



Advance Care Planning – Myth Busting the Conversation That Matters

The Webinar will begin shortly

Welcome

Advance Care Planning – Myth Busting the Conversation That Matters

Date: 12th Oct 2026

Host: Peter Bullen



Housekeeping



COMFORT BREAKS



BEHAVIOUR



TECHNOLOGY



TIME KEEPING



CONFIDENTIALITY



STRUCTURE



ASK QUESTIONS



KEEP LEARNING



Learning Objectives

- Understand what Advance Care Planning is and why it matters
- Recognise common misconceptions surrounding ACP
- Understand the different documents and processes that may form part of Advance Care Planning
- Clarify the role of care providers, individuals, families and health professionals.
- Gain confidence in supporting timely and meaningful ACP conversations

Introductions



Leonie Lowrie - 07736976744
Clinical Advice Line - 01923 606030
Leonie.lowrie@renniegrovepeace.org

Learning&development@renniegrovepeace.org



Wendy Freeman - 07843218316
Clinical Advice Line – 01707 382575
Wendy.freeman@isabelhospice.org.uk
education@isabelhospice.org.uk

Why are we talking about Advance Care Planning?

- Gives our service users the opportunity to express their views about their future care, promoting choice and control
- Individualized plan and the person feels listened to. Can be changed at anytime.
- Encourages open and honest discussions to take place within families and with care providers
- Increases likelihood of persons wishes being observed and the person is less likely to die in an unfamiliar place. Comes into effect when a person loses the ability to express their needs.
- Maybe shared with other professionals caring for that person





**What are your common
challenges and
misconceptions?**



Is ACP only for people at the end of their life?

An Advance Care Plan (ACP) is for anyone at any stage who wants to start the conversation and focuses on future wishes and preferences



**A ReSPECT form is the same
as Advance Care Planning**

ReSPECT is only one component of a wider ACP process



ACP is only about DNACPR Decisions

ACP covers so much more, including personal wishes, care preferences, legal arrangements and future planning.



Families own or make the Advance Care Plan

The persons wishes remain central wherever possible.



**Advance Care Planning is the
responsibility of health
professionals only**

Care providers have a vital role in supporting conversations, understanding wishes and sharing information appropriately.

