



My Future Wishes

A Guide to Advance Care Planning

(August 2020)



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"....professionals in all specialisms, at every level, should be armed with the knowledge and skills they need to sensitively but confidently 'have the conversation' with their patients about their priorities, concerns and wishes for the end of life; encourage them to do the same with their families; and, crucially, support them to record their wishes in a thorough advance care plan that can be easily accessed by medical staff." [Extract from Compassion in Dying letter to Sunday Times](#), April 2020



It is with great pleasure that we introduce this guide to support people and their families, as well as professionals, to have conversations about advance care planning and their future wishes. The guide helps both groups to navigate through what can be a very difficult subject, although some sections are written particularly with professionals in mind. As the subject is often an emotional one, it is frequently not explored in a timely way and this can lead to regret on behalf of both families and professionals. We hope that you find that the resource takes a sensitive approach to exploring the issue and it will be important to remember that good advance care planning is about conversations and time - it is not a sprint to the finish. People should feel that clinicians acted with compassion and that the experience, though difficult, was rewarding and therapeutic.

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Using this resource

You can read this resource from start to finish if that's your preference. Or you can use the diagram below to navigate straight to those sections of the resource of most interest to you. The section on how to talk about future wishes (pages 10-16) has been written particularly with staff in mind so may have limited use to others.

My Future Wishes - A Guide to Advance Care Planning



[What is advance care planning?](#)



[Why is advance care planning important?](#)



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[How to talk about future wishes](#)



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What is advance care planning?

Advance care planning is a discussion in which a person may choose to express their views, preferences and wishes about their future care. It is NOT usually a one-off process. It is an ongoing conversation, likely to involve those people (family and unpaid carers, clinical and non-clinical staff) who provide support and care.

An advance care plan should usually evolve slowly, over a period of time. Wherever possible, it should involve someone who already knows the person. There should be no pressure for the individual or their family to make rapid decisions.

An advance care plan isn't written in stone. People should be prompted and supported to regularly review their plan, particularly when their health or other circumstances change ([go to Opportunities and triggers for future wishes conversations >](#)).

An advance care plan is an often overlooked and yet crucial aspect of personalised care planning which has come to the fore during the COVID-19 pandemic. It differs from general care planning in that it is usually used in the context of progressive illness and anticipated deterioration. This [open letter to the Health Secretary](#) calls for advance care planning to become mainstream activity during the COVID-19 pandemic. This [palliative care toolkit from Kirkwood Hospice](#) also emphasises the importance of advance care planning during COVID-19.



An advance care plan may include a person's:

- Concerns e.g. for things that they don't want to happen in future or who will care for loved ones or pets
- Important values or personal goals for care
- Future wishes
- Understanding of illness and prognosis
- Preferences for types of care or treatment that maybe helpful in future and understanding of the availability of these
- Carer emergency care plans.

These [Top Tips for Clinicians](#) published by Bradford and Airedale CCG are focused on Advance Care Planning and future wishes conversations.

This [Guide to Advance Care Planning](#) was developed by the education hub leads at St Gemma's Hospice and Wakefield Hospice.

How does advance care planning fit together?

Advance care planning is an umbrella term that covers many aspects of future care planning. Having an advance care plan is a bit like planning ahead for a rainy day.

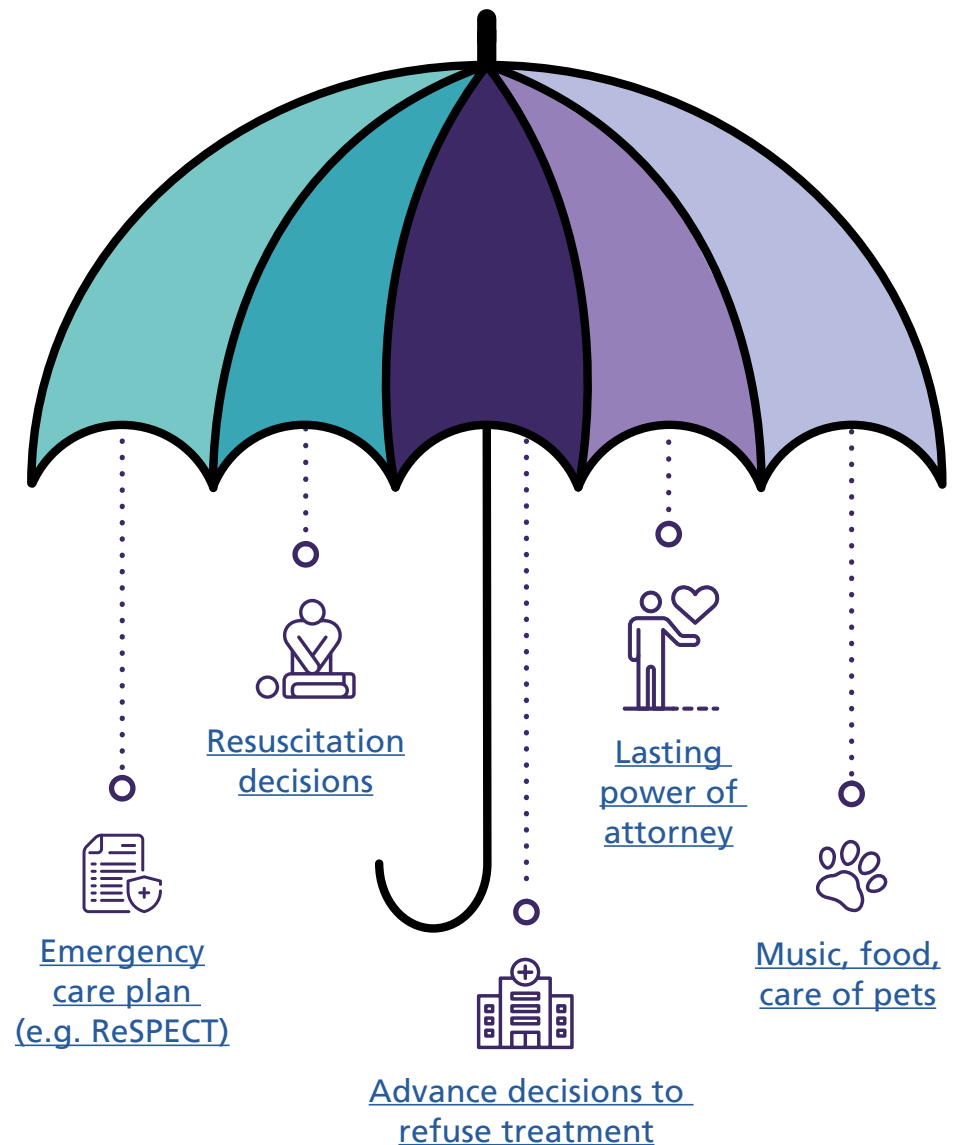
A person's advance care plan may incorporate any or even all of the following. It may include 'formal' statements of wishes like an [Emergency Care Plan](#), an [Advance Decision to Refuse Treatment](#) (which is legally binding if the circumstances apply) and/or someone's preferences relating to resuscitation. If the person relies on support from a family carer, then their Emergency Care Plan may also be helpful to include. West Yorkshire and Harrogate Health and Care Partnership have published a [Carer's Toolkit which includes a Carer's 'Plan B' Emergency Care Plan](#).

