Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

POLICY ON ADVANCE CARE PLANNING (includes Advance Decisions to Refuse Treatment) Clin Corp 05

Target Audience				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**
All medical staff involved in patient Advance Decisions.	x	x	x	x

CONTENTS (Ctrl + click on hyperlink to relevant section)

Explanation of terms used in this policy

Advance Decision to Refuse Treatment (ADRT)

1. INTRODUCTION

The Advance Care Planning process encompasses making an Advance Statement of Wishes, Naming a Spokesperson, appointing a Lasting Power of Attorney for Health and Welfare and/or making an Advance Decision to Refuse Treatment (previously known as Advance Directives or Living Wills). These processes inform the making of 'Best Interests Decisions' by clinicians, once an individual loses capacity to make decisions for him/herself.

Patients may already have, wish to discuss or want to make, an Advance Care Plan.

This policy applies when:

- A patient wishes to discuss Advance Care Planning
- A patient wishes to make a general Advance Statement of Wishes or Name a Spokesperson
- A patient requests to make a Lasting Power of Attorney for Health and Welfare
- A patient requests to make an Advance Decision to Refuse Treatment.
- A patient with one or more element of an Advance Care Plan is admitted to hospital or requires treatment in their care setting

    I. Advance Statement of Wishes
    II. Named Spokesperson
    III. Lasting Power of Attorney for Health and Welfare
    IV. Advance Decision to Refuse Treatment

Individual patients are under no compulsion to have an Advance Care Planning conversation or make any type of **Advance Care Plan** but must have the opportunity to do so.

All health professionals should be competent to have an Advance Care Planning conversation with patients, should the patient wish to discuss their general personal wishes and preferences. Staff should be able to outline the possible options for them and provide them with appropriate literature.

As with all conversations, these discussions should be documented as part of the clinical record and the patient's wishes, preferences and preferred **Named Spokesperson** noted.

If a patient wishes to make a **Lasting Power of Attorney** they should be advised to speak with a solicitor of their choosing or a social worker.

2. PURPOSE

The Department of Health, through the End of Life Programme, has made it clear that people should have the opportunity to make their wishes and preferences known in advance, or nominate a spokesperson, who can relay their preferences to clinical staff, about how they would like to be treated if they become unable to make their wishes known themselves.

A person who understands the implications of their choices may additionally make a Lasting Power of Attorney for Health and Welfare or an Advance Decision to Refuse Treatment for a time when they might suffer loss of capacity.

Staff working within the organisation need to understand the principles of Advance Care Planning (ACP), be able to have ACP discussions where patients choose to do so and signpost people towards further information or assistance.

3. OBJECTIVES

This policy applies to all staff employed by Southport & Ormskirk Hospital NHS Trust who have responsibility for managing patients who have an existing Advance Statement on admission or a patient who requests that an Advance Statement be drawn up.

4. MAIN ELEMENTS OF AN ADVANCE CARE PLAN (ACP)

An informal general statement reflecting an individual's aspirations and preferences with regard to future care is known as an Advance Statement of Wishes, which is informal and not legally binding. It can be verbal or written.

An 'other person' may be nominated to be consulted at the time a decision has to be made, in the event of the patient losing capacity. This Named Spokesperson cannot make or take decisions on behalf of the patient, rather their role is to make the patient's wishes and preferences clear to health professionals who are required to act and make decisions in the patient's best interests. It should be noted that this person is not being asked for their opinion or decision, and this is not legally binding.

A Lasting Power of Attorney for Health and Welfare LPA (who may be the same or a different person from the Lasting Power of Attorney for Property and Affairs if there is one), is a person, appointed by the patient, to assume responsibility for legally binding decision making regarding health issues, in the event that the patient loses the capacity to do so. An application is completed whilst the patient has capacity, and registered with the Office of the Public Guardian, until such time as it requires to be activated. When the patient loses capacity to make their own

decisions, the LPA is activated by the person nominated as LPA. They do so by contacting the Office of Public Guardian

http://www.**publicguardian**.gov.uk and this activation may take up to two weeks. Decisions about life sustaining treatment are only included if specifically stated in the LPA. Until such time as the LPA is activated, health professionals are required to act in the best interests of the patient.

