

Preparing for Later Life without "Someone You Trust"

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Our Agenda

- A societal issue not just a personal one
- Putting plans in place today
- How the state steps in when needed
- Gaps in support, future solutions
- Resources for advance care planning

Disclaimer

This presentation is for general educational use only.

I am not legally trained or qualified. While I believe the factual content is accurate, it may include errors and omissions. The presentation also includes personal opinions.

I describe provisions under the Mental Capacity Act 2005 which applies in England and Wales. I do not cover the Adults with Incapacity (Scotland) Act 2000 or provisions in Northern Ireland.

References to organisations or individuals are not recommendations.

Nothing in this presentation is intended as personal or professional advice. You should not rely on it and should undertake your own research.

A Societal Issue



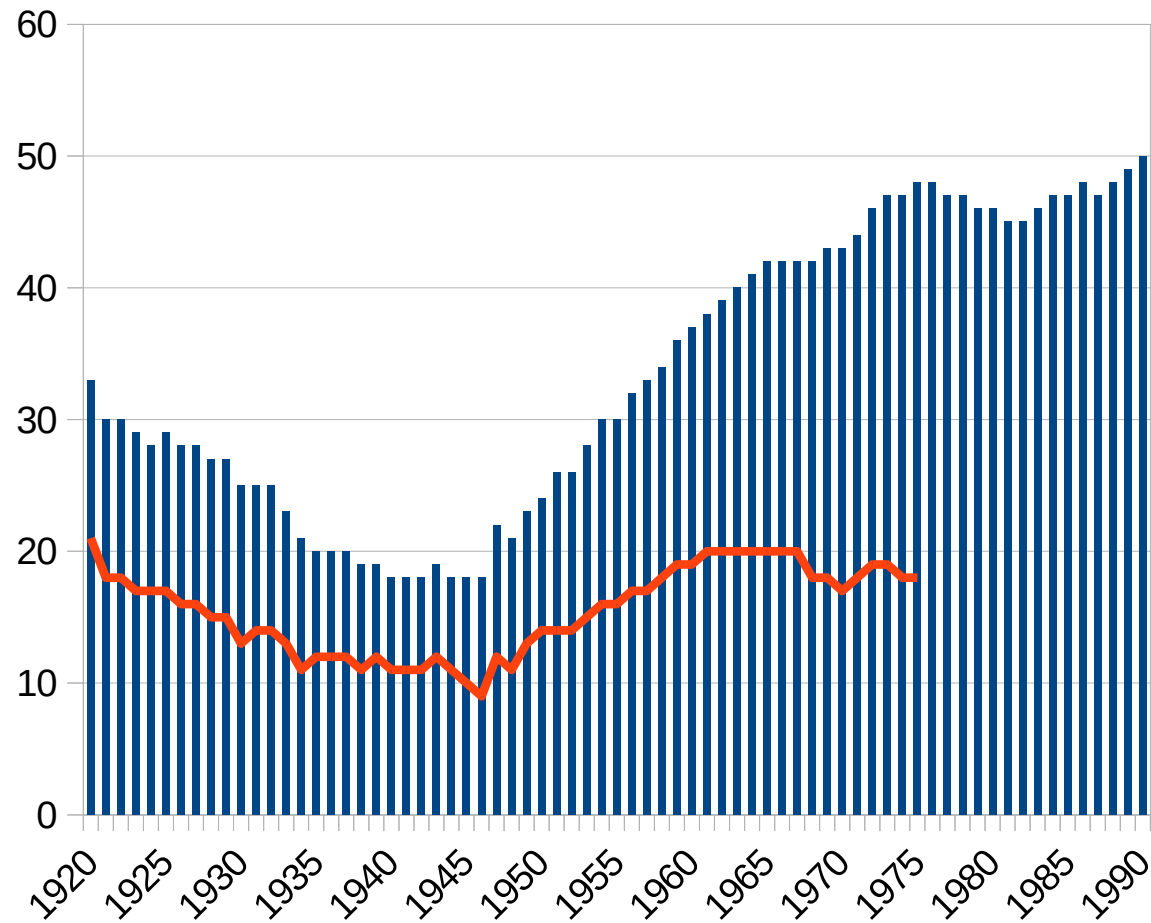


<https://powerofattorney.campaign.gov.uk/>

“Where to start:

