Future Care Planning – Information for Professionals

What is Future Care Planning?

Future Care Planning is a person-centred, proactive approach to help people to plan ahead and to be more in control and able to manage any changes in their health and wellbeing.

At the heart of this is a conversation between individuals, those people who are important to them, for example a relative or carer, and their health or social care professional.

What is a Future Care Plan?

The decisions made during these conversations are recorded in a **Future Care Plan**.

The plan should include:

- reflections on an individual's situation and priorities in the context of their health
- information about specific treatments or care that would be appropriate for an individual, when they would consider or accept this care, and where they would like to be cared for
- information on who should be involved in supporting future decisions about treatment and care.

How do I use an Future Care Plan to inform care?

People's wishes and the wishes of those that matter to them, must always be taken into account when deciding on treatment plans. By doing this you will make a plan specific to this individual and based on what is important for them.

An Future Care Plan can help us plan for where treatment should be delivered and this in turn may lead to discussions about the level of treatment which can be provided in these locations. It is important that we come to an understanding with people regarding their health goals so that we can make realistic plans.

What are my responsibilities?

Start the Conversation: It is the responsibility of all staff, in all areas, to start the conversation about the benefits of Future Care Planning. This may involve asking them to think about specific aspects of their care or reflect on their current experience. This could be linked to a recent acute admission, a new diagnosis or a progression of a Long Term Condition. It may also be an introductory conversation about the benefits of future planning and signposting people to further information (www.nhsggc.scot/planningcare)

Record the Information: If people give their consent, information should be recorded in the **Future Care Plan Summary** which can be found on Clinical Portal (also available in PDF). By storing information on the system other services can also access and update information as they have further conversations. The Clinical Portal system will automatically inform the GP when new information is added and ask them to update the Key Information Summary (KIS). A guide to using the Future Care Plan Summary can be found on the back of this page.

Revisit the Situation: This process requires ongoing conversations as people's goals and preference may change throughout their life. It is important that staff revisit these topics, particularly if there is any change to diagnosis, prognosis or treatment options.

Where can I find more information?

Visit www.nhsggc.scot/planningcare to find further information about all aspects of future planning including Future Care Plans and Power of Attorney.

You can also find training opportunities including an eModule which all staff should complete (also available on Learnpro GGC028: Future Care Planning).

Using the Future Care Plan Summary - what information to document.

Consent

- Explicit Consent has been removed
- If someone choses to decline an summary this is recorded on Clinical Portal. Please provide details including if/when the conversation could be revisited.
- If there are any issues or things that need to be highlighted, add them in the "special notes" section e.g. if family are not to be told etc.

Next of Kin/ Carer Information

Remember to offer the carer a referral to carer support services - contact info found at www.nhsggc.scot/carers

Possible Other Agencies Involved

- Social work
- Pharmacy
- Local support
- Carers support services
- Palliative care services
- District nurses
- Hospice services

Preferred Place of Care/ Hospital Admission

- Current place of care and future wishes
- Escalation plans/potential triggers for change in care plan
- Family understanding of diagnosis, prognosis and treatment plan

Resucitation

- Referral for DNACPR if required
- Location of DNACPR form
- Family agreement/ knowledge of DNACPR

We are sharing this information for routine patient care as part of our Board's duty to provide healthcare to our patients. Under article 6(1)(e) of the UKGDPR and in conjunction with the Intra NHS Scotland Sharing Accord, we **do not** require consent to share this information. However, it is best practice for staff to make sure the individual and/or their legal proxy is aware this information will be shared when conducting Future Care Planning conversations. If the patient would like further information about how the Board uses their data it can be found in our Privacy Notice here: https://www.nhsggc.org.uk/patients-and-visitors/faqs/data-protection-privacy/#

Date of Review:		Date of Next Review:	
Reviewer:		HSCP/Directorate:	Job Family:

0. Reason for Plan and Special Notes

Reason for Plan (Please note, this is mandatory)

Trigger for plan /Update (please select one) :			
	Patient Requested ☐	Long Term Condition Diagnosis/Progression ☐	
	Family/Carer/POA Requested ☐	Receiving Palliative Care ☐	
	Professional Requested ☐	Moved to Residential/Nursing Home ☐	
	Frailty Identified ☐	Other (please specify):	

Frailty Score

Please select Frailty Score* from list: 0 - Not Applicable

If frailty assessment is not applicable, please select "0 – Not Applicable".

*Clinical Frailty Scale Guidance can be found on last page or scan this QR code

Special Notes / What is important to the individual?

Overview of person including family circumstances, accommodation information, health goals, what matters to them, emergency planning information etc. If person is a carer, or has informal carers please state. If person lacks capacity ensure this is recorded alongside who has been present during any discussions.