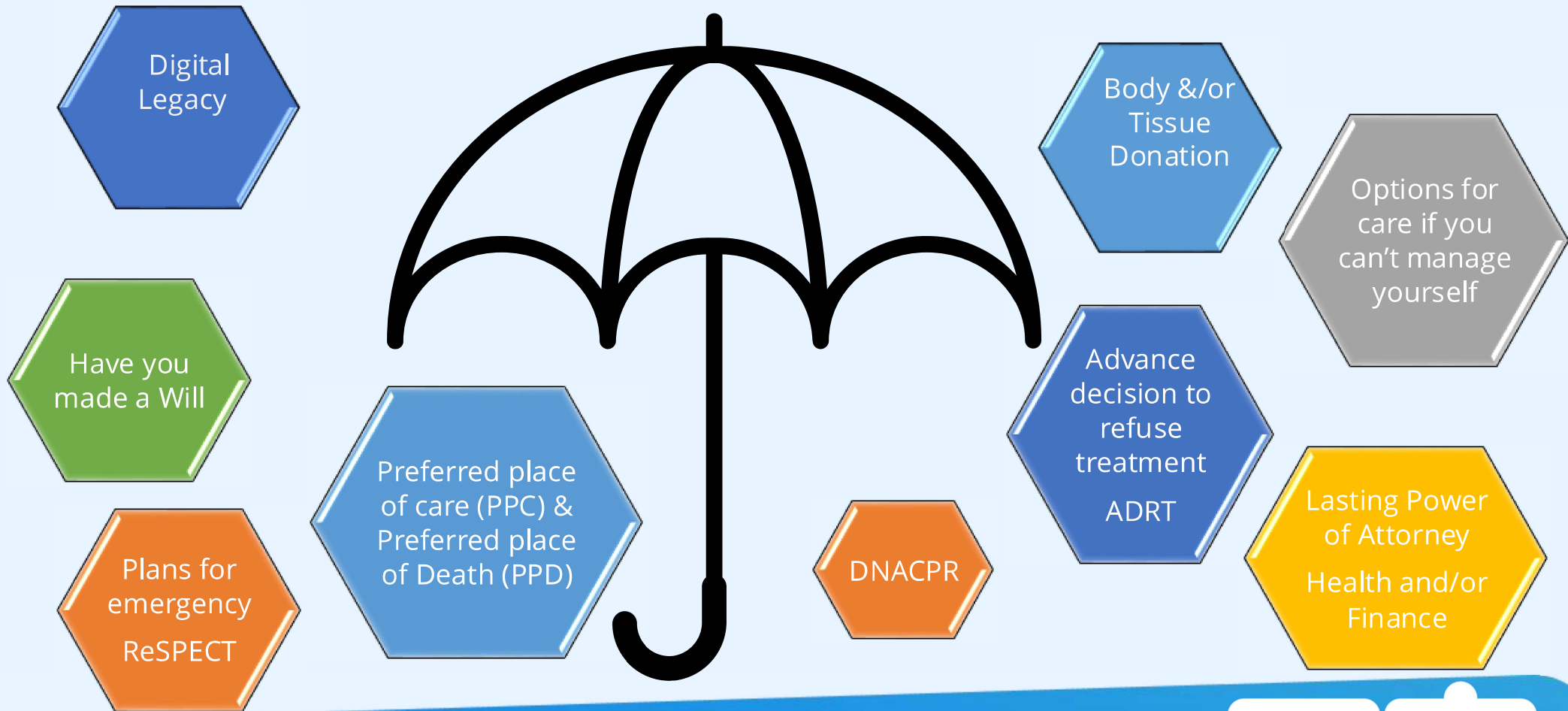
Definition

- ACP is a voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for their future care, while they have the mental capacity for meaningful conversation about these.
- The process, which is likely to involve a number of conversations over time, must have due consideration and respect for the person's wishes and emotions at all times. As a result, the person should experience a greater sense of involvement and the opportunity to reflect and share what matters most to them.

<https://www.england.nhs.uk/wp-content/uploads/2022/03/universal-principles-for-advance-care-planning.pdf>

- **Advance Care planning** is a key means to improving **care** for **people** nearing the end of life and of enabling better **planning** and provision of **care**, to help them live **well** and die **well** in the place and the manner of their choosing. (WHICH 2020)

What is Advance Care Planning?



What skills do we use to support Advance Care Planning?

- LISTENING
- PICKING UP CUES
- HONESTY/EMPATHY
- TIME

WHAT SUPPORTS US IN HAVING THESE CONVERSATIONS?



- Mental Capacity Act
- Lasting power of Attorney for Health
- Best Interest Decisions

Hope for the best.....plan for the worst.



WHY IS ADVANCE CARE PLANNING IMPORTANT?