1. Start a conversation with someone you trust”

England & Wales: Childless Women



% by Date of Birth
of Woman

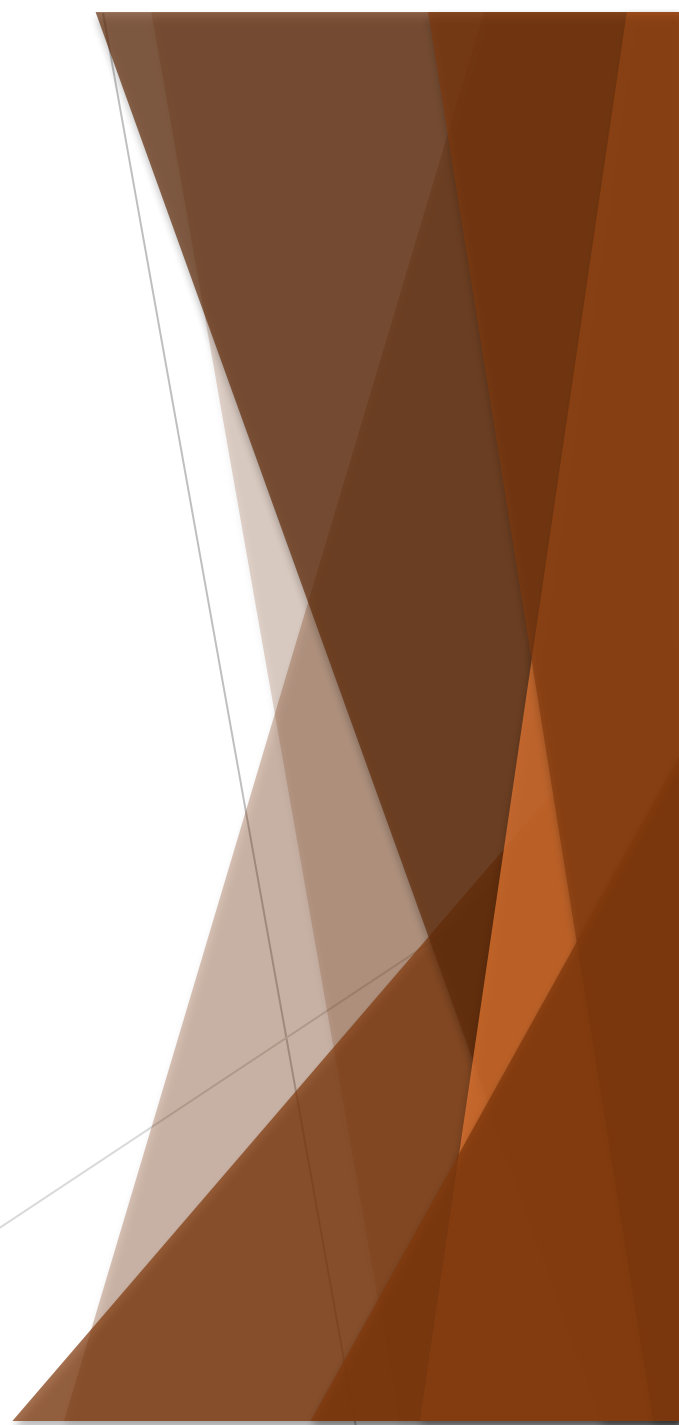
■ By 30th birthday
— By end of childbearing

Born 1946: 9%

Born 1966: 20%

Source: Office for
National Statistics

Putting Plans in
Place Today



Advance Care Planning: Documents

Lasting Power of Attorney

- Health & Welfare
- Property & Financial Affairs

Other

- Advance Decision to Refuse Treatment (ADRT)
- Advance Statement / Statement of Wishes
- ReSPECT Form
- DNACPR Form
- Financial & Health Records: "Life Book"

Advance Decision to Refuse Treatment (ADRT)

Compassion in Dying.
Your end of life. Your way.

Information for GPs

This is an Advance Decision to refuse treatment. You may know it as an Advance Directive or Living Will.

An Advance Decision is a form people can use to refuse any medical treatment in advance. It only applies if a decision needs to be made about treatment and the person does not have mental capacity to decide.