1. Demographics

Person's Details

Title:		Gender M ☐ F ☐	CHI:	
Forename (s):			Surname:	
Date of Birth:				
Address inc. Postcode:				
Tel No:				
Access Information e.g. key safe:				

GP / Practice details

GP/Practice Name:	
Address inc. postcode:	
Telephone No:	

Next of Kin

Title:		Gender M ☐ F ☐	Relationship:		Keyholder? Yes ☐ No ☐
Forename (s):				Surname:	
Address inc. Postcode:					
Tel No:			Is Next of Kin also Carer?		Yes ☐ No ☐

Carer

All staff have a duty to identify carers as soon as possible and inform them of their right to support. Carers can be referred to local Carer Support Services Contact details of local carers services can be found at www.nhsggc.org.uk/carers (carers can also self-refer if they wish).

Title:		Gender M ☐ F ☐	Relationship:		Keyholder? Yes ☐ No ☐
Forename (s):				Surname:	
Address inc. Postcode:					
Tel No:					

Other Agencies Involved

Organisation / Main Contact	Contact Numbers

2. Summary of Clinical Management Plan/Current Situation

Current Health Problems/Significant Diagnoses

Overview of health issues and diagnoses. Baseline functional and clinical status to help clinician identify deterioration – e.g. baseline O2%, 6-CIT score, level of mobility, current or planned treatments.

Essential Medication and Equipment	Yes	No	Notes
Oxygen therapy	☐	☐	
Anticipatory Medication At Home	☐	☐	
Continence / Catheter Equipment At Home	☐	☐	
Syringe Pump	☐	☐	
Moving and Handling Equipment At Home	☐	☐	
Mobility Equipment At Home	☐	☐	

3. Legal Powers

Adults with Incapacity / Legal Powers	Yes	No	Notes e.g. Guardian's details, date of appointment
Does the individual have a Combined Power of Attorney (financial and welfare)?	☐	☐	
Does the individual have a Continuing Power of Attorney (finance and property)?	☐	☐	
Does the individual have a Welfare Power of Attorney (health and/or personal welfare)?	☐	☐	
Is Power of Attorney in use?	☐	☐	
Is an Advanced Directive in place (living will)?	☐	☐	
Is an Adult with Incapacity Section 47 held?	☐	☐	
Has a Guardianship been appointed under the Adults with Incapacity (Scotland) Act 2000?	☐	☐	

Power of Attorney or Guardianship Details

Title:		Gender M ☐ F ☐	Relationship:		Keyholder? Yes ☐ No ☐
Forename (s):				Surname:	
Address inc. Postcode:					
Tel No:					Notes e.g. if process is in progress, where paperwork is located etc.
Date of Appointment					
Paperwork Verified by Professional	Yes ☐ No ☐				
Date Verified					
Name of Verifier					

4. Preferred Place of Care & Resuscitation

My preferred place of care

Depending on the person's own circumstances and health journey, this may include preference about long term care, place of treatment or place of death. Details of current level of care being provided by informal carers and/or any discussions which have occurred regarding on going and future care they might be able to provide.

My views about hospital admission/views about treatment and interventions/family agreement

Where possible please give details regarding hospital admissions in different scenarios. For example, people may be willing to be admitted for a short period for symptom management, however would be unwilling to be admitted if it was likely they would be in hospital for long periods.

Resuscitation

*Whilst these conversations can be helpful to plan future care, they should be held sensitively and appropriately. They are **not** mandatory.*		Comments
Has DNACPR been discussed?	Yes ☐ No ☐	
If YES, is a DNACPR Form in place?	Yes ☐ No ☐	
If YES, where is the documentation kept in the home?		
Refer to GP for further discussion re DNACPR?	Yes ☐ No ☐	

Trigger for Plan/Update

- Record trigger for discussion.

Frailty Score

- Consider a Rockwood frailty assessment. If not applicable select "0"

Special Notes

- What matters to the person e.g. motivations and health goals, faith or cultural aspects that are important
- Family situation inc. understanding and involvement in decisions, if they have a caring role for someone else etc.
- Accommodation situation inc. accessibility for equipment e.g. stretcher, key safe details, adaptations e.g. stairlift
- Possible risks/ difficulties e.g. pets, family dynamics, psychological states
- Preferred names
- Other care plans available
- Communication needs

Clinical Notes

- Main diagnosis/ prognosis
- Allergies
- Current medication
- Access to medication and equipment
- Level of mobility/ functionality
- Assessed capacity
- MUST/NEWS scores (if applicable)
- History of falls

Legal Information

- Power of Attorney
- Guardianship
- Adullts with Incapacity

Remember

Depending on your role and relationship, you may only know some of this information. Please input as much information as you can. Your colleagues will also be adding to this form.