An Advance Decision to Refuse Treatment (ADRT) is a clear instruction refusing in advance some, or all, of the medical procedures which could be refused contemporaneously. An ADRT must state specifically what is to be refused and under what specific circumstances. If life-sustaining treatment is refused the ADRT must be signed, dated and witnessed. It is not necessary for it to be made with or signed by a health professional. If valid, the ADRT is legally binding.

5. GUIDANCE ABOUT ADVANCE DECISIONS TO REFUSE TREATMENT (ADRT)

Competent informed adults have an established legal right to refuse medical procedures in advance. They can refuse in advance, any procedure they could refuse contemporaneously except 'basic care'. Healthcare professionals are bound to comply when a valid refusal specifically addresses the situation that has arisen.

An Advance Decision to Refuse Treatment (ADRT), found to be invalid and therefore not legally binding, should still be taken into account as evidence of the person's wishes when assessing whether a particular treatment would be of overall benefit to them.

If an ADRT is valid and applicable to the circumstances, it has the same effect as a contemporaneous decision that is made by a person with capacity. Therefore health care professionals must follow the decision.

If the decision refuses life-sustaining treatment it must:

- Be in writing
- Be signed and witnessed
- State clearly that the decision applies even if life is at risk

An advance decision cannot require a health professional to carry out a positive act which would hasten death, or to administer futile or inappropriate treatment. An ADRT cannot demand treatment.

An ADRT should be checked for validity against the Validity Checklist (ADRT website www.adrt.nhs.uk and see Appendix 4). If health professionals are satisfied that an ADRT is valid and applicable they must follow it.

The terms of the Mental Health Act take precedence and must prevail regarding treatment for mental disorder. A compulsorily detained adult can make a legally binding advance refusal of treatment which is not covered by Mental Health Legislation, if it is made at a time when they have the mental capacity to do so. For further guidance please refer to the Mental Capacity Policy (CLIN CORP 61)

An ADRT cannot include refusal of basic care to maintain an incompetent person's comfort, defined as the maintenance of bodily cleanliness, warmth, shelter and the offer of appropriate food and drink by mouth. In the absence of an ADRT, health care professionals have a duty to act in the best interests of a person without capacity.

Although analgesia is not perceived as a treatment, it is still an artificial intervention, which can be refused as part of an advance decision although most people would not want to refuse analgesia as a comfort measure.

Relatives' or carers' recollections of the wishes and preferences of a person without capacity should be sought and may be helpful, but cannot override those of the person themselves, or supplant the duty of the health professional to assess and act in the person's best interests.

At all stages of life, timely discussion of treatment options is an important part of the duty of care owed by health professionals. Recognising and respecting the individual patient's preferences are fundamental aspects of good practice.

Staff will have training appropriate to their ethical responsibilities, including the skills of sensitive communication.

6. PROCEDURE FOR ADVANCE DECISIONS TO REFUSE TREATMENT (ADRT)

6.1. A patient has an existing Advance Decision to Refuse Treatment (ADRT).

A copy of any ADRT provided by the patient should be filed in the patient's clinical records. In hospital, the clinical record contains a dedicated 'Advance Statement' section located at the beginning of the case note. Any documents added to this section should be acknowledged by a tick on the patient alert record, located on the inside of the front cover of the case-notes

Competent patients are advised of the importance of regularly reviewing any ADRT.

The current validity of the ADRT is checked during assessment in the community and on admission into hospital, and the response recorded on the ADRT, signed, and dated. An ADRT that is no longer valid should be crossed through, signed, and dated, and the patient advised to ensure any other copies are updated.