What to do next

1. Scan and upload a copy to the person's medical records.
2. Add the relevant SNOMED CT code.
3. Share with the local ambulance trust, hospital and out of hours team.

Important information

- It is legally binding in England and Wales under the Mental Capacity Act 2005. This means it must be followed by healthcare professionals if it meets certain requirements.
- A solicitor is **not required** to make an Advance Decision.
- Any adult with capacity can make one, they do not need to be unwell or over a certain age.
- As a GP you do not need to sign the form.
- This may be an opportunity to discuss a DNACPR if you think it is appropriate.

This form was made by Compassion in Dying. We are the leading provider of Advance Decisions in the UK. If you have any questions contact us by phone on **0800 999 2434** or email info@compassionindying.org.uk.

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Advance Decision to Refuse Treatment

This Advance Decision to Refuse Treatment sets out the situations in which I want to refuse medical treatment should I lack capacity to make or communicate that decision in the future. I have carefully considered these decisions and I confirm that I have capacity to make them. I understand that decisions about my diagnosis and prognosis will be made by the doctor in charge of my care.

Need help filling this in?
If you have any questions, you can contact Compassion in Dying's Information Line on:
☎ **0800 999 2434**
✉ info@compassionindying.org.uk

1. About me

Name: _____
Address: _____
Date of birth: _____ NHS number: _____
Distinguishing features: _____

2. GP details

Name: _____ Surgery: _____
Address: _____
Phone number: _____


3. I have discussed this Advance Decision with

1

Compassion in Dying.
Your end of life. Your way.

Making an Advance Decision to Refuse Treatment

Guidance notes



Need help?
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ReSPECT Form

(Recommended Summary Plan for Emergency Care and Treatment)

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name _____
Date of birth _____
Address _____
NHS/CHI/Health and care number _____

1. This plan belongs to:
Preferred name _____
Date completed _____

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition
Summary of relevant information for this plan including diagnoses and relevant personal circumstances: _____

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer): _____

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 6 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency
Living as long as possible matters most to me ☐ Quality of life and comfort matters most to me ☐
What I most value: _____ What I most fear / wish to avoid: _____

4. Clinical recommendations for emergency care and treatment
Prioritise extending life ☐ Balance extending life with comfort and valued outcomes ☒ Prioritise comfort ☐
clinician signature _____ clinician signature _____ clinician signature _____
Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance: _____

SPECIMEN COPY - NOT FOR USE

CPR attempts recommended ☐ For modified CPR ☐ CPR attempts NOT recommended ☐
Adult or child _____ Child only, as detailed above _____ Adult or child _____
clinician signature _____ clinician signature _____ clinician signature _____

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www.respectprocess.org.uk

5. Capacity for involvement in making this plan
Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No
If no, in what way does this person lack capacity? _____
Document the full capacity assessment in the clinical record. If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan
The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):
☐ A This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
☐ B This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
☐ C This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
☐ 1 They have sufficient maturity and understanding to participate in making this plan
☐ 2 They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
☐ 3 Those holding parental responsibility have been fully involved in discussing and making this plan.
☐ D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures
Grade/speciality Clinician name GMC/NMC/HCPC no. Signature Date & time
Senior responsible clinician: _____

8. Emergency contacts and those involved in discussing this plan
Name (tick if involved in planning) Role and relationship Emergency contact no. Signature
Primary emergency contact: ☐ optional
☐ optional
☐ optional
☐ optional
☐ optional

9. Plan reviewed (e.g. for change of care setting) and remains relevant
Review date Grade/speciality Clinician name GMC/NMC/HCPC No. Signature
SPECIMEN COPY - NOT FOR USE

If this page is on a separate sheet from the first page: Name: _____ DoB: _____ ID number: _____