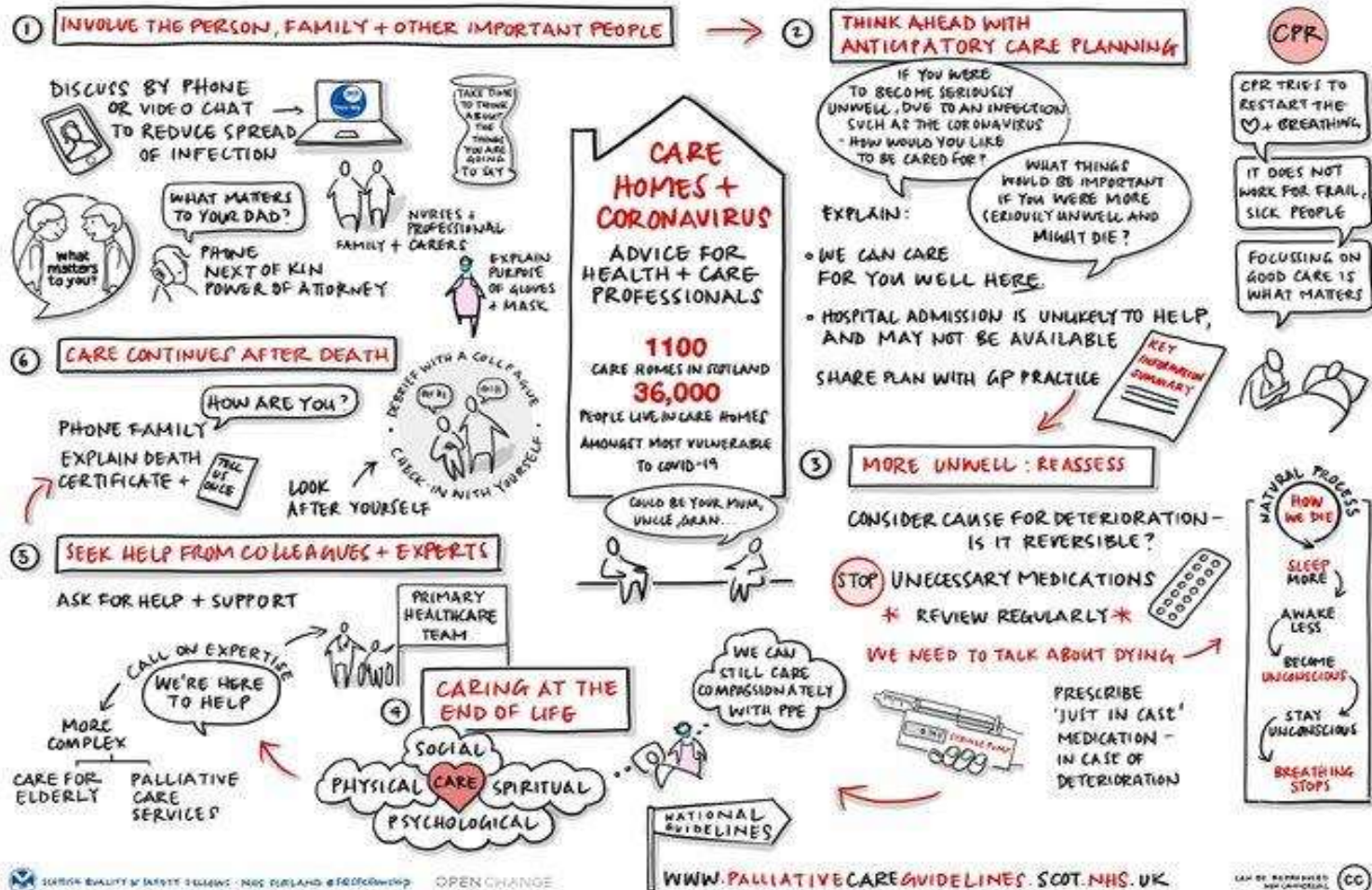
- Gives our service users the opportunity to express their views about their future care, promoting choice and control
- Individualized plan and the person feels listened to. Can be changed at anytime.
- Encourages open and honest discussions to take place within families and with care providers
- Increases likelihood of persons wishes being observed and the person is less likely to die in an unfamiliar place. Comes into effect when a person loses the ability to express their needs.
- Maybe shared with other professionals caring for that person

Benefits:

- Service users can put this worry aside and live well , knowing when the time comes all will know their wishes.
- Helps staff deliver good, personalized care as directed by the person we support
- Aids families to know what their loved one wanted/didnt want
- Supports good bereavement outcomes

Benefits continued:

- Directs professionals in what to do or not to do in a crisis
- Empowers service users to direct their future care
- A tool to opening up a difficult conversation



Introduce and start the conversation early.

Think how do we do this?