If there are reasonable grounds to believe an ADRT exists and time permits, a copy is sought for the patient's clinical records by contacting the GP with whom the

patient is registered or people close to the patient. Emergency treatment should not be delayed.

A patient can use an ADRT to refuse artificial nutrition and hydration (ANH) in a Persistent Vegetative State (PVS) but it is especially important to ensure that the ADRT is valid and applicable. In this clinical situation legal advice is likely to be helpful. Such advice must always be taken if there is any doubt or disagreement on the status of the ADRT.

If an ADRT exists, is valid and is applicable to the circumstances, it is legally binding

If doubt exists about what the individual intends, the law supports a presumption in favour of providing clinically appropriate treatment. The consultant in hospital or GP in the community, responsible for the patient, must consider the available evidence of the patient's wishes and act in their best interests.

If the matter cannot be clarified and doubt or disagreement remains about the scope and validity of an ADRT, emergency treatment is given and the case referred to the courts.

If a health professional cannot, for reasons of conscience accede to a request for limitation of treatment, the patient's management must be passed on to a colleague.

6.2. A patient requests that an Advance Decision to Refuse Treatment (ADRT) be drawn up.

An ADRT is an aid to, not a substitute for, open dialogue between patients and health care professionals

Patients are provided with information in an accessible form to allow them to make informed choices. Foreseeable options and implications are explained and information leaflets are provided to aid and support the decision making process. (See www.adrt.nhs.uk for patient and health professional leaflets.) If needed, advice regarding access to an interpreter can be found in the Policy for the use of interpreter and translation service (CORP 30).

Health professionals consulted about helping a patient to make an ADRT take reasonable steps to ensure decisions are not made under duress and consider whether the patient is mentally competent.

Capacity is assumed. However in the event of the patient wishing to make an ADRT good practice suggests that an assessment of the mental state of the patient should be recorded in the hospital notes, and the entry signed, dated and timed. Guidelines about the assessment of capacity using the Two Stage Test can be

found in literature about the Mental Capacity Act 2005 and the Trust's Mental Capacity Policy.(CLIN CORP 61)

Health professionals should try to ensure that the patient is aware of the advantages and disadvantages of making an ADRT, and of the legal status of such documents.

A model form of an ADRT is attached in appendix 1 and available from www.adrt.nhs.uk but clear statements in any format are valid. The statement must include:

- Full name, date of birth and address
- Name and address of GP
- Whether advice was sought from health professional
- A clear statement of the decision, the treatment to be refused and the circumstances in which it will apply
- A statement that this applies even if life is at risk, if life sustaining treatment is to be refused

If the ADRT includes refusal of life-sustaining treatment, it must be signed by the patient, dated, and witnessed by a person appointed by the patient. Patients should be reminded that the witness should not be a nurse or doctor involved in their care or treatment.

A copy of the ADRT is placed in the medical and nursing notes in the section for the purpose. The patient is advised to ensure that their GP and the hospital (particularly A&E) are given a copy of the ADRT and that those close to the patient are made aware of the ADRT.

On discharge the patient should be asked whether they intend to alter the ADRT in any way. If that is the case it should be removed from the case sheet. Otherwise, if the patient agrees, it will be retained. It is the responsibility of the patient to return any new version to the Trust when the changes have been made.

7. LINKS TO RELEVANT LEGISLATION

None

7.1. Links to Relevant National Standards

The differences between general care planning and decisions made in advance. Joseph, Sheila. End of Life Care Programme. Department of Health. May 2010

Advance Care Planning: It all ADSE up. National End of Life Care Programme. Department of Health. October 2012

Mental Capacity Act 2005 Code of Practice: Issued April 2007

Capacity, care planning and advance care planning in life limiting illness: A guide for health and social care staff. Department of Health. August 2008

Advance Decisions to Refuse Treatment: A guide for health and social care professionals. National End of Life Care Programme. Department of Health. January 2013

Planning for your future care: A guide for patients. National End of Life Care Programme. Department of Health. February 2012

Treatment and care towards the end of life: good practice in decision making. General Medical Council. May 2010 www.gmc-uk.org

Advance Decisions Checklist. NHS End of Life Care. Department of Health.