The person may wish to formally identify, using a [Lasting Power of Attorney](#), one or more people to speak on their behalf, should they lose the capacity to make their wishes known.

They may also wish to make known who they would like to look after their pets if they are no longer able to, what music they would like played in their room and any food likes and dislikes.

All of these different elements combine to form a person's advance care plan, making clear their wishes and preferences for the future.

NHS Wales have published a range of Advance Care Planning resources, including videos and a jargon buster – all available to access [here](#).



Why is advance care planning important?

Recording future wishes can be empowering and a way for people to feel more in control when the future seems uncertain. If at a future time, the person is no longer able to make their wishes known, they will have the assurance that their wishes will still be heard.

“We can make different choices but need to make the plans, get the choices down, make it while you can. I want to be treated with dignity and care.”

Wishes can be reviewed and updated at any time – no one will be held to an advance care plan if they change their mind. Although an advance care plan has no legal standing, people making best interest decisions for someone who lacks capacity, are duty bound to consider the wishes that the person has previously stated.

This [Conversation Starter Pack](#) developed as part of the West Yorkshire and

Harrogate Health and Care Partnership National Dementia Pilot project, has been designed for people who are living with a long-term condition. It helps individuals and families to consider and discuss the issues that are important to them.

The [Which? Guide to Advance Care Planning](#) includes sections on why plan ahead, how planning ahead makes a difference and how to start planning ahead. The social care institute for excellence has provided this [overview of capacity assessment and best interest decision making](#).

Why it is helpful for family carers?

Families can often find contributing to best interest discussions difficult. It is frequently assumed that family will know what decisions a person would have made had they not lost capacity or been unable to communicate their wishes. Family members are often asked what loved ones would have wanted in relation to complex issues around whether to treat or withhold treatment. It is usual for clinicians to ask for carer views as a proxy which may influence treatment decisions such as cardiopulmonary resuscitation (CPR).

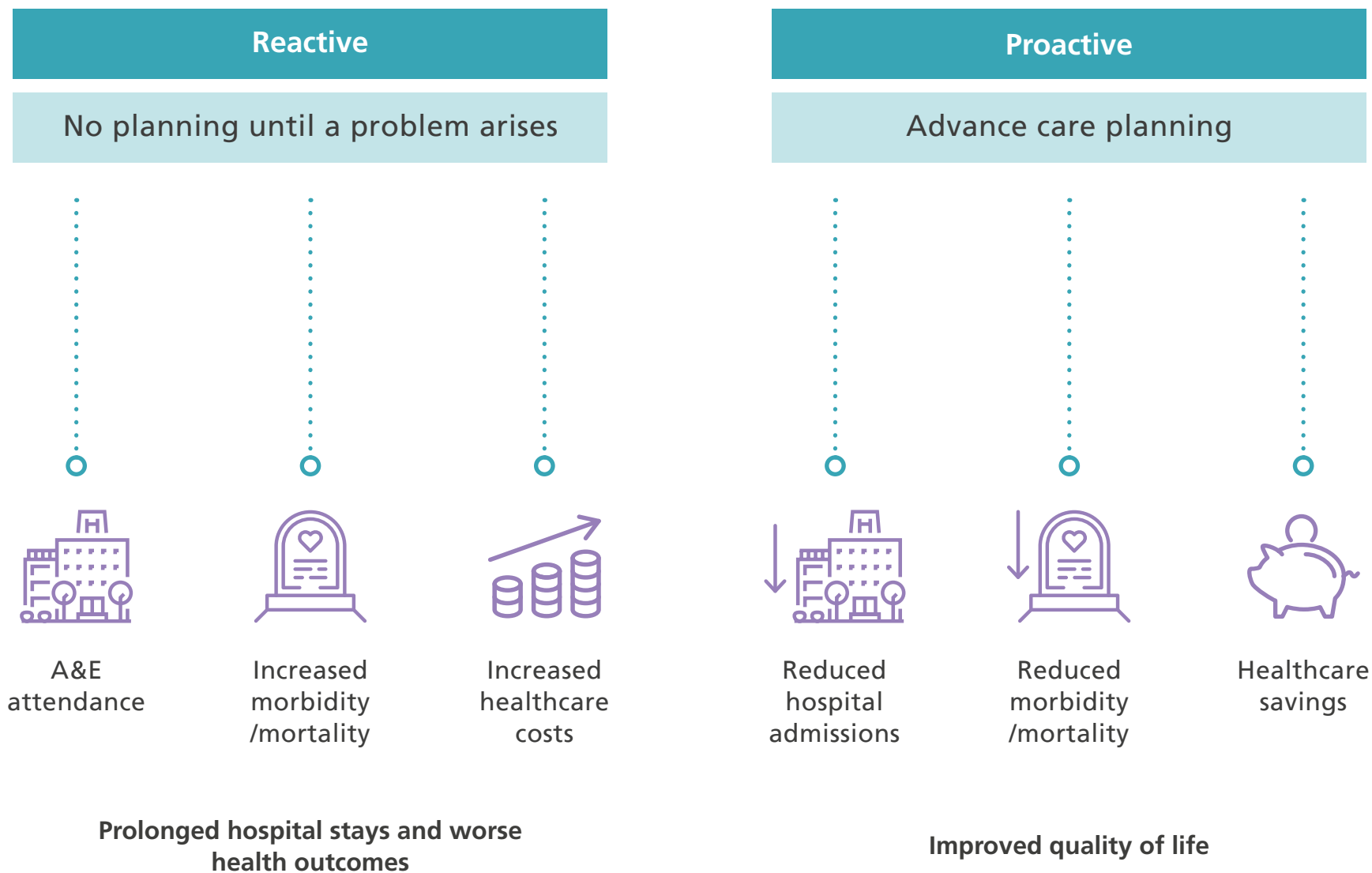
However, in the absence of previous discussions or an advance care plan, a carers' ability to accurately predict the treatment preferences of a family member who is living with dementia has been found to be no better than chance ([Harrison Dening et al., 2016](#)). This paper showed that the more psychologically distressed carers are feeling and the more aggressive the treatments being considered, the less able the family were to predict the treatment preferences of their loved one.