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Mental Capacity Act 2005

New Oversight Organisations

Court of Protection

Office of the Public Guardian

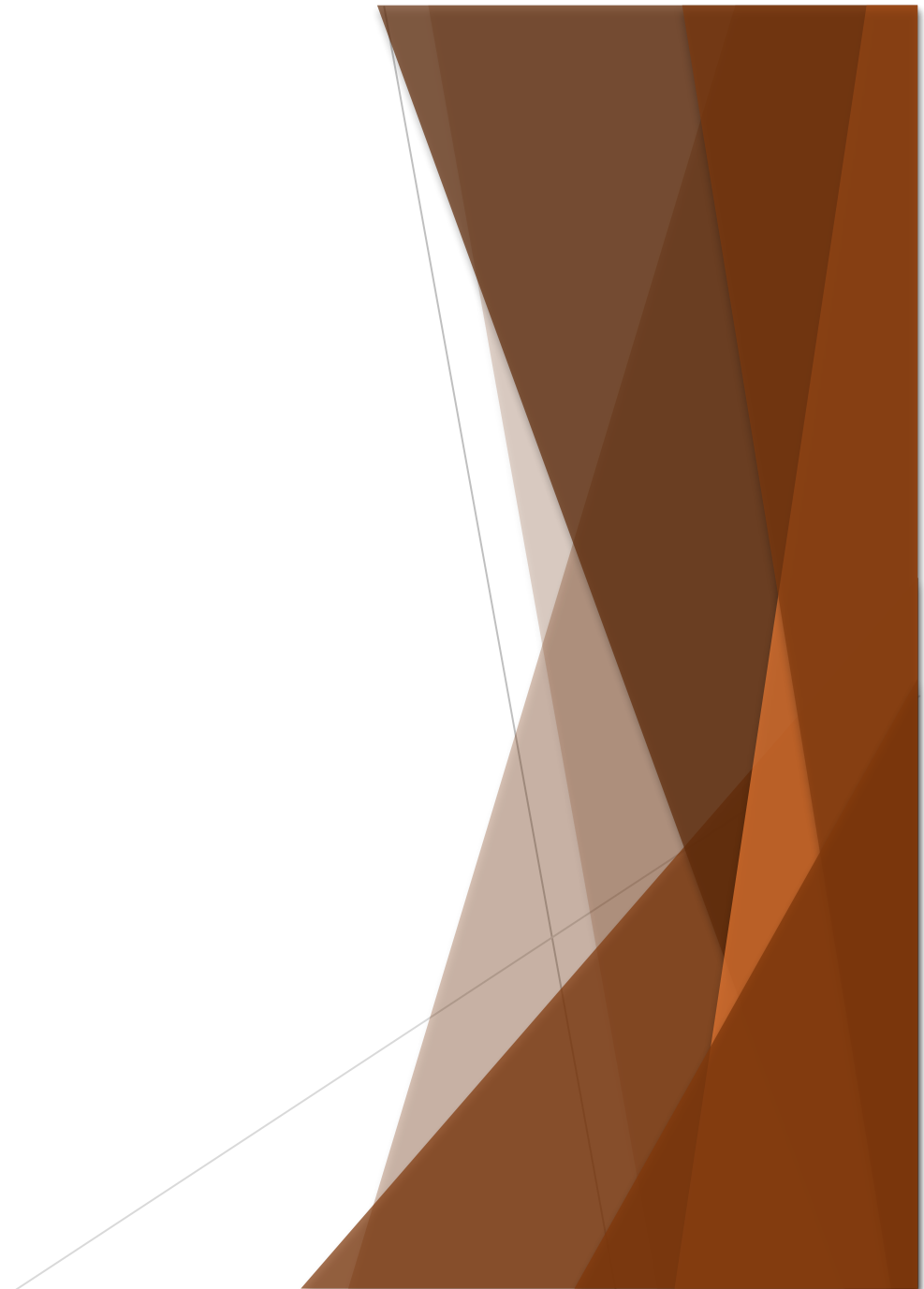
Delegated Decision Makers

Lasting Power of Attorney

- donor appoints "someone they trust"
- light touch regulation

Deputy

- court appoints and sets powers
- higher regulation



Lasting Power of Attorney (LPA)

- Two LPA Types
 - Property and Financial Affairs
 - Health and Welfare
- Visit the "Office of the Public Guardian" website and YouTube channel for information
- "Someone you trust" - family, friend, professional
- Must follow Statutory Principles & Code of Practice
- Light touch regulation