Concise Guidance to Good Practice 12: Advance Care Planning: National Guideline. Royal College of Physicians. February 2009 www.rcplondon.ac.uk

Practical Guidance for Best Interests Decisions Making and Care Planning at End of Life. Hutchinson, Christine. Foster, Julie. East Lancashire tPCT & Central Lancashire PCT. May 2008

Making Decisions: A guide for people who work in health and social care. Mental Capacity Act 2005. 4th Edition. Department of Health. 2009

Advance Decision to Refuse Treatment: NHS Choices (accessed February 2017)
NHS Choices: Advance Decisions

Advance Decision to Refuse Treatment: A guide for health & social care professionals, NHS National End of Life Care Programme, 2013 (accessed February 2017)
ADRT National End of Life Care Programme

7.2. Links to other key policy/s

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CLIN CORP 04 –	Policy for Consent to Examination or Treatment, Southport & Ormskirk NHS Trust,
CLIN CORP 09 -	Policy for the Decision relating to a Do Not Attempt to Resuscitate (DNAR) order, Southport & Ormskirk NHS Trust
CLIN CORP 61 –	Mental Capacity Policy, Southport & Ormskirk NHS Trust
CLIN CORP 02 -	Withdrawal of Treatment, Southport & Ormskirk NHS Trust
CORP 30 –	Policy for the use of the interpreter and translator service, Southport & Ormskirk NHS Trust

8. ROLES AND RESPONSIBILITIES FOR THIS POLICY

Title	Role	Responsibilities
Responsibility of Clinical Staff		To ensure that the policy adheres to statutory requirements and professional guidance To ensure that the policy is monitored To ensure that the policy is reviewed
Responsibility of Teams / Responsibility of Clinical Managers		Managers must ensure that staff are aware of the policy and can access it easily Must ensure that the policy is implemented Must ensure that staff have appropriate training in managing patients who have and/or request an Advance Decision to Refuse Treatment as appropriate to their role. The consultant in charge of the patient's care in hospital and/or the General Practitioner in charge of the patient's care at home are responsible for ensuring that all medical staff involved understand the policy and action as appropriate
Responsibility of Trust Board		To adhere to the policy To notify line managers of any training needs It is the responsibility of the patient and/or their family or carers to ensure the health care team inside and/or outside hospital, is made aware of any existing Advance Care Plans. Staff have a responsibility to sensitively enquire about the existence of an ACP or ADRT during admission of a patient

		In hospital, staff admitting the patient, should check the 'Advance Statement' section of the case notes (located at front of records immediately before the correspondence section), if there is one, as a matter of course, to note if an Advance Decision to Refuse Treatment exists. If a health professional is told that an Advance Decision to Refuse Treatment exists for a patient who now lacks capacity to consent, they should make reasonable efforts to find out what the decision is. Reasonable might include discussing with relatives, looking in the case notes and contacting the GP with whom the patient is registered. Once a health professional knows that an Advance Decision to Refuse Treatment exists they must determine whether it is valid and applicable to the proposed treatment. Once a health professional knows that an Advance Decision to Refuse Treatment exists they have a responsibility to communicate this decision to other healthcare professionals who need to know about it Where appropriate, when discussing options with people who have capacity, the healthcare professional should ask if there are any wishes and preferences they wish to make known, or specific types of treatment they do not wish to receive, if ever they should lack capacity to consent in the future

9. TRAINING

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
all	Hospital, primary care staff	NO	Specialist Palliative Care Services as required	Specialist Palliative Care Services	once	End of Life Strategy Steering Group

