge that it has been reviewed and/or amended.

The service user should consider reviewing and amending their Advance Statement / Advance Decision whenever their personal circumstances change – be this medically, socially, or personally.

This is important, particularly with Advance Decisions, as it is only applicable when the specific circumstances in it are met. If the service users circumstances have changed since the Advance Decision was made, the Advance Decision is open to challenge on the basis that it was not made with the service user's current circumstances in mind.

There may be occasions where complex situations arise with regard to Advance Decisions. In these cases staff may seek advice from the Mental Capacity Act Organisational Lead for the Trust who will refer to the Executive Lead, Trust solicitors, User and Carer Practice Forums or the Practice Standards Committee as appropriate.

7. DEFINITIONS

The term '**service user**' is used in this guideline for clarity, to refer to the individual who can make an Advance Statement or Advance Decision regarding their healthcare. However, the Trust recognises that those who access mental health or learning disability services may prefer to be referred to by other terms including patients, client, or users.

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?		YES
Monitoring Requirements and Methodology	Frequency	Further Actions
Line Manager and Clinical leads to monitor staff compliance with the policy as part of clinical reviews	Ongoing	Line managers / Clinical leads to address any non-compliance with staff at the meeting
The Trust's Complaints procedure will apply where issues are raised regarding the clinical implementation of an Advance Statement/Advance Decision.	On-going	The Patient experience team will advise line managers where there any issues have been identified; these will then be addressed with staff
All Care Co-ordinators or named professional care workers will have the responsibility for making all service users aware of the option of having an Advance Statement/Advance Decision. This will be monitored by line managers as part of clinical reviews	ongoing	Line managers / Clinical leads to address any non-compliance with staff at the meeting

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm incidents, Regulation 20 Duty of Candour requirements must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources.

10. TRAINING

Training on use of Advance Statements/Advance Decisions and information on how Advance Statements/Advance Decisions need to become part of everyday practice will be incorporated into the Induction Programmes for all new staff, Care Coordination training programme, the Recovering Strategy for the Trust, and the Trust Mental Capacity Act training.

Training and information for staff will be given initially on induction to the Trust. Line Managers should ensure all appropriate staff members are aware of the local implementation of the guidance.

11. REFERENCES

Gloucestershire Multi Agency Mental Capacity Act Policy 2019

Mental Capacity Act Code of Practice 2005

Making reasonable adjustments to end of life care for people with learning disabilities, Public Health England July 2014

12. ASSOCIATED DOCUMENTS

- Consent to Examination or Treatment Policy (CLP213)
- Consent Guidelines for Learning Disability
- Advance Directive (Specialist Learning Disability Format)
- Advance Statement Declaration (GPT Master Template)
- Advance Statement (Rainy Day Care Plan)
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy (CLP239)
- Handling and Resolving Complaints and Concerns Policy and Procedure (CGP010)
- Gloucestershire Multi Agency MCA Policy 2019
- The Mental Health Act Policy
- Assessment and Care Management Policy (CLP247)