Some Questions when selecting a Professional Attorney

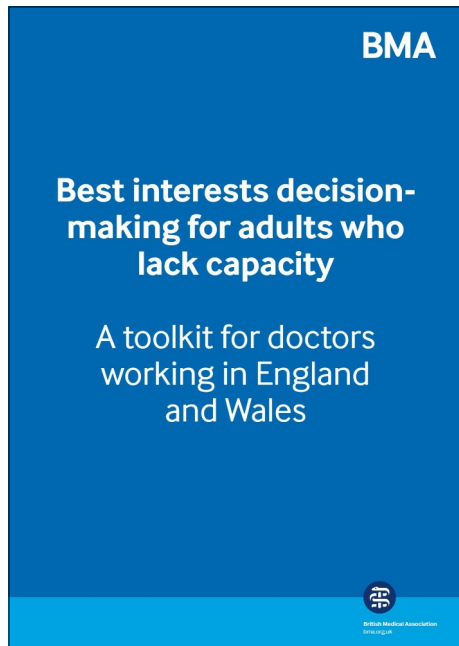
1. What are their contractual terms?
2. How are they regulated?
3. How are their costs set (including increases)?
4. Will an individual or a trust corporation be appointed, and what happens if my chosen professional retires or leaves the firm?
5. How do they manage conflicts of interest?
6. Will they still act for me if my money runs out?
7. Will they act as Health & Welfare attorney or only Property and Financial Affairs?
8. Health and Welfare: Are they willing to authorise/reject life sustaining treatment?

How the State
steps in



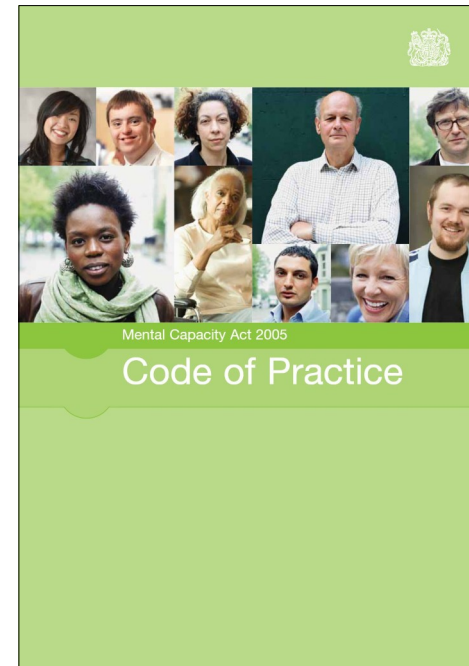
“Best Interests” Decision Making

*when you have no Health & Welfare LPA
and no relevant Advance Decision to Refuse Treatment*

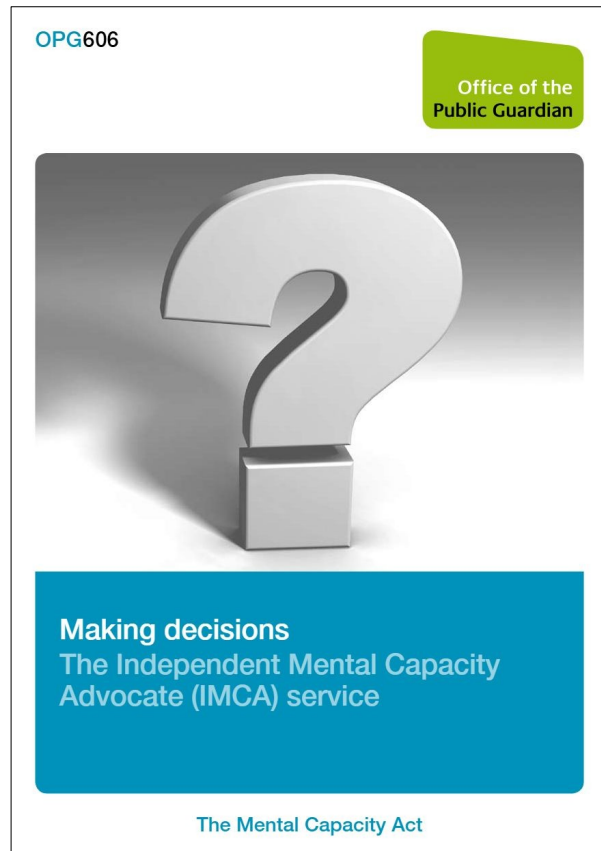


Inputs:

1. Your advance statement of wishes (not legally binding)
2. Your current wishes (with independent advocacy support)
3. Information from people who know you



Independent Mental Capacity Advocate (IMCA) service

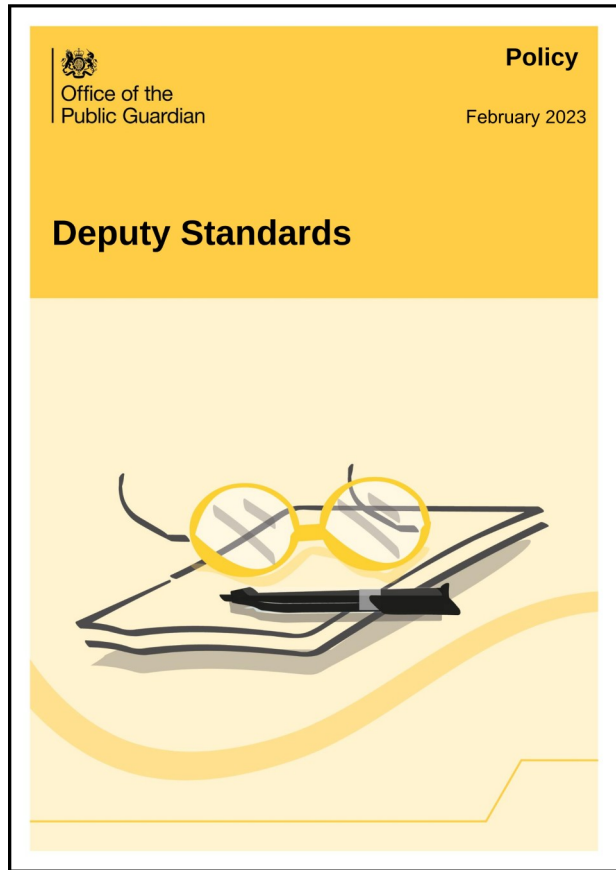


- Independent, issue-based, time-limited, and free at the point of request
- Funded by local authority
- Contract awarded to specialist advocacy organisation

Court-Appointed Deputies

- Appointed by the Court of Protection
- More regulated
- Used mainly for Property and Financial Affairs
- Three types
 - **Lay Deputies** (Family, Friends)
 - **Public Authority Deputies**
 - **Professional Deputies**
 - (Solicitors, "Trust Corporations", Charities)
- Panel Deputies = "Deputy of Last Resort"

Appointment & Regulation of Deputies



Court of Protection

- Deputyship order
- CoP makes decisions outside scope of order
- Court-set deputy fees
- Security bond
- "Practice Directives"

Office of the Public Guardian

- Supervision, Annual Report, Notification of Major Decisions
- Standards, "Practice Notes"

Gaps in Support, Future Solutions



Advance Care Planning for AWOCs: Issues

1. **Appropriate information** for those without “someone they trust”
2. Amount of **professional capacity** within the system for the growing number of AWOCs
3. **Regulatory requirements**: are they fit for purpose?
4. **Governance of the providers**, eg. ownership, longevity, management of conflicts of interest
5. **Appropriate cost**
6. **Transition** on losing capacity and on death
7. **Wider issues** potentially impacting AWOCs, eg. frictions in the banking system for attorneys and deputies; underdeveloped market for care annuities.²⁰