Making an advance care plan can really help families to understand what their loved one wants for their future care, which can reduce stress for families further down the line. An advance care plan also gives the clinician assurance that decision-making and treatment choices are consistent with the wishes which were previously expressed by the individual.

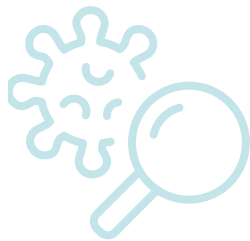
“We planned everything when mum still had capacity. It gives me comfort. Now I don't have to worry because I know what my mum wanted. It would be useful for other carers to have these”

It is also important that carers are supported to [consider their own wishes](#) for their future care.

Advance care planning improves outcomes for people and their families



Source: Dementia UK



Impact of COVID-19

Death rates from COVID-19 are much higher in the older age group and in those with other illnesses ([see Treatment implications of COVID](#)). A person is likely to become ill and deteriorate quickly with COVID-19. Once unwell, the opportunity for discussion and involving the individual in decision-making may be limited or lost and the professionals providing care at that stage may not know the patient well.

Many staff have established relationships with patients who are already very frail. For these patients, an automatic hospital admission may not be the right escalation of care. Giving patients the opportunity to consider and discuss their wishes for future care, will enable families and staff to be clear about their preferences should their condition deteriorate. Royal College of Physicians has published, [“Ethical dimensions of COVID-19 for frontline staff”](#) to support good ethical practice during the pandemic.



Honest conversations about goals of care should be started as early as possible and ideally prior to the onset of any acute illness. See Leeds Palliative Care Network, [Discussions about goals of care](#) for a checklist of key points to consider when discussing ceilings of treatment.

For people who are living with dementia, these conversations should be offered early in their dementia journey while they are still able to communicate their wishes.

For people with an existing advance care plan, including care home residents, these should be reviewed “as a matter of urgency” in light of the COVID-19 pandemic.

[Go to Talking about Future Wishes during COVID >](#)

When should advance care planning be started?

Opportunities and triggers for future wishes conversations

This section includes resources to help you think about and prepare for conversations about someone's future wishes for care. It can help people to discuss their wishes for future care if we provide opportunities for discussion at a time that is right for them.

"I've been wanting to talk about this for ages but no-one will"

For people living with dementia, this will need to be at an earlier stage in the patient journey when they are still able to engage in the conversation and make their wishes known. This [guidance document](#) from NHS England provides information and signposting to support staff to have advance care planning conversations with people who are living with dementia in any care setting.

Think about the language you use when you are having these conversations -

talking about someone's future wishes sounds less clinical than an 'advance care plan'. The COVID-19 pandemic has led many people to consider their future care wishes for the first time. Other triggers or changes in circumstance may prompt people to think about their future care wishes, leading them to review and/or change an existing advance care plan.

Other 'triggers' for future wishes conversations

There is no agreed standard frequency with which to review an advance care plan, so the interval should be based on patients' wishes, taking into account their clinical condition.

Triggers include:

- Patient initiates the conversation

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- Diagnosis of a progressive life limiting illness
- The diagnosis of a condition with a predictable trajectory, which is likely to result in a loss of capacity, such as dementia or motor neurone disease
- A change or deterioration in condition
- Change in a patient's personal circumstances, such as moving into a care home or loss of a family member
- Routine clinical review of the patient, such as clinic appointments or home visits
- When the previously agreed review interval elapses

[SPICT™ is a clinical tool](#) to help identify people whose health is deteriorating due to one or more advanced, progressive conditions or a new life-threatening illness. It helps clinicians decide when it is time to start talking with people and their families about what is important to them and the available treatment and care options.

Who is involved in advance care planning?