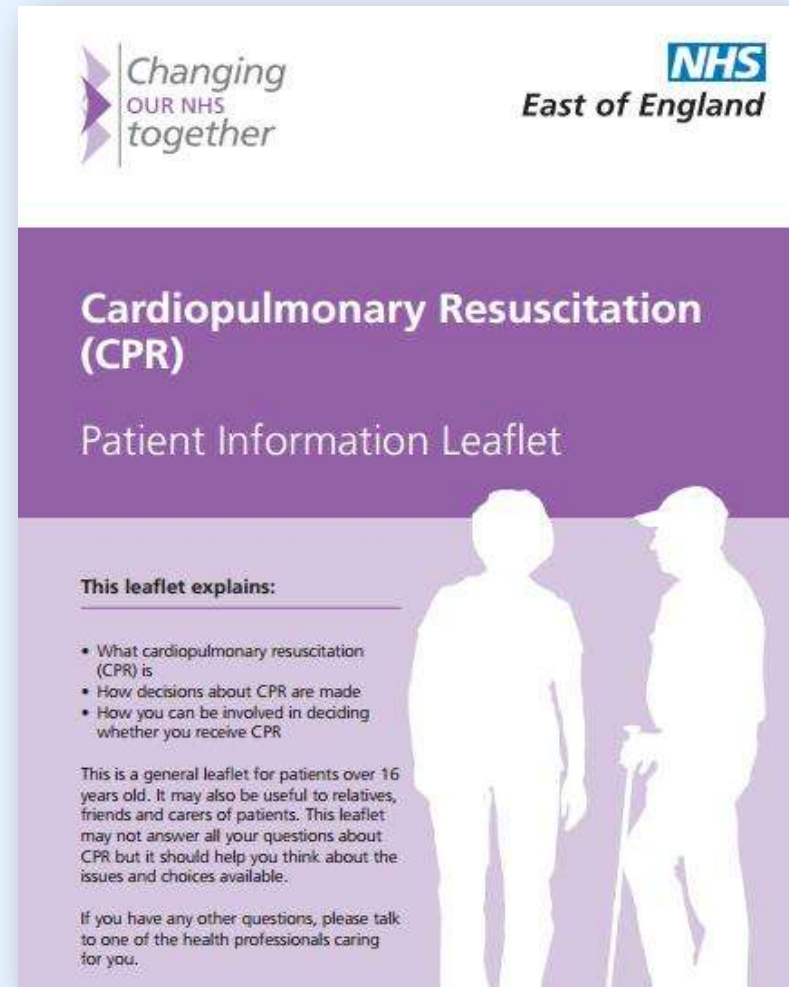
What are the elements to ACP?

PPC = Preferred place of care

PPD = Preferred place of death

Information we should be sharing:

[dnacpr_patient_information_leaflet_generic_-_can_be_used_nationally_produced_by_east_of_england.pdf \(hee.nhs.uk\)](#)



Do not attempt Cardio- Pulmonary Resuscitation DNACPR

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION	
Adults aged 16 years and over	
Name _____	Date of DNACPR decision: _____
Address _____	/ /
Date of birth _____	DO NOT PHOTOCOPY
NHS number _____	
In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.	
1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO	
If "YES" go to box 2	
If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 6 YES / NO	
If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. YES / NO	
All other decisions must be made in the patient's best interests and comply with current law. Go to box 2	
2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:	
3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:	
4 Summary of communication with patient's relatives or friends:	
5 Names of members of multidisciplinary team contributing to this decision:	
6 Healthcare professional recording this DNACPR decision:	
Name _____	Position _____
Signature _____	Date _____ Time _____
7 Review and endorsement by most senior health professional:	
Signature _____	Name _____ Date _____
Review date (if appropriate): _____	
Signature _____	Name _____ Date _____
Signature _____	Name _____ Date _____

DNACPR OLD
FORM



Recommended Summary Plan for
Emergency Care and Treatment

- Recommended
- Summary
- Plan for
- Emergency
- Care and
- Treatment

An alternative process...

...for discussing, making and recording recommendations about future emergency care and treatment, including CPR

Records treatments to be considered...

...as well as those that are not wanted or would not work



- Further Information

Further training and resources available via:

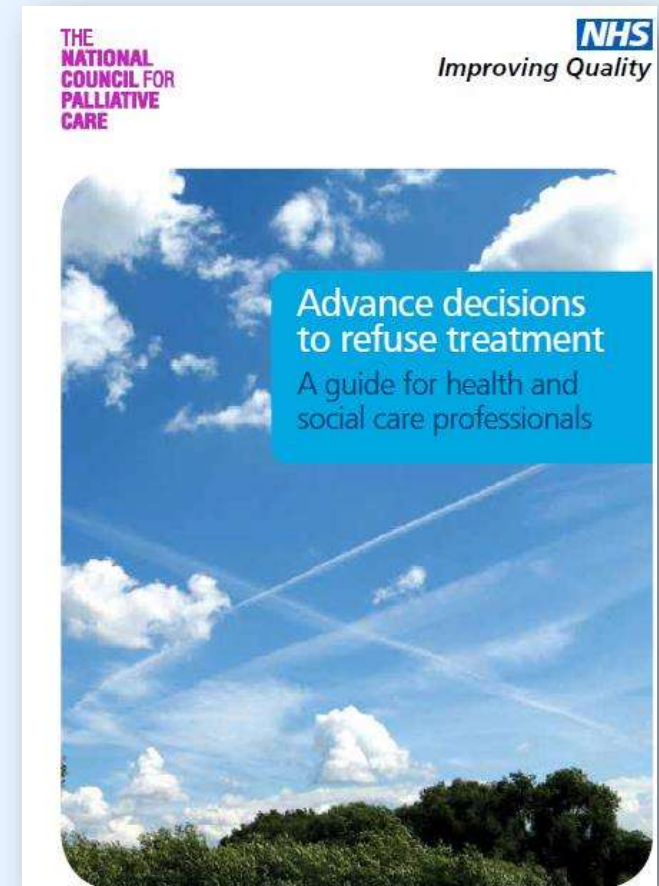
<https://www.resus.org.uk/respect/respect-healthcare-professionals>

An Advance Decision to Refuse Treatment.

- A decision to refuse specific treatment.
 - Treatments declined must be named with the statement 'even if my life is put at risk'
 - Needs to be written down if it is life threatening, signed by the patient and witnessed
 - Recommended to be done in conjunction with a competent clinician and ensure GP/Consultant is aware of your wishes.
- **Is an advance decision legally binding?**
 - Yes it is, as long as it:
 - complies with the Mental Capacity Act
 - is valid
 - applies to the situation

Link to ADRT document.

<http://endoflifecareambitions.org.uk/wp-content/uploads/2016/09/Advance-Decisions.pdf>



Lasting Power of Attorney (LPA)

- This is a legal document that allows the person (donor) to appoint one or more people (attorney) to help the person to make a decision or make a decision on their behalf
- To make an LPA the person must be over 18yrs and have mental capacity
- Two types:
 - Health and welfare
 - Property and financial affairs
- Once the form is complete it needs to be registered with the Office of Public Guardian
- This costs money, and takes at least 6 weeks

Future care arrangements:

- Self
- Animals
- Children
- Significant others

WHAT IS A Treatment Escalation Plan (TEP)

A **TEP** is a guide to help your decision making in an emergency situation or when a person's condition has deteriorated to the extent that they are unable to tell you their wishes.

A **TEP** will inform you of what **treatments** are acceptable for each individual.

TEP can work alongside ReSPECT.



WHO IS A TEP FOR?

A TEP can be used for anyone with ill health or complex needs, but they **should** become part of Advance Care Planning when individuals have been identified as likely to be in their last year of life.

Wouldn't you want to have a say in what you would or wouldn't want whilst you can?

No decision made without me.....
Individualised and empowering.



WHO IS RESPONSIBLE FOR COMPLETING A TEP?

- GP's and medical staff
- Senior nurses such as Specialist Nurses and Community Matrons
- Anyone that has received the competency training to complete DNACPR forms. (Advanced comms and psychological skills level 2)

However.....ANYONE can have the conversation with the patient about their future and how to plan for it they would just need to communicate this to others.



Collaborating for Excellence in Care

Think Digital legacy



<https://digitallegacyassociation.org/wp-content/uploads/2017/07/Digital-Assets-and-Digital-Legacy-Framework-April-2018-1.pdf>

www.dyingmatters.org~:digitallegacy

Funeral Planning



Donating your body to medical science is a generous and valuable act that can help train the next generation of doctors and support vital research. If you're considering this option, it's important to understand what's involved, how to register, and what your loved ones should expect.

Must register before you die with the medical school you wish to donate your body too.

Must be over 18yrs. Inclusion and exclusion criteria.

In the UK, body donation is arranged directly with medical schools that are licensed by the Human Tissue Authority (HTA). You can find a list of these on [the HTA website](#).

Wills

A will is a legal document that ensures your estate is distributed according to your wishes after your death.

Purpose of a Will

A will allows you to decide how your money, property, and possessions are distributed, and who will manage your estate after you die. Without a will, the law determines who inherits your assets, which may not reflect your wishes. Making a will is important regardless of the size of your estate, as it provides clarity and can prevent disputes among family members.