10. EQUALITY ANALYSIS ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Governance Team.

11. DATA PROTECTION AND FREEDOM OF INFORMATION

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

12. MONITORING THIS POLICY IS WORKING IN PRACTICE

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

Monitoring this policy is working in practice	**Where described in the policy?**	**How will they be monitored? (method + sample size)**	**Who will undertake this monitoring?**	**How Frequently ?**	**Group/Committee that will receive and review results**	**Group/Committee to ensure actions are completed**	**Evidence this has happened**
Advance Care Planning process is carried out as per policy	5.0 6.0	ADRT documents Clinical records	Palliative Medicine Consultant	Annual	End of Life Group	End of Life Group	

13. APPENDIX

Appendix 1 Example Advance Decision to Refuse Treatment

Appendix 2 Difference between general care planning and decisions made in advance.

Appendix 3 Example Advance Care Plan including Advance Statement of Wishes West Lancs, Southport & Formby Palliative Care Services 2011

Appendix 4 Validity Checklist

13.1. Appendix 1 Example Advance Decision to Refuse Treatment

My Advance Decision to Refuse Treatment

Name	Any distinguishing features in the event of unconsciousness
Address Postcode	Date of Birth Telephone Number

What is this document is for?

This advance decision to refuse treatment has been written by me to specify **in advance** which treatments I don't want in the future. These are my decisions about my healthcare, **in the event that I have lost mental capacity and cannot consent to or refuse treatment**. This advance decision replaces any previous advance decision I have made.

Please Check

Please do not assume I have lost capacity before any actions are taken. I might need help and time to communicate when the time comes to make a decision.

If I have lost capacity for a particular decision, please **check that my advance decision is valid and applicable to the circumstances that exist at the time**.

This advance decision becomes legally binding and must be followed if professionals are satisfied it is valid and applicable. **This includes checking that it has not been varied or revoked by me either verbally or in writing since it was made.** Please help to share this information with people who are involved in my treatment and care and need to know about this.

Please also check if I have made any other advance statement about my preferences or decisions that might be relevant to this advance decision.

This advance decision does not refuse the offer and/or provision of basic care, support and comfort.

I have discussed this with (e.g. name of healthcare professional)
Profession / Job Title Contact Details Date
I give permission for this document to be discussed with my relatives / carers YES ☐ NO ☐
My General Practitioner is Dr Address Telephone number
Optional Review Comment Date
Maker's Signature Witness signature