Enabling and supporting people to talk about their future wishes is everyone's business. People may choose to discuss their future wishes with anyone who provides them with care and support, irrespective of their role or employing organisation. So nursing, medical staff, allied health professionals, care

home, domiciliary care and voluntary sector staff all need to feel confident and comfortable about having these conversations with the people who they support and care for. They may also need to assess an individual's capacity to make decisions as part of this process.

It is likely that several different staff will be involved in supporting a person to develop their advance care plan. Discussions about refusing treatment need to be had with a suitably qualified practitioner, for example. With the person's permission, their information can be passed onto someone who is best-placed to help with that part of the conversation.

"I need help with having this conversation. If I'd done it a year after my diagnosis, it would have given me a peace of mind."

Putting an advance care plan in place is appropriate for everyone – we all need to work towards having these conversations with our families and friends.

[Go to how to record your future wishes >](#)



How to talk about future wishes

Some staff will be having these conversations regularly. For the individual, however, this may be the first time they've ever talked about dying with someone else so it's really important to get these conversations right.

"Professionals are scared to talk about end of life. We have limited time to get death right. It's sad that people thought they may not get either what they need or what they want."

Loughborough University has published [evidence-based advice for difficult conversations](#), including preparing yourself and your environment. There are also various [video and e-learning resources](#) to help you prepare to have these important conversations well.



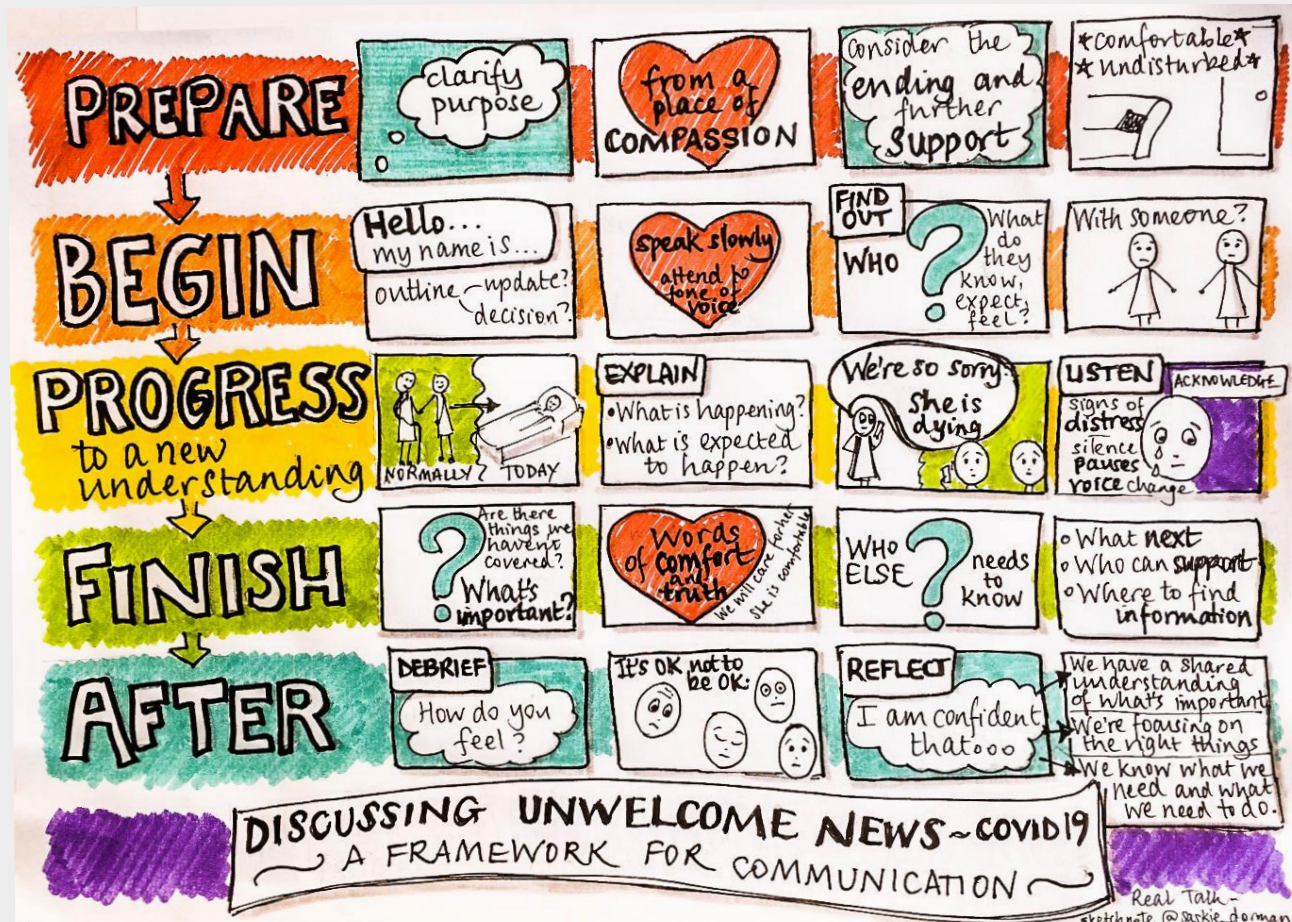
It is more likely to be a good experience for the person when:

- ✓ You allow time for the conversation
- ✓ You start with open questions like 'How are you?', 'How are you coping?' and 'Who is getting your shopping/medication?'
- ✓ You ensure it's personalised – using open questions enables them to lead the conversation
- ✓ You listen more than you speak and acknowledge what you hear. This is about establishing a relationship if you don't already have one
- ✓ You listen for clues that someone wants to move onto a discussion about their worries and choices of care
- ✓ You only go as far as someone wants to go - some people may want to go on with the conversation around their future wishes but others will not and that is OK. You can offer a further opportunity at a later date
- ✓ You don't make assumptions. For example, it's important that you provide culturally sensitive care without making assumptions based on a person's religion or culture.