Remember

Take time

Really listen and be Present with the Patient

ACP is an ongoing process that may take many conversations....often these are bitesize.

Go at the patient's pace

Listen for important cues.

If you feel you do not have enough time, explain you will pick up where you left off on the next visit.

Always check understanding and involve family members if possible.

ACP is never set in stone and so needs reviewing as the patient needs require.

Document and share at MDT/GSF.

- Be Brave
- Be Honest
- Make a difference
- No time like the present



Any questions?

Please use the chat box

Resources

- [Thinking Ahead - Advance Care Planning \(ACP\)](#)
- NHS End of Life Care Programme - [Advance Care Planning Powerpoint presentation 2008](#) by Prof. Keri Thomas
- GMC have new guidance for doctors, [Treatment and care towards the end of life: good practice in decision making](#), came into effect on 1 July 2010
- GMC End of Life Care Guidance: Learning Materials - [Case Studies](#)
- GMC End of Life Care: [Advance Care Planning](#)
- The National Council for Palliative Care - 'Planning for your future care' - a simple guide to introducing advance care planning discussions to patients.
- [An introduction to advance care planning in practice](#) - A Mullick, J Martin and L Sallnow, BMJ 2013;347:f6064 doi: 10.1136/bmj.f6064 (Published 21 October 2013)

GSF Signposting and Guidance on COVID 19

- www.goldstandardsframework.org.uk/advance-care-planning.
- www.youtube.com/watch?v=12K6U6inIjQ
- Guide to decisions around CPR
- https://www.dyingmatters.org/sites/default/files/DNACPR%20Patient%20leaflet_A4.pdf
- DNACPR and Covid 19
- Resuscitation council statements on coronavirus and CPR in different healthcare settings
 - <https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/>

Communication & Conversations

- Talk CPR website providing helpful video clips to support conversations about treatment and CPR
 - <http://talkcpr.wales/>
- Helpful guide to having significant conversations
 - <https://www.realtalktraining.co.uk/covid19-evidence-based-advice-difficult-conversations>
- Useful e-Learning around communication
 - <https://portal.e-lfh.org.uk>
- Hospice UK
 - www.hospiceuk.org/what-we-offer/clinical-and-care-support/coronavirus-guidance.
- Scottish Quality Framework 2020 Kings College London” Field Smith and Robinson PCT
West Middlesex Hospital 2020

- Buckman R (1984) Breaking Bad News: why is it still so difficult? *Br Med J*(CLIN RES Ed) 288, 1597-9
- Henry Clare (2015) What is important to me. A review of choice at the end of life. <http://www.ncpc.org.uk/news/choice-review-published>
- National end of life Intelligence network (2012) What do we know that we didn't know a year ago? http://www.endoflifecare-intelligence.org.uk/resources/publications/what_we_know_now
- NHS England (2014) Actions for End of Life Care 2014-2016 <https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>
- Martin E et al (2015) Clinicians recognition and management of emotions during difficult health care conversations. *Patient education and Counselling* vol98 p1248-1254
- Stiefel F & Bourquin C (2016) Communication in oncology: now we train - but how well? *Annals of Oncology* 27: 1660–1663
- No Regrets (2017) Macmillan https://www.macmillan.org.uk/_images/no-regrets-talking-about-death-report_tcm9-311059.pdf

Recap

- Understand what Advance Care Planning is and why it matters
- Recognise common misconceptions surrounding ACP
- Understand the different documents and processes that may form part of Advance Care Planning
- Clarify the role of care providers, individuals, families and health professionals.
- Gain confidence in supporting timely and meaningful ACP conversations