Copies of this document are with

13.2. Appendix 2 Difference between general care planning and decisions made in advance.

NHS

National End of Life Care Programme

Improving end of life care

The differences between general care planning and decisions made in advance

	General Care Planning	Advance Care Planning (ACP) - advance statement	Advance Decisions to Refuse Treatment (ADRT)	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
What is covered?	Can cover any aspect of current health and social care.	Can cover any aspect of future health and social care.	Can only cover refusal of specified future treatment. May be made as an option within an advance care planning discussion.	Only covers decision about withholding future CPR.
Who completes it?	Can be written in discussion with the individual who has capacity for those decisions. or Can be completed for an individual who lacks capacity in their best interests.	Is written by the individual who has capacity to make these statements. May be written with support from professionals, and relatives or carers. Cannot be written if the individual lacks capacity to make these statements.	Is made by the individual who has capacity to make these decisions. May be made with support from a clinician. Cannot be made if an individual lacks capacity to make these decisions.	Completed by a clinician with responsibility for the patient. Patient consent is sought only if an arrest is anticipated and CPR could be successful. Can be completed for an individual who does not have capacity if the decision is in their best interests.
What does it provide?	Provides a plan for current and continuing health and social care that contains achievable goals and the actions required.	Covers an individual's preferences, wishes, beliefs and values about future care to guide future best interests decisions in the event an individual has lost capacity to make decisions.	Only covers refusal of future specified treatments in the event that an individual has lost capacity to make those decisions.	Documents either - that CPR cannot be successful and should not be attempted - an individual's advance decision to refuse CPR.
Is it legally binding?	No - advisory only.	No - but must be taken into account when acting in an individual's best interests.	Yes - legally binding if the ADRT is assessed as complying with the Mental Capacity Act and is valid and applicable. If it is binding it takes the place of best interests decisions about that treatment.	Yes - if it is part of an ADRT. Otherwise it is advisory only, i.e. clinical judgement takes precedence.
How does it help?	Provides the multidisciplinary team with a plan of action.	Makes the multidisciplinary team aware of an individual's wishes and preferences in the event that the patient loses capacity.	If valid and applicable to current circumstances it provides legal and clinical instruction to multidisciplinary team.	Makes it clear whether CPR should be withheld in the event of a cardiac or respiratory arrest.
Does it need to be signed and witnessed?	Does not need to be signed or witnessed.	A signature is not a requirement, but its presence makes clear whose views are documented.	For refusal of life sustaining treatment, it must be written, signed and witnessed and contain a statement that it applies even if the person's life is at risk.	Does not need to be witnessed, but the usual practice is for the clinician to sign.
Who should see it?	The multidisciplinary team as an aid to care.	Patient is supported in its distribution, but has the final say on who sees it.	Patient is supported in its distribution, but has the final say on who sees it.	Clinical staff who could initiate CPR in the event of an arrest.

13.3. Appendix 3 Example Advance Care Plan including Advance Statement of Wishes West Lancs, Southport & Formby Palliative Care Services 2011

MY THOUGHTS FOR THE FUTURE

'Planning for the worst & hoping for the best'

My name:	**Date of Birth:**
Address:	**NHS Number:**

Thinking ahead…

1. What is important to me now and for the future

2. What I would like people who might care for me to know about my wishes / preferences

3. What concerns I have for the future. What I worry about or fear happening.

If there is something you don't want to happen you may need to make an Advance Decision to Refuse Treatment.

My **Preferred Place of Care** **At home ☐ Not at home ☐ (Care Home ☐)** Carer's preferred place of care **At home ☐ Not at home ☐ (Care Home ☐)**	will explain my wishes and preferences to health professionals if I am unable to? **(Named Spokesperson)**	I have a **Lasting Power of Attorney for Health** **Yes ☐ No ☐** Name Contact Tel::	I have an **Advance Decision to Refuse Treatment** **Yes ☐ No ☐** It can be found…
Signature:		Date:	
Date completed:		Date for review:	

Family members involved in Advance Care Planning discussions:

Name:	Relationship:	Signature:	Contact tel:
Name:	Relationship:	Signature:	Contact tel:

Healthcare Professional involved in Advance Care Planning discussions:

Name:	Role:	Signature:	Contact tel:

13.4. Appendix 4 Validity Checklist

An advance decisions checklist

	Question	Answer
1	Does the person have capacity to give consent to or refuse treatment him or herself, with appropriate support where necessary?	**YES:** The person has capacity to make the decision him or herself. The advance decision is not applicable. Ask what s/he wants to do. **NO:** Continue with check list.
2	Has the person withdrawn the advance decision? (This can be done verbally or in writing).	**YES:** This is not a valid advance decision. Make sure that you have identified and recorded the evidence that the person withdrew the advance decision. **NO:** Continue with check list.
3	Since making the advance decision, has the person created a lasting power of attorney (LPA) giving anybody else the authority to refuse or consent to the treatment in question?	**YES:** This is not a valid advance decision. The donee(s) of the LPA must give consent to or refuse the treatment. The LPA decision must be in the person's best interests. **NO:** Continue with check list.
4	Are there reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the advance decision and which would have affected his/her decision had s/he anticipated them?	**YES:** If such reasonable grounds exist, this will not be an applicable advance decision. It is important to identify the grounds, discuss this with anybody close to the person, and identify why they would have affected his/her decision had s/he anticipated them, and record your reasoning. **NO:** Continue with the checklist.
5	Has the person done anything that is clearly inconsistent with the advance decision remaining his/her fixed decision?	**YES:** This is not a valid advance decision. It is important to identify what the person has done, discuss this with anybody close to the person, explain why this is inconsistent with the advance decision remaining his/her fixed decision, and record your reasons. **NO:** The advance decision is valid. Continue with the checklist.
6	a) Does the advance decision specify which treatment the person wishes to refuse? (b) Is the treatment in question that specified in the advance decision?	**YES:** to both (a) and (b): Continue with the checklist. **NO:** This is not an applicable advance decision.
7	If the advance decision has specified circumstances in which it is to apply, do all of those circumstances exist at the time that the decision whether to refuse treatment needs to be made?	**YES:** Continue with the checklist. **NO:** This is not an applicable advance decision.
8	Is the decision both valid and applicable according to the criteria set out above?	**YES:** Continue with the check list. **NO:** This is not a binding advance decision to refuse the specified life sustaining treatment.
9	In your opinion is the treatment in question necessary to sustain the person's life?	**YES:** Continue with the checklist. **NO:** This is a binding advance decision to refuse the specified non-life-sustaining treatment. It must be respected and followed.
10	Does the advance decision contain a statement that it is to apply even if the person's life is at risk?	**YES:** Continue with the checklist. **NO:** This is not a binding advance decision to refuse the specified life-sustaining treatment.
11	Is the advance decision: • In writing AND • Signed by the person making it or by somebody else on his behalf and at his direction AND • Signed by a witness.	**YES TO ALL:** This is a binding advance decision to refuse the specified life-sustaining treatment. It must be respected and followed. **NO TO ANY:** This is not a binding advance decision to refuse the specified life-sustaining treatment.

Policy Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	Policy on Advance Care Planning
Is this New or revision of an existing policy	Revised
Name and role of Policy Lead	Karen Groves Palliative Medicine Consultant

Give a Brief Overview of the Policy

The Advance Care Planning process encompasses making an Advance Statement of Wishes, Naming a Spokesperson, appointing a Lasting Power of Attorney for Health and Welfare and/or making an Advance Decision to Refuse Treatment (previously known as Advance Directives or Living Wills). These processes inform the making of 'Best Interests Decisions' by clinicians, once an individual loses capacity to make decisions for him/herself.

What are the main changes in practice that should be seen from the policy?

Minor updates to previous policy

Who is affected directly or indirectly by this policy?

Patients and relatives

Implications

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training?	
Explain the issues? None	**Explain how this has been resolved** N/A
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established?	
Explain the issues? None	**Explain how this has been resolved** N/A
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** **K Groves**. **Date Approved** …July 2017.

Policy Details

Title of Policy	Policy on Advance Care Planning
Unique Identifier for this policy is	SOHNHST- Clin Corp 05-POL-2.0.0
State if policy is **New** or **Revised**	Revised
Previous Policy Title where applicable	Remains the same
Policy Category Clinical, HR, H&S, Infection Control, Finance etc.	Clin Corp
Executive Director *whose portfolio this policy comes under*	Rob Gillies
Policy Lead/Author *Job titles only*	K Groves Palliative care Consultant P Mansour Deputy Medical Director
Committee/Group responsible for the approval of this policy	End of life group
Month/year consultation process completed	June 2017
Month/year policy approved	July 2017
Month/year policy ratified and issued	August 2017
Next review date	August 2020
Implementation Plan completed	Yes
Equality Impact Assessment completed	yes
Previous version(s) archived	Yes v1.0.0
Disclosure status	Full disclosure
Key words for this policy	End life, care planning ,death,

For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Integrated Governance.

Review and Amendment History

Version	Date	Details of Change
1.0.0	July 2013	New policy
2.0.0	August 2017	Minor changes due to changes from an ICO