Having conversations about the priorities that matter most to people

Atul Gawande is an American Surgeon who wrote "Being Mortal: Medicine and What Matters in the End". These are the questions he uses to understand a person's wishes for their future care:

- What's your understanding of where you are with your health or illness at this time?
- What are your fears and worries if your health worsens in the future and for your health overall?
- What are your goals and priorities if time is short?
- What are you willing to go through (and not willing to go through) for the sake of more possible time?
- Who will make decisions if you can't? (70% of us will come to the end of our lives with others making decisions on our behalf)



^ Ref: [Academic Health Science Network \(2020\)](#)

Atul Gawande videos:



QUICK WATCH: [How to talk end of life care with a dying patient](#)
(4 mins)



[Late Life: A Conversation](#)
(56 mins)



Talking about future wishes during COVID-19

During the COVID pandemic, conversations are frequently taking place over the phone or by videocall. Communicating by telephone introduces an additional barrier.

Pre-planning will be needed for calls with people who are hard of hearing, with those who have cognitive impairment and for those for whom English is not their first language. The Royal College of Nursing have produced guidance for '[Having Courageous Conversations by Telephone or Video](#)' and the Royal College of General Practitioners has shared this video giving [Top 10 Tips for GP video consultation during COVID](#).

'Cold calling', when a conversation has not been prompted by the patient is particularly difficult, especially where you have no established relationship with that person. During COVID, these conversations are often carried out with the person alone and not, in the usual way, with family present. Be aware of how conversations with an individual may be related back to and interpreted by their family – think about how to involve the family wherever possible, with the person's agreement.

Cold calling needs very careful handling to avoid causing emotional trauma and coming across as 'we are having these conversations because we think you/they may die'. Leeds Palliative Care

Network have produced an example 'script' for calling patients to discuss advance care plans, available [here](#).

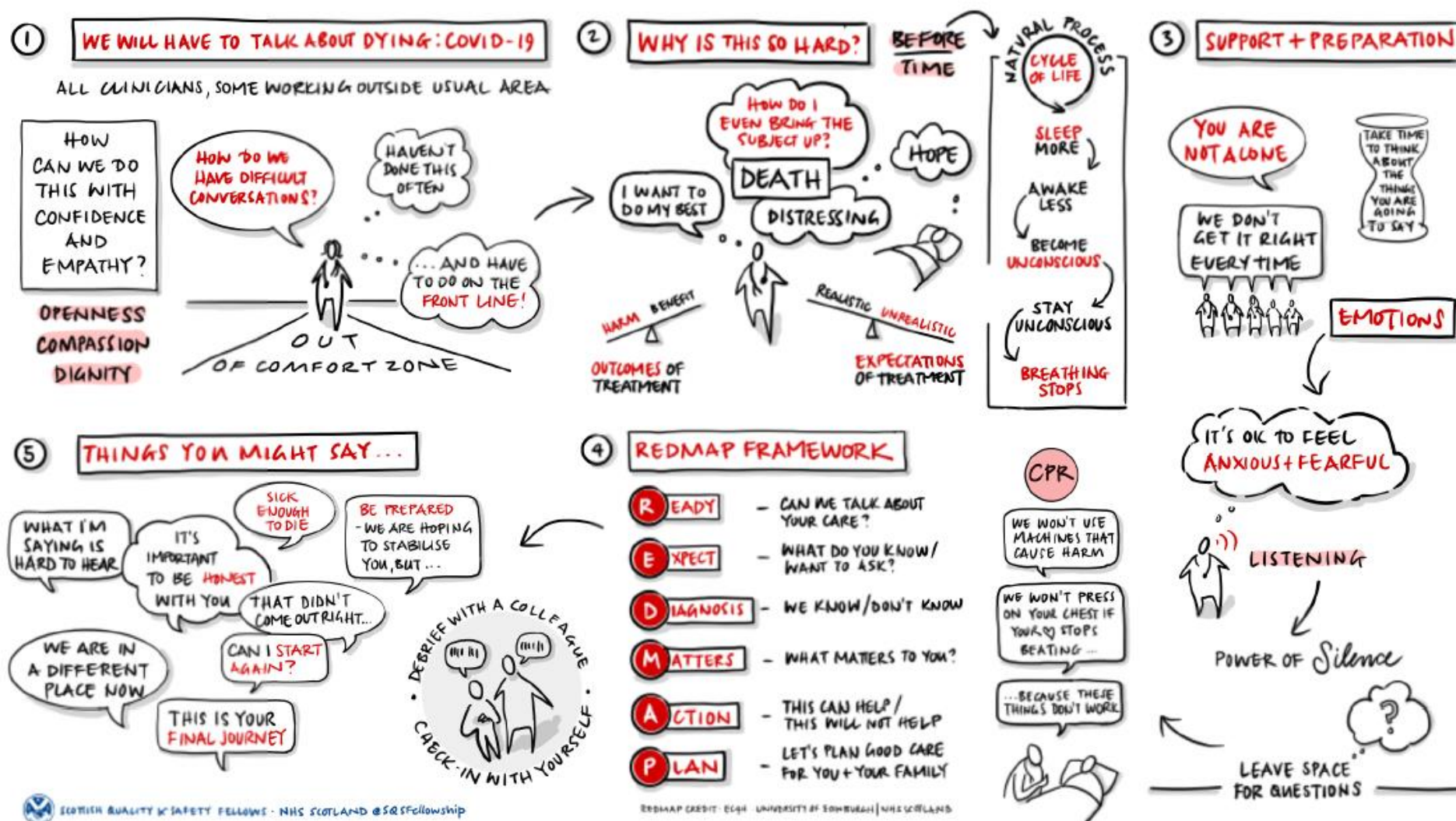
Wearing personal protective equipment also has a negative effect on communication, particularly for those with hearing loss (evident in over 70% of people over 70). This [article](#), written by a deaf neurology registrar and published by the Royal College of Physicians, highlights the issue and some communication tools that can help.