The HCPA Resource Library

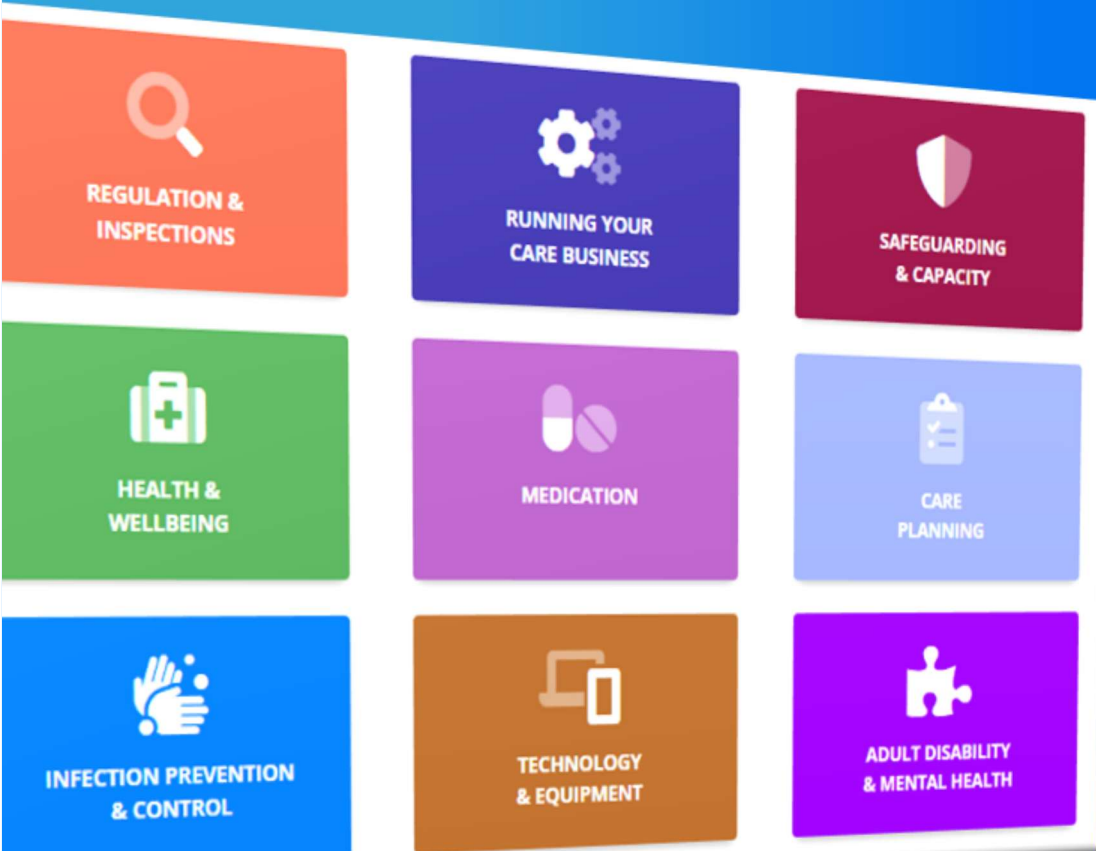
Everything you need, all in one place

Available to everyone, 24/7

Includes local and national resources, tools, guidance, policies, and contacts in a wide variety of areas

Perfect tool to support your business

hcpa.info/members-zone



Support Service Directory

All the contacts you need, in one place

Up to date contact details for all the Hertfordshire support services you need

hcpa.info/supportservicedirectory



Newsletters

Stay up to date with sector news!

Ensure you and your leadership team are signed up to receive HCPA's newsletters.

Subscribe to our mailing list





The Care Professional Academy

Enjoy discounts at all these top retailers & more...





The Care Professional Academy

Upload your certificates, get more rewards...

Certificates will be uploaded to the Academy for you.

This is the only way you can access your certificates.

Keep adding to your certificates, the more certificates you add, the more points you get to move up the tiers.

Not yet signed up to the Academy?

Join here... careprofessional.co.uk

or scan the QR code



THE HCPA CARE PROVIDER HUB PROVIDING PEACE OF MIND.....



ASK us anything! We are your support service, here to answer your questions on all topics Adult Social Care related.

- Govt guidance, laws, standards and expectation
- Covid: PPE, vaccinations and infection control
- Liaison with Hertfordshire County Council
- Funding, contracting and commissioning
- Staff wellbeing and recognition
- HR, Staffing and recruitment
- Training and education
- Business continuity
- Data protection
- Monitoring
- Equipment
- Insurance

Your hub, your support service.....

01707 708108 / assistance@hcpa.co.uk (Mon to Fri - 9am to 5pm). **www.hcpa.info/hub**

HCPA: 'Sharing best practice in care through partnership'



Thanks for joining us...

Before you go, please
scan the QR code and
leave us feedback