The Future: One Vision

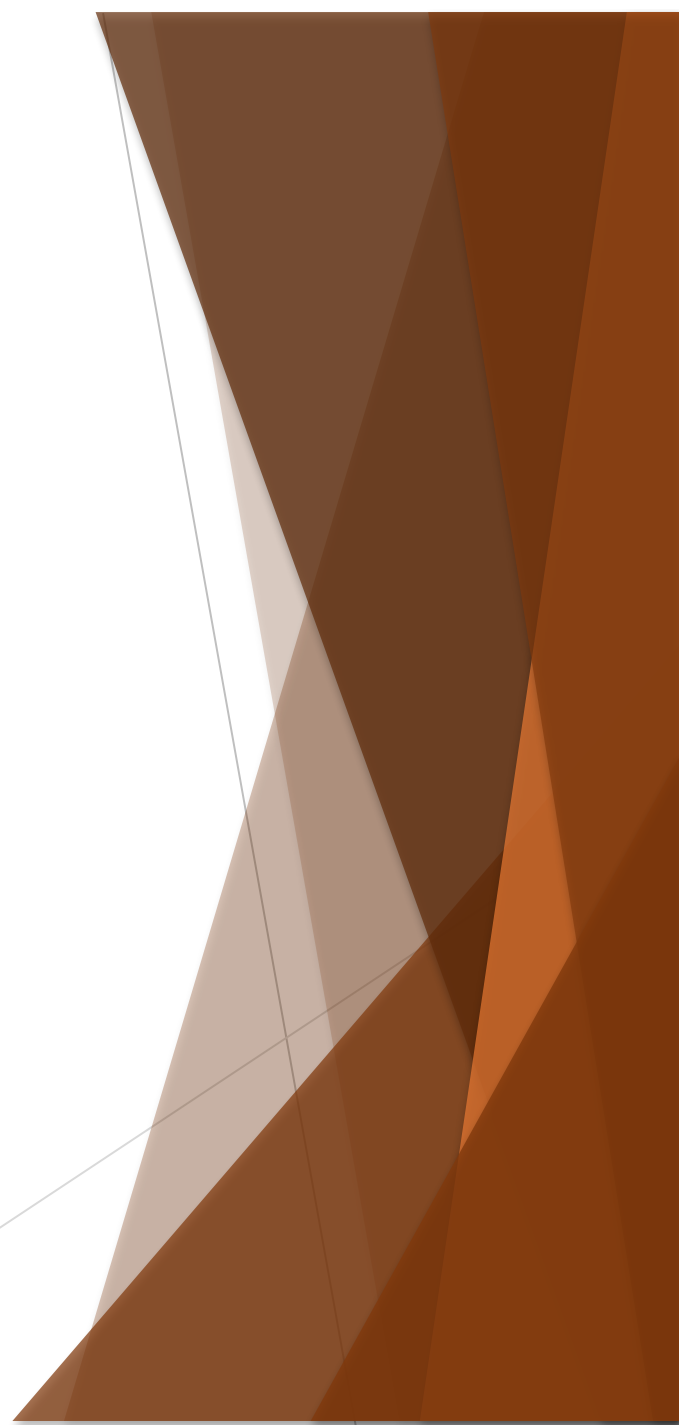
Kith Cooperative

- A Power of Attorney & Personal Secretary service
- A non-profit consumer cooperative, owned and controlled collectively by people ageing without children - "one member one vote"

Kith (Old English) = knowledge, one's native land, friends and neighbours

What is your vision?

Resources for Advance Care Planning



Resources



Office of the
Public Guardian



<https://powerofattorney.campaign.gov.uk/>

Resources

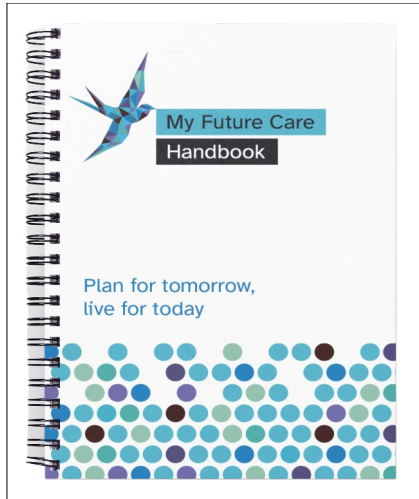


Office of the
Public Guardian

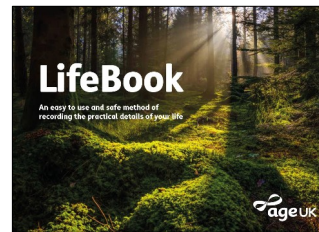
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ageing without children
www.awoc.org.uk
/blog



 **Resuscitation
Council UK**



*Conversations about Advance Care Planning
Episode 101: Ageing Without Children
and Advance Care Planning with Penny Shepherd
<https://speakforme.co.uk/podcast-episode-101>*

[Your Local Hospice]



awoc

ageing without children

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