Also see [Top Tips for GPs Caring for Care Homes during COVID](#).

[Also see other resources >](#)



Overview of unwelcome news conversation materials



^ Source: [Unwelcome conversations framework](#)

[Go to recording future wishes during COVID >](#)

Resuscitation decisions

These are clinical decisions to be made on an individual basis, given the individual's circumstances. Blanket Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders should NOT be applied in any circumstances. This is made clear in the [Joint statement on advance care planning](#) from the British Medical Association, Care Provider Alliance, Care Quality Commission and Royal College of GPs.

There is a strong presumption that cardiopulmonary resuscitation (CPR) will be attempted for any person in whom cardiac or respiratory function ceases, unless there is a direct order not to attempt CPR. Where appropriate, having a documented and communicated Do Not Attempt (DNACPR) decision helps to:

- Avoid unwanted or futile CPR where there is no prospect of success
- Reduce unnecessary burden/distress to family and maintain the person's dignity around the time of death

Individuals and their significant others (including those with lasting power of attorney) have no absolute right to insist on treatments that are clinically inappropriate, where there is no realistic

prospect of success. This includes CPR. If a DNACPR decision is made, you should complete the standard form and inform relevant members of the care team. Ensure the detail and rationale for any DNACPR decision is recorded in the patient record, including the details of any discussion with the patient and significant others and when/if the decision will need to be reviewed.



The Resuscitation Council has published [a series of FAQs about Making Resuscitation Decisions](#)

[Also see Other Resources section >](#)

Resuscitation decisions – involving patients and families

You should always give people as much information as they want about their clinical situation. Don't avoid discussing CPR for the sole reason that it may cause them distress or because CPR attempts may be futile. It's important that people have the opportunity to understand what treatments and interventions will and won't be attempted and why.

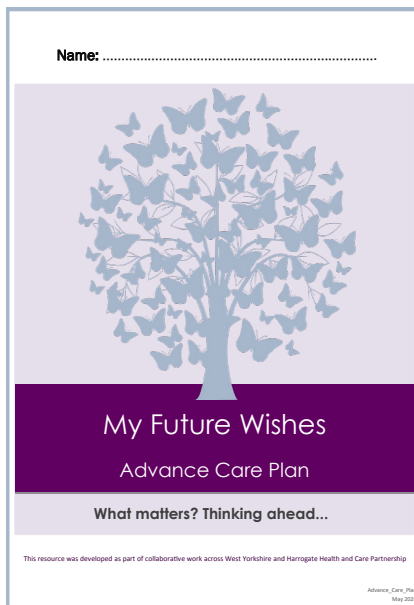
Where individuals or their family are insistent that CPR should be attempted, consider their wishes and try to understand why they hold this view. It may help to give information about likely outcomes, risk and stats ([go to Impact of COVID >](#)) and to point out that other care or treatment will still be given. There may be cultural issues to consider and if disagreements are not resolved, it is good practice to offer the person and their family the opportunity to seek a second opinion.

A DNACPR order is a statement in the patient's notes to the effect that cardiopulmonary resuscitation (CPR) should not be attempted. The theme of this [Top Tips for Clinicians document](#), published by Bradford and Airedale Clinical Commissioning Group, is resuscitation and DNACPR.



How to record future wishes

There are many resources available for people to use to record their future wishes for care. It is also important that these are shared (with their permission) with staff involved in their care.



This document, [My Future Wishes – Advance Care Plan](#) has been developed by health, social care and voluntary sector staff working across WYH ICS. Although this is a generic document, people affected by dementia were involved in the development process. It can be downloaded [here](#).

The final two pages of the document are designed for you to tear off and return to your GP practice so that they're aware of your wishes. With your permission, the practice can record these onto their computer system and share the information with other staff who are involved in your care.





Recording future care wishes during COVID-19

[My COVID-19 Advance Care Plan](#) was launched in Spring 2020. It is designed to help individuals outline their preferences regarding treatment and support, should they develop severe COVID-19 symptoms and need urgent care.

A person with a COVID-19 infection is likely to be separated from the people who usually support or speak for them and COVID-19 may make them too breathless to speak. Documenting their wishes in advance ensures that they will be known to staff, should they contract COVID-19. The document includes: a summary of any underlying health conditions and medication; things that are important to them that they want health and care staff to know; emergency contact details.



An advance care plan should record someone's wishes in a way that is accessible for a healthcare professional called out in an emergency situation. A paper copy should be kept in a prominent place at home or in the care home records (where relevant). And wherever possible, an electronic version should be used which can be shared with relevant services.

Anyone can contract COVID-19 so we should all be thinking about writing our own advance care plan.

[Information for people who want to start their own conversations >](#)

What is an emergency care plan?

An emergency care plan provides concise, relevant, rapidly accessible clinical recommendations for use in an emergency.

Advance care plans and emergency care plans are complementary – they may be developed together or completion of one may prompt consideration of the other.

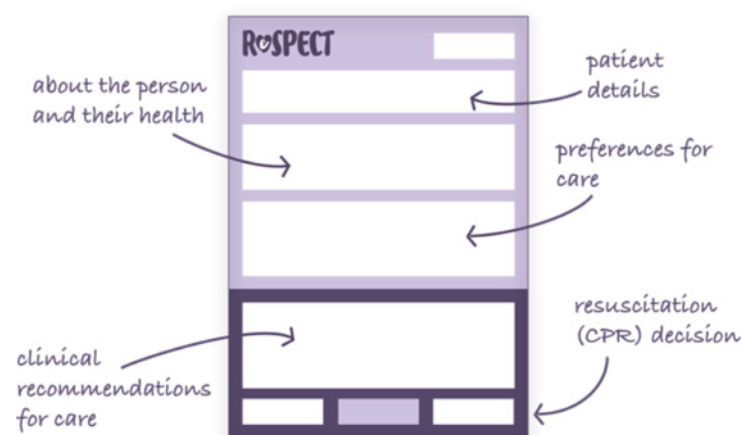
Support and advice from a clinician will be needed to complete an emergency care plan is are likely to be needed for some aspects of an advance care plan too.

One example of an emergency care plan is the national ReSPECT document in use in some areas within West Yorkshire and Harrogate.

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

Find out more at: www.resus.org.uk/respect or watch the film [here](#).

Also see this [explanation of how ReSPECT and advance care planning work together from Leeds Palliative Care Network](#).





Advance Decision to Refuse Treatment

A valid advance decision to refuse treatment (sometimes known as an ADRT):

- Is made by a person aged over 18 years who has capacity at the time to make those decisions
- States specifically what treatment is being refused e.g. CPR, artificial nutrition or hydration – a general statement saying they don't want to be treated isn't enough although it can state that 'all life-sustaining treatment' is refused
- States the circumstance(s) when the treatment is refused e.g. if the person has a heart attack or stroke.

If life-sustaining treatment is being refused, the ADRT must also:

- Be in writing
- State that the advance decision applies even if your life is at risk or shortened as a result of refusing treatment
- Be signed and witnessed.

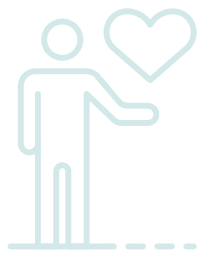
You do not need a solicitor to write an advance decision to refuse treatment.

An advance decision to refuse treatment ONLY applies if:

- The person lacks capacity to make a decision about their medical treatment
- It covers their current circumstances
- It covers the treatments in question
- There's no reason to think that they've changed their mind about what they've written in their advance decision

[This NHS England guide for health and social care professionals explains more about advance decisions to refuse treatment.](#)

For more information, about making a valid advance decision to refuse treatment, visit [Compassion in Dying](#)



Lasting power of attorney (LPA) and cardiopulmonary resuscitation (CPR) decisions

The Mental Capacity Act allows adults over 18 years of age who have capacity to give another person authority to make a decision on their behalf.

A lasting power of attorney is the legal document that allows them to do so. To be valid, the lasting power of attorney must be registered with the Office of the Public Guardian (OPG). The appointed person (attorney) can make health and personal decisions on the patient's behalf once capacity is lost.

If cardiopulmonary resuscitation (CPR) may be able to restart the heart and breathing, and a decision on whether to attempt CPR is based on the balance of benefits and burdens, the attorney's decision must be sought. If the decision being made by the attorney does not appear to be in the patient's best interests, then it may be necessary



to apply to the Court of Protection for declaration as to the patient's best interests.

Where CPR has a limited chance of success and considered clinical judgement is that it would not be of benefit, this should be discussed with the attorney. If the attorney requests that CPR is attempted, in spite of the burdens and risks, or if they are sure that this is what the patient wanted, you should explore the reasons for the request. If, after further discussion, you still consider that attempting CPR would not be of overall benefit for the patient, you are not obliged to offer to attempt CPR in the circumstances envisaged.

You should explain your reasons and any other options that may be available to the legal proxy, including their right to seek a second opinion.

There is more information about lasting power of attorney on the [Dementia UK website](#).

A video explaining the importance of lasting power of attorney is available on [the social care institute for excellence website](#).



Information for patients, families, friends and carers

Many of us don't want to ignore the fact that our time is limited. There are things we want to get sorted out - we may want to talk to those close to us about our feelings for them, what should be done if we become dependent, or what happens to those who are left behind. But these aren't easy subjects to raise. This 4-minute film from Speak Up focuses on [Talking about End of Life Care](#).

The National Council for Palliative Care, the lead charity of Dying Matters, has produced a booklet, '[Planning For Your Future Care](#)'. It provides a simple explanation about advance care planning and the different options open to you.

A series of [five videos](#) recorded by Dr Justin Emery, a palliative care consultant based in Oxford, have been recorded for older people and their families who may be anxious about COVID-19.



[The My Future Wishes Conversation Starter Pack](#) developed as part of the West Yorkshire and Harrogate Health and Care Partnership National Dementia Pilot project has been designed for people who are living with a long-term condition. It helps individuals and families to consider and discuss the issues that are important to them.

The [Which? Guide to Advance Care Planning](#) includes sections on why to plan ahead, how planning ahead makes a difference and how to start planning ahead.

Other resources

There are many resources available for people to use to record their future wishes for care. It is also important that these are shared (with their permission) with staff involved in their care.



The Conversation Game helps people to explore and communicate wishes and preferences for the best possible end of life care.

Fink cards help people to 'start the conversations that matter'

These **Top Tips for Important Conversations** from South Tees Hospital NHS Foundation Trust cover four topic areas: breaking bad news; starting a future care planning discussion; completing a DNACPR form and introducing plans when caring for a dying person.



COVID-ready communication skills from VITALtalk provides 'super-concentrated tips' focused on having conversations during COVID.

Marie Curie has published information for healthcare professionals to support them when **'Talking to someone about dying'**

British Institute of Human Rights - End of life care and human rights

Issues to consider for Muslim families who lose a loved one

GMC Treatment and Care Towards the End of Life: Good Practice in Decision Making

NICE COVID-19 rapid guideline: managing symptoms (including EoL) in the community

Having these conversations can be emotional for us as staff and it's important that we support ourselves and colleagues during this time: **Coping with stress associated with COVID advice to staff.**

Health and social care staff can access the **Apps library** which includes support and information to help staff manage stress and improve wellbeing, sleep management, staying fit and nutrition.



Grief and bereavement support

A new **West Yorkshire and Harrogate Grief and Loss Support Service** has been launched to help people through grief and loss. The practical and emotional support and advice service will be available 7 days a week, from 8am to 8pm.

Telephone support line **0808 196 3833** or www.griefandlosswyh.co.uk

The End of Life Partnership has published a [resource for volunteers](#) supporting people who are self-isolating and also experiencing loss and grief during the COVID pandemic.

One section of the **Cruse Bereavement Support** website focuses specifically on [Coronavirus, bereavement and grief](#).



Resources for care homes and care at home services

A West Yorkshire and Harrogate Health and Care Partnership package of resources has been developed for carers working within care at home services and care homes during the COVID-19 pandemic. The aim is to introduce advance care planning and provide support to help staff develop the skills and confidence to have conversations with clients and residents about their future wishes for care. It can be accessed remotely and at a time to suit the learner.



The package includes:

- One-hour recorded training session, delivered by the education hub leads from St Gemma's Hospice in Leeds and Wakefield Hospice – link to access recording is [here](#)
- Supporting slide pack – available to download [here](#)
- A guide to advance care planning available [here](#)
- More information [here](#)

Also see: [a guide to advance care planning for managers of care homes and home care services](#)





Video and training resources



[Let's talk: information to support planning ahead](#) - four short videos explaining how clinical decisions are made, options for place of care, how to plan when recovery is uncertain and DNACPR decisions.



[E-Learning for Healthcare – Coronavirus resources \(open access\)](#) - within the Coronavirus resources section, you will find: Resources to support staff with difficult conversations and end of life care (open access).



[Royal College of Nursing](#) and [Royal College of General Practitioners videos](#) about having conversations by phone or videocall



[Atul Gawande videos](#) about end of life and late life conversations



A [series of 5 videos](#) by a palliative care consultant, have been recorded for older people and their families who might be anxious about the COVID virus



[An E-learning session](#) to help you to understand the skills required to communicate effectively with individuals and families affected by bereavement, demonstrating empathy and signposting to other services where appropriate.



[Reframing conversations about end of life care from difficult to important](#) – a film with people affected by dementia about why conversations about end of life care are so important



The British Islamic Medical Association has produced a [series of videos](#) in both Arabic and English which cover dying at home, how to cope with bereavement due to COVID and what are palliative care medicines



[A video](#) explaining the importance of Lasting Power of Attorney is available on the social care institute for excellence website.



[A 2-minute video](#) explaining the purpose of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

References

Understanding advance care planning

[Planning For Your Future Care](#)

[Which? Guide to Advance Care Planning](#)

[Guide to Advance Care Planning](#)

COVID-related resources

[Videos from a palliative care consultant](#)

[E-Learning for Healthcare – Coronavirus resources \(open access\)](#)

[COVID-ready communication skills](#)

[Top 10 Tips for GP video consultation during COVID](#)

Having future wishes conversations

[Talking to Someone about Dying \(Marie Curie\)](#)

[How to talk end of life care with a dying patient](#)

[Evidence-based advice for difficult conversations](#)

[Leeds Palliative Care Network ACP 'script' for calling patients](#)

[Unwelcome news conversation materials](#)

[Talking about End of Life Care](#)

[My Future Wishes Conversation Starter Pack](#)

[COVID-ready communication skills](#)

[Having Courageous Conversations by Telephone or Video](#)

[Top Tips for Important Conversations](#)

[Let's talk: information to support planning ahead](#)

[Reframing conversations about end of life care from difficult to important](#)

[Late Life: A Conversation](#)

[Top 10 Tips for GP video consultation during COVID](#)

[Read my lips: the downside of PPE](#)

[Conversation Game](#)

[fink cards](#)

Care homes and home care services

[Top Tips for GPs Caring for Care Homes during COVID](#)

[Advance care planning and conversation skills training](#)

[Guide to Advance Care Planning for managers of care homes and home care services](#)

Resuscitation decisions

[Joint statement on advance care planning](#)

[Top Tips for Clinicians](#)

Recording future wishes

[WYH HCP My Future Wishes – Advance Care Plan](#)

[My COVID-19 Advance Care Plan](#)

Lasting power of attorney

[Dementia UK information](#)

[Importance of Lasting Power of Attorney](#)

ReSPECT

Main website: www.resus.org/respect

[What is ReSPECT video](#)

Resources relating to Black, Asian and minority ethnic groups

[British Islamic Medical Association videos](#) in both Arabic and English

[Issues to consider for Muslim families who lose a loved one](#)

[Religious leaders perceptions of advance care planning](#)

Advance decision to refuse treatment

[NHS England guide to Advance Decisions to Refuse Treatment](#)

[Compassion in Dying](#)

Human rights and end of life care

[British Institute of Human Rights - End of life care and human rights](#)

Clinical guidance

[GMC Treatment and Care Towards the End of Life: Good Practice in Decision Making](#)

[NICE COVID-19 rapid guideline: managing symptoms \(including EoL\) in the community](#)

Coping with stress – resources for staff

[Coping with stress associated with COVID - advice to staff](#)

[Apps library](#)

Grief and Loss Support Service

www.griefandlosswyh.co.uk

[Resource for volunteers](#)

[Coronavirus, bereavement and grief](#)

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